RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 27, 2015

Prospective Vendor(s):

Subject: Solicitation Number: AHCA ITN 002-14/15

Title: Medicaid Third Party Liability

This solicitation is being issued by the State of Florida, Agency for Health Care Administration, hereinafter referred to as "**AHCA**" or "**Agency**", to select a vendor to provide Medicaid Third Party Liability Recovery Services. The solicitation package consists of this transmittal letter and the following attachments:

Attachment	**A**	PUR 1001, State of Florida General Instructions to Respondents
Attachment	**B**	PUR 1000, State of Florida General Contract Conditions
Attachment	**C**	Special Conditions
Attachment	**D**	Scope of Services
Attachment	**E**	Evaluation Criteria
Attachment	**F**	Past Performance – Client Reference Form
Attachment	**G**	Required Certifications
Attachment	**H**	Standard Contract
Attachment	**I**	Certification of Drug-Free Workplace Form
Attachment	**J**	Cost Proposal
Attachment	**K**	Required Statements
Attachment	**L**	Vendor Certification Regarding Scrutinized Companies Lists
Attachment	**M**	Information Technology Security Plan

Your response must comply fully with the instructions that stipulate what is to be included in the response. Prospective vendors submitting a response to this solicitation shall identify the solicitation number, date and time of opening on the envelope transmitting their response. This information is used only to put the AHCA mailroom on notice that the package received is a response to an AHCA solicitation and therefore should not be opened, but delivered directly to the Issuing Officer.

The designated AHCA Issuing Officer for this solicitation is the undersigned. All communications from prospective vendors shall be made in writing and directed to my attention at the address provided in Attachment C, Special Conditions, Section C.5, unless otherwise instructed in the ITN.

The term “response” or “reply” may be used interchangeably and mean the prospective vendor’s submission to this ITN.

Sincerely,

Jennifer Barrett

Jennifer Barrett, Chief
Bureau of Support Services

ATTACHMENT A
State of Florida
PUR 1001
General Instructions to Respondents

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1. Definitions. The definitions found in s. 60A-1.001, F.A.C. shall apply to this agreement. The following additional terms are also defined:

(a) "Buyer" means the entity that has released the solicitation. The "Buyer" may also be the "Customer" as defined in the PUR 1000 if that entity meets the definition of both terms.
(b) "Procurement Officer" means the Buyer's contracting personnel, as identified in the Introductory Materials.
(c) "Respondent" means the entity that submits materials to the Buyer in accordance with these Instructions.
(d) "Response" means the material submitted by the respondent in answering the solicitation.
(e) "Timeline" means the list of critical dates and actions included in the Introductory Materials.

2. General Instructions. Potential respondents to the solicitation are encouraged to carefully review all the materials contained herein and prepare responses accordingly.

3. Electronic Submission of Responses. Respondents are required to submit responses electronically. For this purpose, all references herein to signatures, signing requirements, or other required acknowledgments hereby include electronic signature by means of clicking the "Submit Response" button (or other similar symbol or process) attached to or logically associated with the response created by the respondent within MyFloridaMarketPlace. The respondent agrees that the action of electronically submitting its response constitutes:

- an electronic signature on the response, generally,
- an electronic signature on any form or section specifically calling for a signature, and
- an affirmative agreement to any statement contained in the solicitation that requires a definite confirmation or acknowledgement.

4. Terms and Conditions. All responses are subject to the terms of the following sections of this solicitation, which, in case of conflict, shall have the order of precedence listed:

- Technical Specifications,
- Special Conditions and Instructions,
- Instructions to Respondents (PUR 1001),
- General Conditions (PUR 1000), and
- Introductory Materials.

The Buyer objects to and shall not consider any additional terms or conditions submitted by a respondent, including any appearing in documents attached as part of a respondent's response. In submitting its response, a respondent agrees that any additional terms or conditions, whether submitted intentionally or inadvertently, shall have no force or effect. Failure to comply with terms and conditions, including those specifying information that must be submitted with a response, shall be grounds for rejecting a response.

5. Questions. Respondents shall address all questions regarding this solicitation to the Procurement Officer. Questions must be submitted via the Q&A Board within MyFloridaMarketPlace and must be RECEIVED NO LATER THAN the time and date reflected on the Timeline. Questions shall be answered in accordance with the Timeline. All questions submitted shall be published and answered in a manner that all respondents will be able to view. Respondents shall not contact any other employee of the Buyer or the State for information with respect to this solicitation. Each respondent is responsible for monitoring the MyFloridaMarketPlace site for new or changing information. The Buyer shall not be bound by any verbal information or by any written information that is not contained within the solicitation documents or formally noticed and issued by the Buyer's contracting personnel. Questions to the Procurement Officer or to any Buyer personnel shall not constitute formal protest of the specifications or of the solicitation, a process addressed in paragraph 19 of these Instructions.

6. Conflict of Interest. This solicitation is subject to chapter 112 of the Florida Statutes. Respondents shall disclose with their response the name of any officer, director, employee or other agent who is also an employee of the State. Respondents shall also disclose the name of any State employee who owns, directly or indirectly, an interest of five percent (5%) or more in the respondent or its affiliates.

7. Convicted Vendors. A person or affiliate placed on the convicted vendor list following a conviction for a public entity crime is prohibited from doing any of the following for a period of 36 months from the date of being placed on the convicted vendor list:

- submitting a bid on a contract to provide any goods or services to a public entity;
- submitting a bid on a contract with a public entity for the construction or repair of a public building or public work;

- submitting bids on leases of real property to a public entity;
- being awarded or performing work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and
- transacting business with any public entity in excess of the Category Two threshold amount ($25,000) provided in section 287.017 of the Florida Statutes.

8. Discriminatory Vendors. An entity or affiliate placed on the discriminatory vendor list pursuant to section 287.134 of the Florida Statutes may not:

- submit a bid on a contract to provide any goods or services to a public entity;
- submit a bid on a contract with a public entity for the construction or repair of a public building or public work;
- submit bids on leases of real property to a public entity;
- be awarded or perform work as a contractor, supplier, sub-contractor, or consultant under a contract with any public entity; or
- transact business with any public entity.

9. Respondent's Representation and Authorization. In submitting a response, each respondent understands, represents, and acknowledges the following (if the respondent cannot so certify to any of following, the respondent shall submit with its response a written explanation of why it cannot do so).

- The respondent is not currently under suspension or debarment by the State or any other governmental authority.
- To the best of the knowledge of the person signing the response, the respondent, its affiliates, subsidiaries, directors, officers, and employees are not currently under investigation by any governmental authority and have not in the last ten (10) years been convicted or found liable for any act prohibited by law in any jurisdiction, involving conspiracy or collusion with respect to bidding on any public contract.
- Respondent currently has no delinquent obligations to the State, including a claim by the State for liquidated damages under any other contract.
- The submission is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive response.
- The prices and amounts have been arrived at independently and without consultation, communication, or agreement with any other respondent or potential respondent; neither the prices nor amounts, actual or approximate, have been disclosed to any respondent or potential respondent, and they will not be disclosed before the solicitation opening.
- The respondent has fully informed the Buyer in writing of all convictions of the firm, its affiliates (as defined in section 287.133(1)(a) of the Florida Statutes), and all directors, officers, and employees of the firm and its affiliates for violation of state or federal antitrust laws with respect to a public contract for violation of any state or federal law involving fraud, bribery, collusion, conspiracy or material misrepresentation with respect to a public contract. This includes disclosure of the names of current employees who were convicted of contract crimes while in the employ of another company.
- Neither the respondent nor any person associated with it in the capacity of owner, partner, director, officer, principal, investigator, project director, manager, auditor, or position involving the administration of federal funds:
  - Has within the preceding three years been convicted of or had a civil judgment rendered against them or is presently indicted for or otherwise criminally or civilly charged for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state, or local government transaction or public contract; violation of federal or state antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; or
  - Has within a three-year period preceding this certification had one or more federal, state, or local government contracts terminated for cause or default.
- The product offered by the respondent will conform to the specifications without exception.
- The respondent has read and understands the Contract terms and conditions, and the submission is made in conformance with those terms and conditions.
- If an award is made to the respondent, the respondent agrees that it intends to be legally bound to the Contract that is formed with the State.
- The respondent has made a diligent inquiry of its employees and agents responsible for preparing, approving, or submitting the response, and has been advised by each of them that he or she has not participated in any communication, consultation, discussion, agreement, collusion, act or other conduct inconsistent with any of the statements and representations made in the response.
- The respondent shall indemnify, defend, and hold harmless the Buyer and its employees against any cost, damage, or expense which may be incurred or be caused by any error in the respondent's preparation of its bid.
- All information provided by, and representations made by, the respondent are material and important and will be relied upon by the Buyer in awarding the Contract. Any misstatement shall be treated as fraudulent concealment from the Buyer of the true facts

relating to submission of the bid. A misrepresentation shall be punishable under law, including, but not limited to, Chapter 817 of the Florida Statutes.

10. Manufacturer's Name and Approved Equivalents. Unless otherwise specified, any manufacturers' names, trade names, brand names, information or catalog numbers listed in a specification are descriptive, not restrictive. With the Buyer's prior approval, the Contractor may provide any product that meets or exceeds the applicable specifications. The Contractor shall demonstrate comparability, including appropriate catalog materials, literature, specifications, test data, etc. The Buyer shall determine in its sole discretion whether a product is acceptable as an equivalent.

11. Performance Qualifications. The Buyer reserves the right to investigate or inspect at any time whether the product, qualifications, or facilities offered by Respondent meet the Contract requirements. Respondent shall at all times during the Contract term remain responsive and responsible. In determining Respondent's responsibility as a vendor, the agency shall consider all information or evidence which is gathered or comes to the attention of the agency which demonstrates the Respondent's capability to fully satisfy the requirements of the solicitation and the contract.

Respondent must be prepared, if requested by the Buyer, to present evidence of experience, ability, and financial standing, as well as a statement as to plant, machinery, and capacity of the respondent for the production, distribution, and servicing of the product bid. If the Buyer determines that the conditions of the solicitation documents are not complied with, or that the product proposed to be furnished does not meet the specified requirements, or that the qualifications, financial standing, or facilities are not satisfactory, or that performance is untimely, the Buyer may reject the response or terminate the Contract. Respondent may be disqualified from receiving awards if respondent, or anyone in respondent's employment, has previously failed to perform satisfactorily in connection with public bidding or contracts. This paragraph shall not mean or imply that it is obligatory upon the Buyer to make an investigation either before or after award of the Contract, but should the Buyer elect to do so, respondent is not relieved from fulfilling all Contract requirements.

12. Public Opening. Responses shall be opened on the date and at the location indicated on the Timeline. Respondents may, but are not required to, attend. The Buyer may choose not to announce prices or release other materials pursuant to s. 119.071(1)(b), Florida Statutes. Any person requiring a special accommodation because of a disability should contact the Procurement Officer at least five (5) workdays prior to the solicitation opening. If you are hearing or speech impaired, please contact the Buyer by using the Florida Relay Service at (800) 955-8771 (TDD).

13. Electronic Posting of Notice of Intended Award. Based on the evaluation, on the date indicated on the Timeline the Buyer shall electronically post a notice of intended award at http://fcn.state.fl.us/owa_vbs/owa/vbs_www.main_menu. If the notice of award is delayed, in lieu of posting the notice of intended award the Buyer shall post a notice of the delay and a revised date for posting the notice of intended award. Any person who is adversely affected by the decision shall file with the Buyer a notice of protest within 72 hours after the electronic posting. The Buyer shall not provide tabulations or notices of award by telephone.

14. Firm Response. The Buyer may make an award within sixty (60) days after the date of the opening, during which period responses shall remain firm and shall not be withdrawn. If award is not made within sixty (60) days, the response shall remain firm until either the Buyer awards the Contract or the Buyer receives from the respondent written notice that the response is withdrawn. Any response that expresses a shorter duration may, in the Buyer's sole discretion, be accepted or rejected.

15. Clarifications/Revisions. Before award, the Buyer reserves the right to seek clarifications or request any information deemed necessary for proper evaluation of submissions from all respondents deemed eligible for Contract award. Failure to provide requested information may result in rejection of the response.

16. Minor Irregularities/Right to Reject. The Buyer reserves the right to accept or reject any and all bids, or separable portions thereof, and to waive any minor irregularity, technicality, or omission if the Buyer determines that doing so will serve the State's best interests. The Buyer may reject any response not submitted in the manner specified by the solicitation documents.

17. Contract Formation. The Buyer shall issue a notice of award, if any, to successful respondent(s), however, no contract shall be formed between respondent and the Buyer until the Buyer signs the Contract. The Buyer shall not be liable for any costs incurred by a respondent in preparing or producing its response or for any work performed before the Contract is effective.

18. Contract Overlap. Respondents shall identify any products covered by this solicitation that they are currently authorized to furnish under any state term contract. By entering into the Contract, a Contractor authorizes the Buyer to eliminate duplication between agreements in the manner the Buyer deems to be in its best interest.

19. Public Records. Article 1, section 24, Florida Constitution, guarantees every person access to all public records, and Section 119.011, Florida Statutes, provides a broad definition of public record. As such, all responses to a competitive solicitation are public records unless exempt by law. Any respondent claiming that its response contains information that is exempt from the public records law shall clearly segregate and mark that information and provide the specific statutory citation for such exemption.

20. Protests. Any protest concerning this solicitation shall be made in accordance with sections 120.57(3)

and 287.042(2) of the Florida Statutes and chapter 28-110 of the Florida Administrative Code. Questions to the Procurement Officer shall not constitute formal notice of a protest. It is the Buyer's intent to ensure that specifications are written to obtain the best value for the State and that specifications are written to ensure competitiveness, fairness, necessity and reasonableness in the solicitation process.

Section 120.57(3)(b), F.S. and Section 28-110.003, Fla. Admin. Code require that a notice of protest of the solicitation documents shall be made within seventy-two hours after the posting of the solicitation.

Section 120.57(3)(a), F.S. requires the following statement to be included in the solicitation: "Failure to file a protest within the time prescribed in section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes."

Section 28-110.005, Fla. Admin. Code requires the following statement to be included in the solicitation: "Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes."

21. Limitation on Vendor Contact with Agency During Solicitation Period. Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.

ATTACHMENT B
State of Florida
PUR 1000
General Contract Conditions

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1. Definitions. The definitions contained in s. 60A-1.001, F.A.C. shall apply to this agreement. The following additional terms are also defined:

(a) "Contract" means the legally enforceable agreement that results from a successful solicitation. The parties to the Contract will be the Customer and Contractor.

(b) "Customer" means the State agency or other entity identified in a contract as the party to receive commodities or contractual services pursuant to a contract or that orders commodities or contractual services via purchase order or other contractual instrument from the Contractor under the Contract. The "Customer" may also be the "Buyer" as defined in the PUR 1001 if it meets the definition of both terms.

(c) "Product" means any deliverable under the Contract, which may include commodities, services, technology or software.

(d) "Purchase order" means the form or format a Customer uses to make a purchase under the Contract (e.g., a formal written purchase order, electronic purchase order, procurement card, contract or other authorized means).

2. Purchase Orders. In contracts where commodities or services are ordered by the Customer via purchase order, Contractor shall not deliver or furnish products until a Customer transmits a purchase order. All purchase orders shall bear the Contract or solicitation number, shall be placed by the Customer directly with the Contractor, and shall be deemed to incorporate by reference the Contract and solicitation terms and conditions. Any discrepancy between the Contract terms and the terms stated on the Contractor's order form, confirmation, or acknowledgement shall be resolved in favor of terms most favorable to the Customer. A purchase order for services within the ambit of section 287.058(1) of the Florida Statutes shall be deemed to incorporate by reference the requirements of subparagraphs (a) through (f) thereof. Customers shall designate a contract manager and a contract administrator as required by subsections 287.057(15) and (16) of the Florida Statutes.

3. Product Version. Purchase orders shall be deemed to reference a manufacturer's most recently release model or version of the product at the time of the order, unless the Customer specifically requests in writing an earlier model or version and the contractor is willing to provide such model or version.

4. Price Changes Applicable only to Term Contracts. If this is a term contract for commodities or services, the following provisions apply.

(a) Quantity Discounts. Contractors are urged to offer additional discounts for one time delivery of large single orders. Customers should seek to negotiate additional price concessions on quantity purchases of any products offered under the Contract. State Customers shall document their files accordingly.

(b) Best Pricing Offer. During the Contract term, if the Customer becomes aware of better pricing offered by the Contractor for substantially the same or a smaller quantity of a product outside the Contract, but upon the same or similar terms of the Contract, then at the discretion of the Customer the price under the Contract shall be immediately reduced to the lower price.

(c) Sales Promotions. In addition to decreasing prices for the balance of the Contract term due to a change in market conditions, a Contractor may conduct sales promotions involving price reductions for a specified lesser period. A Contractor shall submit to the Contract Specialist documentation identifying the proposed (1) starting and ending dates of the promotion, (2) products

involved, and (3) promotional prices compared to then-authorized prices. Promotional prices shall be available to all Customers. Upon approval, the Contractor shall provide conspicuous notice of the promotion.

(d) Trade-In. Customers may trade-in equipment when making purchases from the Contract. A trade-in shall be negotiated between the Customer and the Contractor. Customers are obligated to actively seek current fair market value when trading equipment, and to keep accurate records of the process. For State agencies, it may be necessary to provide documentation to the Department of Financial Services and to the agency property custodian pursuant to Chapter 273, F.S.

(e) Equitable Adjustment. The Customer may, in its sole discretion, make an equitable adjustment in the Contract terms or pricing if pricing or availability of supply is affected by extreme and unforeseen volatility in the marketplace, that is, by circumstances that satisfy all the following criteria: (1) the volatility is due to causes wholly beyond the Contractor's control, (2) the volatility affects the marketplace or industry, not just the particular Contract source of supply, (3) the effect on pricing or availability of supply is substantial, and (4) the volatility so affects the Contractor that continued performance of the Contract would result in a substantial loss.

5. Additional Quantities. For a period not exceeding ninety (90) days from the date of solicitation award, the Customer reserves the right to acquire additional quantities up to the amount shown on the solicitation but not to exceed the threshold for Category Two at the prices submitted in the response to the solicitation.

6. Packaging. Tangible product shall be securely and properly packed for shipment, storage, and stocking in appropriate, clearly labeled, shipping containers and according to accepted commercial practice, without extra charge for packing materials, cases, or other types of containers. All containers and packaging shall become and remain Customer's property.

7. Inspection at Contractor's Site. The Customer reserves the right to inspect, at any reasonable time with prior notice, the equipment or product or plant or other facilities of a Contractor to assess conformity with Contract requirements and to determine whether they are adequate and suitable for proper and effective Contract performance.

8. Safety Standards. All manufactured items and fabricated assemblies subject to operation under pressure, operation by connection to an electric source, or operation involving connection to a manufactured, natural, or LP gas source shall be constructed and approved in a manner acceptable to the appropriate State inspector. Acceptability customarily requires, at a minimum, identification marking of the appropriate safety standard organization, where such approvals of listings have been established for the type of device offered and furnished, for example: the American Society of Mechanical Engineers for pressure vessels; the Underwriters Laboratories and/or National Electrical Manufacturers' Association for electrically operated assemblies; and the American Gas Association for gas-operated assemblies. In addition, all items furnished shall meet all applicable requirements of the Occupational Safety and Health Act and state and federal requirements relating to clean air and water pollution.

9. Americans with Disabilities Act. Contractors should identify any products that may be used or adapted for use by visually, hearing, or other physically impaired individuals.

10. Literature. Upon request, the Contractor shall furnish literature reasonably related to the product offered, for example, user manuals, price schedules, catalogs, descriptive brochures, etc.

11. Transportation and Delivery. Prices shall include all charges for packing, handling, freight, distribution, and inside delivery. Transportation of goods shall be FOB Destination to any point within thirty (30) days after the Customer places an Order. A Contractor, within five (5) days after receiving a purchase order, shall notify the Customer of any potential delivery delays. Evidence of inability or intentional delays shall be cause for Contract cancellation and Contractor suspension.

12. Installation. Where installation is required, Contractor shall be responsible for placing and installing the product in the required locations at no additional charge, unless otherwise designated on the Contract or purchase order. Contractor's authorized product and price list shall clearly and separately identify any additional installation charges. All materials used in the installation shall be of good quality and shall be free of defects that would diminish the appearance of the product or render it structurally or operationally unsound. Installation includes the furnishing of any equipment, rigging, and materials required to install or replace the product in the proper location. Contractor shall protect the site from damage and shall repair damages or injury caused during installation by Contractor or its employees or agents. If any alteration, dismantling, excavation, etc., is required to achieve installation, the Contractor shall promptly restore the structure or site to its original condition. Contractor shall perform installation work so as to cause the least inconvenience and interference with Customers and with proper consideration of others on site. Upon completion of the installation, the location and surrounding area of work shall be left clean and in a neat and unobstructed condition, with everything in satisfactory repair and order.

13. Risk of Loss. Matters of inspection and acceptance are addressed in s. 215.422, F.S. Until acceptance, risk of loss or damage shall remain with the Contractor. The Contractor shall be responsible for filing, processing, and collecting all damage claims. To assist the Contractor with damage claims, the Customer shall: record any evidence of visible damage on all copies of the delivering carrier's Bill of Lading; report damages to the carrier and the Contractor; and provide the Contractor with a copy of the carrier's Bill of Lading and damage inspection report. When a Customer rejects a product, Contractor shall remove it from the premises within ten days after notification or rejection. Upon rejection notification, the risk of loss of rejected or non-conforming product shall remain with the Contractor. Rejected product not removed by the

Contractor within ten days shall be deemed abandoned by the Contractor, and the Customer shall have the right to dispose of it as its own property. Contractor shall reimburse the Customer for costs and expenses incurred in storing or effecting removal or disposition of rejected product.

14. Transaction Fee. The State of Florida has instituted MyFloridaMarketPlace, a statewide eProcurement System ("System"). Pursuant to section 287.057(23), Florida Statutes (2002), all payments shall be assessed a Transaction Fee of one percent (1.0%), which the Contractor shall pay to the State, unless exempt pursuant to 60A-1.032, F.A.C.

For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the Contractor. If automatic deduction is not possible, the Contractor shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), F.A.C. By submission of these reports and corresponding payments, Contractor certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee.

Contractor shall receive a credit for any Transaction Fee paid by the Contractor for the purchase of any item(s) if such item(s) are returned to the Contractor through no fault, act, or omission of the Contractor. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the Contractor's failure to perform or comply with specifications or requirements of the agreement.

Failure to comply with these requirements shall constitute grounds for declaring the Contractor in default and recovering reprocurement costs from the Contractor in addition to all outstanding fees. **CONTRACTORS DELINQUENT IN PAYING TRANSACTION FEES MAY BE SUBJECT TO BEING REMOVED FROM THE DEPARTMENT OF MANAGEMENT SERVICES' VENDOR LIST AS PROVIDED IN RULE 60A-1.006, F.A.C.**

15. Invoicing and Payment. Invoices shall contain the Contract number, purchase order number if applicable, and the appropriate vendor identification number. The State may require any other information from the Contractor that the State deems necessary to verify any purchase order placed under the Contract.

At the State's option, Contractors may be required to invoice electronically pursuant to guidelines of the Department of Management Services. Current guidelines require that Contractor supply electronic invoices in lieu of paper-based invoices for those transactions processed through the system. Electronic invoices shall be submitted to the Customer through the Ariba Supplier Network (ASN) in one of the following mechanisms – EDI 810, cXML, or web-based invoice entry within the ASN.

Payment shall be made in accordance with sections 215.422 and 287.0585 of the Florida Statutes, which govern time limits for payment of invoices. Invoices that must be returned to a Contractor due to preparation errors will result in a delay in payment. Contractors may call (850) 413-7269 Monday through Friday to inquire about the status of payments by State Agencies. The Customer is responsible for all payments under the Contract. A Customer's failure to pay, or delay in payment, shall not constitute a breach of the Contract and shall not relieve the Contractor of its obligations to the Department or to other Customers.

16. Taxes. The State does not pay Federal excise or sales taxes on direct purchases of tangible personal property. The State will not pay for any personal property taxes levied on the Contractor or for any taxes levied on employees' wages. Any exceptions to this paragraph shall be explicitly noted by the Customer in the special contract conditions section of the solicitation or in the Contract or purchase order.

17. Governmental Restrictions. If the Contractor believes that any governmental restrictions have been imposed that require alteration of the material, quality, workmanship or performance of the products offered under the Contract, the Contractor shall immediately notify the Customer in writing, indicating the specific restriction. The Customer reserves the right and the complete discretion to accept any such alteration or to cancel the Contract at no further expense to the Customer.

18. Lobbying and Integrity. Customers shall ensure compliance with Section 11.062, FS and Section 216.347, FS.The Contractor shall not, in connection with this or any other agreement with the State, directly or indirectly (1) offer, confer, or agree to confer any pecuniary benefit on anyone as consideration for any State officer or employee's decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty, or (2) offer, give, or agree to give to anyone any gratuity for the benefit of, or at the direction or request of, any State officer or employee. For purposes of clause (2), "gratuity" means any payment of more than nominal monetary value in the form of cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. Upon request of the Customer's Inspector General, or other authorized State official, the Contractor shall provide any type of information the Inspector General deems relevant to the Contractor's integrity or responsibility. Such information may include, but shall not be limited to, the Contractor's business or financial records, documents, or files of any type or form that refer to or relate to the Contract. The Contractor shall retain such records for the longer of (1) three years after the expiration of the Contract or (2) the period required by the General Records Schedules maintained by the Florida Department of State (available at: http://dlis.dos.state.fl.us/barm/genschedules/gensched.htm). The Contractor agrees to reimburse the State for the reasonable costs of investigation incurred by the Inspector General or other authorized State official for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the State which results in the suspension or debarment of the Contractor. Such costs shall include, but shall not be limited to: salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Contractor shall not be responsible for any costs of investigations that do not result in the Contractor's suspension or debarment.

19. Indemnification. The Contractor shall be fully liable for the actions of its agents, employees, partners, or subcontractors and shall fully indemnify, defend, and

hold harmless the State and Customers, and their officers, agents, and employees, from suits, actions, damages, and costs of every name and description, including attorneys' fees, arising from or relating to personal injury and damage to real or personal tangible property alleged to be caused in whole or in part by Contractor, its agents, employees, partners, or subcontractors, provided, however, that the Contractor shall not indemnify for that portion of any loss or damages proximately caused by the negligent act or omission of the State or a Customer.

Further, the Contractor shall fully indemnify, defend, and hold harmless the State and Customers from any suits, actions, damages, and costs of every name and description, including attorneys' fees, arising from or relating to violation or infringement of a trademark, copyright, patent, trade secret or intellectual property right, provided, however, that the foregoing obligation shall not apply to a Customer's misuse or modification of Contractor's products or a Customer's operation or use of Contractor's products in a manner not contemplated by the Contract or the purchase order. If any product is the subject of an infringement suit, or in the Contractor's opinion is likely to become the subject of such a suit, the Contractor may at its sole expense procure for the Customer the right to continue using the product or to modify it to become non-infringing. If the Contractor is not reasonably able to modify or otherwise secure the Customer the right to continue using the product, the Contractor shall remove the product and refund the Customer the amounts paid in excess of a reasonable rental for past use. The customer shall not be liable for any royalties.

The Contractor's obligations under the preceding two paragraphs with respect to any legal action are contingent upon the State or Customer giving the Contractor (1) written notice of any action or threatened action, (2) the opportunity to take over and settle or defend any such action at Contractor's sole expense, and (3) assistance in defending the action at Contractor's sole expense. The Contractor shall not be liable for any cost, expense, or compromise incurred or made by the State or Customer in any legal action without the Contractor's prior written consent, which shall not be unreasonably withheld.

20. Limitation of Liability. For all claims against the Contractor under any contract or purchase order, and regardless of the basis on which the claim is made, the Contractor's liability under a contract or purchase order for direct damages shall be limited to the greater of $100,000, the dollar amount of the contract or purchase order, or two times the charges rendered by the Contractor under the purchase order. This limitation shall not apply to claims arising under the Indemnity paragraph contain in this agreement.

Unless otherwise specifically enumerated in the Contract or in the purchase order, no party shall be liable to another for special, indirect, punitive, or consequential damages, including lost data or records (unless the contract or purchase order requires the Contractor to back-up data or records), even if the party has been advised that such damages are possible. No party shall be liable for lost profits, lost revenue, or lost institutional operating savings. The State and Customer may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them. The State may set off any liability or other obligation of the Contractor or its affiliates to the State against any payments due the Contractor under any contract with the State.

21. Suspension of Work. The Customer may in its sole discretion suspend any or all activities under the Contract or purchase order, at any time, when in the best interests of the State to do so. The Customer shall provide the Contractor written notice outlining the particulars of suspension. Examples of the reason for suspension include, but are not limited to, budgetary constraints, declaration of emergency, or other such circumstances. After receiving a suspension notice, the Contractor shall comply with the notice and shall not accept any purchase orders. Within ninety days, or any longer period agreed to by the Contractor, the Customer shall either (1) issue a notice authorizing resumption of work, at which time activity shall resume, or (2) terminate the Contract or purchase order. Suspension of work shall not entitle the Contractor to any additional compensation.

22. Termination for Convenience. The Customer, by written notice to the Contractor, may terminate the Contract in whole or in part when the Customer determines in its sole discretion that it is in the State's interest to do so. The Contractor shall not furnish any product after it receives the notice of termination, except as necessary to complete the continued portion of the Contract, if any. The Contractor shall not be entitled to recover any cancellation charges or lost profits.

23. Termination for Cause. The Customer may terminate the Contract if the Contractor fails to (1) deliver the product within the time specified in the Contract or any extension, (2) maintain adequate progress, thus endangering performance of the Contract, (3) honor any term of the Contract, or (4) abide by any statutory, regulatory, or licensing requirement. Rule 60A-1.006(3), F.A.C., governs the procedure and consequences of default. The Contractor shall continue work on any work not terminated. Except for defaults of subcontractors at any tier, the Contractor shall not be liable for any excess costs if the failure to perform the Contract arises from events completely beyond the control, and without the fault or negligence, of the Contractor. If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is completely beyond the control of both the Contractor and the subcontractor, and without the fault or negligence of either, the Contractor shall not be liable for any excess costs for failure to perform, unless the subcontracted products were obtainable from other sources in sufficient time for the Contractor to meet the required delivery schedule. If, after termination, it is determined that the Contractor was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Customer. The rights and remedies of the Customer in this clause are in addition to any other rights and remedies provided by law or under the Contract.

24. Force Majeure, Notice of Delay, and No Damages for Delay. The Contractor shall not be responsible for delay resulting from its failure to perform if neither the fault nor the negligence of the Contractor or its employees or agents contributed to the delay and the delay is due directly to acts of God, wars, acts of public enemies, strikes, fires, floods, or other similar cause wholly beyond the Contractor's control, or for any of the foregoing that affect subcontractors or suppliers if no alternate source of supply is available to the Contractor. In case of any delay the Contractor believes is excusable, the Contractor shall notify the Customer in writing of the delay or potential delay and describe the cause of the delay either (1) within ten (10) days after the cause that creates or will create the delay first arose, if the Contractor could reasonably foresee that a delay could occur as a result, or (2) if delay is not reasonably foreseeable, within five (5) days after the date the Contractor first had reason to believe that a delay could result. **THE FOREGOING SHALL CONSTITUTE THE CONTRACTOR'S SOLE REMEDY OR EXCUSE WITH RESPECT TO DELAY.** Providing notice in strict accordance with this paragraph is a condition precedent to such remedy. No claim for damages, other than for an extension of time, shall be asserted against the Customer. The Contractor shall not be entitled to an increase in the Contract price or payment of any kind from the Customer for direct, indirect, consequential, impact or other costs, expenses or damages, including but not limited to costs of acceleration or inefficiency, arising because of delay, disruption, interference, or hindrance from any cause whatsoever. If performance is suspended or delayed, in whole or in part, due to any of the causes described in this paragraph, after the causes have ceased to exist the Contractor shall perform at no increased cost, unless the Customer determines, in its sole discretion, that the delay will significantly impair the value of the Contract to the State or to Customers, in which case the Customer may (1) accept allocated performance or deliveries from the Contractor, provided that the Contractor grants preferential treatment to Customers with respect to products subjected to allocation, or (2) purchase from other sources (without recourse to and by the Contractor for the related costs and expenses) to replace all or part of the products that are the subject of the delay, which purchases may be deducted from the Contract quantity, or (3) terminate the Contract in whole or in part.

25. Changes. The Customer may unilaterally require, by written order, changes altering, adding to, or deducting from the Contract specifications, provided that such changes are within the general scope of the Contract. The Customer may make an equitable adjustment in the Contract price or delivery date if the change affects the cost or time of performance. Such equitable adjustments require the written consent of the Contractor, which shall not be unreasonably withheld. If unusual quantity requirements arise, the Customer may solicit separate bids to satisfy them.

26. Renewal. Upon mutual agreement, the Customer and the Contractor may renew the Contract, in whole or in part, for a period that may not exceed 3 years or the term of the contract, whichever period is longer. Any renewal shall specify the renewal price, as set forth in the solicitation response. The renewal must be in writing and signed by both parties, and is contingent upon satisfactory performance evaluations and subject to availability of funds.

27. Purchase Order Duration. Purchase orders issued pursuant to a state term or agency contract must be received by the Contractor no later than close of business on the last day of the contract's term to be considered timely. The Contractor is obliged to fill those orders in accordance with the contract's terms and conditions. Purchase orders received by the contractor after close of business on the last day of the state term or agency contract's term shall be considered void.

Purchase orders for a one-time delivery of commodities or performance of contractual services shall be valid through the performance by the Contractor, and all terms and conditions of the state term or agency contract shall apply to the single delivery/performance, and shall survive the termination of the Contract.

Contractors are required to accept purchase orders specifying delivery schedules exceeding the contracted schedule even when such extended delivery will occur after expiration of the state term or agency contract. For example, if a state term contract calls for delivery 30 days after receipt of order (ARO), and an order specifies delivery will occur both in excess of 30 days ARO and after expiration of the state term contract, the Contractor will accept the order. However, if the Contractor expressly and in writing notifies the ordering office within ten (10) calendar days of receipt of the purchase order that Contractor will not accept the extended delivery terms beyond the expiration of the state term contract, then the purchase order will either be amended in writing by the ordering entity within ten (10) calendar days of receipt of the contractor's notice to reflect the state term contract delivery schedule, or it shall be considered withdrawn.

The duration of purchase orders for recurring deliveries of commodities or performance of services shall not exceed the expiration of the state term or agency contract by more than twelve months. However, if an extended pricing plan offered in the state term or agency contract is selected by the ordering entity, the contract terms on pricing plans and renewals shall govern the maximum duration of purchase orders reflecting such pricing plans and renewals.

Timely purchase orders shall be valid through their specified term and performance by the Contractor, and all terms and conditions of the state term or agency contract shall apply to the recurring delivery/performance as provided herein, and shall survive the termination of the Contract.

Ordering offices shall not renew a purchase order issued pursuant to a state term or agency contract if the underlying contract expires prior to the effective date of the renewal.

28. Advertising. Subject to Chapter 119, Florida Statutes, the Contractor shall not publicly disseminate any information concerning the Contract without prior written approval from the Customer, including, but not limited to mentioning the Contract in a press release or other promotional material, identifying the Customer or the State as a reference, or otherwise linking the Contractor's name and either a description of the

Contract or the name of the State or the Customer in any material published, either in print or electronically, to any entity that is not a party to Contract, except potential or actual authorized distributors, dealers, resellers, or service representative.

29. Assignment. The Contractor shall not sell, assign or transfer any of its rights, duties or obligations under the Contract, or under any purchase order issued pursuant to the Contract, without the prior written consent of the Customer. In the event of any assignment, the Contractor remains secondarily liable for performance of the contract, unless the Customer expressly waives such secondary liability. The Customer may assign the Contract with prior written notice to Contractor of its intent to do so.

30. Antitrust Assignment. The Contractor and the State of Florida recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Florida. Therefore, the contractor hereby assigns to the State of Florida any and all claims for such overcharges as to goods, materials or services purchased in connection with the Contract.

31. Dispute Resolution. Any dispute concerning performance of the Contract shall be decided by the Customer's designated contract manager, who shall reduce the decision to writing and serve a copy on the Contractor. The decision shall be final and conclusive unless within twenty one (21) days from the date of receipt, the Contractor files with the Customer a petition for administrative hearing. The Customer's decision on the petition shall be final, subject to the Contractor's right to review pursuant to Chapter 120 of the Florida Statutes. Exhaustion of administrative remedies is an absolute condition precedent to the Contractor's ability to pursue any other form of dispute resolution; provided, however, that the parties may employ the alternative dispute resolution procedures outlined in Chapter 120.

Without limiting the foregoing, the exclusive venue of any legal or equitable action that arises out of or relates to the Contract shall be the appropriate state court in Leon County, Florida; in any such action, Florida law shall apply and the parties waive any right to jury trial.

32. Employees, Subcontractors, and Agents. All Contractor employees, subcontractors, or agents performing work under the Contract shall be properly trained technicians who meet or exceed any specified training qualifications. Upon request, Contractor shall furnish a copy of technical certification or other proof of qualification. All employees, subcontractors, or agents performing work under the Contract must comply with all security and administrative requirements of the Customer and shall comply with all controlling laws and regulations relevant to the services they are providing under the Contract. The State may conduct, and the Contractor shall cooperate in, a security background check or otherwise assess any employee, subcontractor, or agent furnished by the Contractor. The State may refuse access to, or require replacement of, any personnel for cause, including, but not limited to, technical or training qualifications, quality of work, change in security status, or non-compliance with a Customer's security or other requirements. Such approval shall not relieve the Contractor of its obligation to perform all work in compliance with the Contract. The State may reject and bar from any facility for cause any of the Contractor's employees, subcontractors, or agents.

33. Security and Confidentiality. The Contractor shall comply fully with all security procedures of the United States, State of Florida and Customer in performance of the Contract. The Contractor shall not divulge to third parties any confidential information obtained by the Contractor or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing Contract work, including, but not limited to, security procedures, business operations information, or commercial proprietary information in the possession of the State or Customer. The Contractor shall not be required to keep confidential information or material that is publicly available through no fault of the Contractor, material that the Contractor developed independently without relying on the State's or Customer's confidential information, or material that is otherwise obtainable under State law as a public record. To insure confidentiality, the Contractor shall take appropriate steps as to its personnel, agents, and subcontractors. The warranties of this paragraph shall survive the Contract.

34.Contractor Employees, Subcontractors, and Other Agents. The Customer and the State shall take all actions necessary to ensure that Contractor's employees, subcontractors and other agents are not employees of the State of Florida. Such actions include, but are not limited to, ensuring that Contractor's employees, subcontractors, and other agents receive benefits and necessary insurance (health, workers' compensations, and unemployment) from an employer other than the State of Florida.

35. Insurance Requirements. During the Contract term, the Contractor at its sole expense shall provide commercial insurance of such a type and with such terms and limits as may be reasonably associated with the Contract. Providing and maintaining adequate insurance coverage is a material obligation of the Contractor. Upon request, the Contractor shall provide certificate of insurance. The limits of coverage under each policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract. All insurance policies shall be through insurers authorized or eligible to write policies in Florida.

36. Warranty of Authority. Each person signing the Contract warrants that he or she is duly authorized to do so and to bind the respective party to the Contract.

37. Warranty of Ability to Perform. The Contractor warrants that, to the best of its knowledge, there is no pending or threatened action, proceeding, or investigation, or any other legal or financial condition, that would in any way prohibit, restrain, or diminish the Contractor's ability to satisfy its Contract obligations. The Contractor warrants that neither it nor any affiliate is currently on the convicted vendor list maintained pursuant to section 287.133 of the Florida Statutes, or on any similar list maintained by any other state or the federal government. The Contractor shall immediately notify the Customer in writing if its ability to perform is compromised in any manner during the term of the Contract.

38. Notices. All notices required under the Contract shall be delivered by certified mail, return receipt requested, by reputable air courier service, or by personal delivery to the agency designee identified in the original solicitation, or as otherwise identified by the Customer. Notices to the Contractor shall be delivered to the person who signs the Contract. Either designated recipient may notify the other, in writing, if someone else is designated to receive notice.

39. Leases and Installment Purchases. Prior approval of the Chief Financial Officer (as defined in Section 17.001, F.S.) is required for State agencies to enter into or to extend any lease or installment-purchase agreement in excess of the Category Two amount established by section 287.017 of the Florida Statutes.

40. Prison Rehabilitative Industries and Diversified Enterprises, Inc. (PRIDE). Section 946.515(2), F.S. requires the following statement to be included in the solicitation: "It is expressly understood and agreed that any articles which are the subject of, or required to carry out, the Contract shall be purchased from the corporation identified under Chapter 946 of the Florida Statutes (PRIDE) in the same manner and under the same procedures set forth in section 946.515(2) and (4) of the Florida Statutes; and for purposes of the Contract the person, firm, or other business entity carrying out the provisions of the Contract shall be deemed to be substituted for the agency insofar as dealings with such corporation are concerned." Additional information about PRIDE and the products it offers is available at http://www.pridefl.com.

41. Products Available from the Blind or Other Handicapped. Section 413.036(3), F.S. requires the following statement to be included in the solicitation: "It is expressly understood and agreed that any articles that are the subject of, or required to carry out, this contract shall be purchased from a nonprofit agency for the Blind or for the Severely Handicapped that is qualified pursuant to Chapter 413, Florida Statutes, in the same manner and under the same procedures set forth in section 413.036(1) and (2), Florida Statutes; and for purposes of this contract the person, firm, or other business entity carrying out the provisions of this contract shall be deemed to be substituted for the State agency insofar as dealings with such qualified nonprofit agency are concerned." Additional information about the designated nonprofit agency and the products it offers is available at http://www.respectofflorida.org.

42. Modification of Terms. The Contract contains all the terms and conditions agreed upon by the parties, which terms and conditions shall govern all transactions between the Customer and the Contractor. The Contract may only be modified or amended upon mutual written agreement of the Customer and the Contractor. No oral agreements or representations shall be valid or binding upon the Customer or the Contractor. No alteration or modification of the Contract terms, including substitution of product, shall be valid or binding against the Customer. The Contractor may not unilaterally modify the terms of the Contract by affixing additional terms to product upon delivery (e.g., attachment or inclusion of standard preprinted forms, product literature, “shrink wrap” terms accompanying or affixed to a product, whether written or electronic) or by incorporating such terms onto the Contractor’s order or fiscal forms or other documents forwarded by the Contractor for payment. The Customer's acceptance of product or processing of documentation on forms furnished by the Contractor for approval or payment shall not constitute acceptance of the proposed modification to terms and conditions.

43. Cooperative Purchasing. Pursuant to their own governing laws, and subject to the agreement of the Contractor, other entities may be permitted to make purchases at the terms and conditions contained herein. Non-Customer purchases are independent of the agreement between Customer and Contractor, and Customer shall not be a party to any transaction between the Contractor and any other purchaser.
State agencies wishing to make purchases from this agreement are required to follow the provisions of s. 287.042(16)(a), F.S. This statute requires the Department of Management Services to determine that the requestor's use of the contract is cost-effective and in the best interest of the State.

44. Waiver. The delay or failure by the Customer to exercise or enforce any of its rights under this Contract shall not constitute or be deemed a waiver of the Customer’s right thereafter to enforce those rights, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or the exercise of any other right.

45. Annual Appropriations. The State’s performance and obligation to pay under this contract are contingent upon an annual appropriation by the Legislature.

46. Execution in Counterparts. The Contract may be executed in counterparts, each of which shall be an original and all of which shall constitute but one and the same instrument.

47. Severability. If a court deems any provision of the Contract void or unenforceable, that provision shall be enforced only to the extent that it is not in violation of law or is not otherwise unenforceable and all other provisions shall remain in full force and effect.

ATTACHMENT C
SPECIAL CONDITIONS

C.1 Solicitation Number: **AHCA ITN 002-14/15**

C.2 Solicitation Type: **Invitation to Negotiate**

C.3 Solicitation Title: **Medicaid Third Party Liability**

C.4 Date of Issuance: **January 27, 2015**

C.5 Issuing Officer:

Jennifer Barrett
Agency for Health Care Administration
Building 2, Suite 203, Mail Stop 15
2727 Mahan Drive
Tallahassee, FL 32308-5403
Fax #: 850-488-0317
Email: procurementadminist@ahca.myflorida.com

C.6 Solicitation Timeline:

The projected solicitation timeline is shown below (all times are Eastern Time). The Agency reserves the right to amend the timeline in the State's best interest. If the Agency finds it necessary to change any of the activities/dates/times listed, all interested parties will be notified by addenda to the original solicitation document posted on the Vendor Bid System (VBS) (http://myflorida.com/apps/vbs/vbs_www.main_menu).

ACTIVITY	DATE/TIME	LOCATION
Solicitation Issued by Agency	January 27, 2015	Electronically Posted http://myflorida.com/apps/vbs/vbs_www.main_menu
Deadline for Receipt of Written Inquiries	February 10, 2015	2727 Mahan Drive, MS# 15 Tallahassee, FL 32308-5403
Anticipated date for Agency Responses to Written Inquiries	February 24, 2015	Electronically Posted http://myflorida.com/apps/vbs/vbs_www.main_menu
Deadline for Receipt of Responses	March 24, 2015 @ 2:00 PM	Address Provided in C.5 above
Public Opening of Responses	March 24, 2015 @ 2:00 PM	2727 Mahan Drive, Building 2 Operations Conference Room, 2nd Floor, Room 200 Tallahassee, FL 32308-5403
Anticipated Dates for Negotiations	April 20, 2015 through April 30, 2015	2727 Mahan Drive, Building 2 Operations Conference Room, 2nd Floor, Room 200 Tallahassee, FL 32308-5403
Anticipated Posting of Notice of Intent to Award	May 4, 2015	Electronically Posted http://myflorida.com/apps/vbs/vbs_www.main_menu

C.7 Mandatory Requirements:

The State has established certain requirements with respect to responses submitted to competitive solicitations. The use of "shall", "must", or "will" (except to indicate futurity) in this ITN, indicates a requirement or condition from which a material deviation may not be waived by the State. A deviation is material if, in the State's sole discretion, the deficient response is not in substantial accord with the ITN requirements, provides an advantage to one respondent over another, or has a potentially significant effect on the quality of the response or on the cost to the State. Material deviations cannot be waived. The words "should" or "may" in this ITN indicate desirable attributes or conditions, but are permissive in nature. Deviation from, or omission of, such desirable feature will not in itself cause rejection of a response.

C.8 Restriction on Communications:

Respondents to this ITN or persons acting on their behalf may not contact, between the release of the ITN and the end of the seventy-two (72) hour period following the Agency posting the notice of intended award, excluding Saturdays, Sundays, and State holidays, any employee or officer of the executive or legislative branch concerning any aspect of this ITN, except in writing to the Issuing Officer or as provided in the ITN documents. Violation of this provision may be grounds for rejecting a response.

C.9 Vendor Questions:

Note: This Special Instruction takes precedence over **Attachment A**, General Condition #5.

The Agency will receive all questions pertaining to this ITN no later than the date and time specified for written inquiries in Section C.6, Solicitation Timeline. All inquiries must be made in writing to the Issuing Officer identified in Section C.5. Questions may be sent by email or fax. (Email is preferred and encouraged.) **No telephone inquiries will be accepted**. The Agency's response to questions received will be posted as an addendum to this ITN as specified in Section C.6, Solicitation Timeline. The Agency reserves the right to consider questions received after the submission deadline on a case-by-case basis. If the Agency, in its sole discretion, determines that all prospective vendors would benefit from a response, an addendum to this ITN will be issued and posted to the Vendor Bid System.

C.10 Solicitation Addenda:

If the Agency finds it necessary to supplement, modify, or interpret any portion of the ITN package during the solicitation period, a written addendum will be posted on the VBS as addenda to this ITN. **It is the prospective vendor's responsibility to check the VBS periodically for any information or updates to this ITN. The Agency bears no responsibility for any resulting impacts associated with a prospective vendor's failure to obtain the information made available through the VBS.**

C.11 Public Opening of Responses:

Responses shall be opened on the date and at the location indicated in Section C.6, Solicitation Timeline. Respondents may, but are not required to, attend. The Agency will only announce the respondent(s) name at the public opening. Pursuant to s. 119.071(1)(b), Florida Statute, no other materials will be released. Any person requiring a special accommodation because of a disability should contact the Issuing Officer at least five (5) business days prior to the solicitation opening. If you are hearing or speech impaired, please contact the Agency by using the Florida Relay Service at (800) 955-8771 (TDD).

C.12 Cost of Response Preparation:

The costs related to the development and submission of a response to this ITN is the full responsibility of the respondent and is not chargeable to the Agency.

C.13 Independent Preparation of Response:

A respondent shall not, directly or indirectly, collude, consult, communicate or agree with any other respondent as to any matter related to the response each is submitting. Additionally, a respondent shall not induce any other respondent to submit or not to submit a response.

C.14 Required Certifications:

The following certifications, contained in **Attachment G**, Required Certifications, are required and must be submitted with the response:

- Acceptance of the Contract Terms and Conditions - certifying that the prospective vendor accepts the terms and conditions as specified in this ITN and in the Agency Standard Contract, **Attachment H**.

- A Statement of No Involvement - certifying that neither the prospective vendor nor any person with an interest in the firm had a noncompetitive Contract involving any of the preliminary work such as a feasibility study or preparing the ITN.

- Non-Collusion Certification – certifying all persons, companies, or parties interested in the response as principals are named; that the response is made without collusion with any other persons, company or parties submitting a response; that it is made in good faith; and the signatory has full authority to legally bind the prospective vendor to the provisions of this ITN.

- Organizational Conflict of Interest Certification – certifying that the prospective vendor (including its subcontractors, subsidiaries and partners) have no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract for this ITN; and the prospective vendor has included information in its response to the ITN detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan".

- Certification Regarding Terminated Contracts – the respondent shall list:

    - All State or Federal Contracts that it or its subsidiaries and affiliates have unilaterally and willfully terminated within the past five (5) years.

    - All State or Federal Contracts of the vendor and its subsidiaries and affiliates that have been terminated within the past five (5) years by a State or the Federal government for cause, prior to the end of the Contract.

THE FORM MAY NOT BE RETYPED AND/OR MODIFIED AND MUST BE SUBMITTED IN THE ORIGINAL FORMAT. ANY CAVEAT(S) AND/OR MODIFICATION(S) TO ATTACHMENT G, REQUIRED CERTIFICATIONS WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. FAILURE TO SUBMIT ATTACHMENT G, REQUIRED CERTIFICATIONS, SIGNED BY AN AUTHORIZED OFFICIAL, WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. ATTACHMENT G,

REQUIRED CERTIFICATIONS IS AVAILABLE FOR RESPONDENTS TO DOWNLOAD AT: http://ahca.myflorida.com/Procurements/index.shtml.

C.15 Original Proposal Guarantee:

The original response must be accompanied by an original proposal guarantee payable to the State of Florida in the amount of **$500,000.00**; the respondent must be the guarantor. The Agency **will not** accept a copy of the proposal guarantee with the original response.

The form of the proposal guarantee shall be a bond, cashier's check, treasurer's check, bank draft, or certified check. The Agency **will not** accept a letter of credit in lieu of the proposal guarantee.

All proposal guarantees will be returned upon execution of the legal Contract with the successful vendor. If the successful vendor fails to execute a Contract within ten (10) consecutive calendar days after a Contract has been presented to the successful vendor for signature, the proposal guarantee shall be forfeited to the State. The proposal guarantee from the successful vendor will be returned only after the Agency has received the performance bond required under this ITN.

The "proposal guarantee" is a firm commitment such as a bid bond, certified check, or other negotiable instrument accompanying the proposal as assurance that the respondent shall, upon the Agency's acceptance of his or her proposal, execute such contractual documents as may be required within the time specified.

FAILURE TO INCLUDE THE ORIGINAL PROPOSAL GUARANTEE WITH THE SUBMISSION OF THE ORIGINAL RESPONSE WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. THE PROPOSAL BOND MUST NOT CONTAIN ANY PROVISIONS THAT SHORTEN THE TIME FOR BRINGING AN ACTION TO A TIME LESS THAN THAT PROVIDED BY THE APPLICABLE FLORIDA STATUTE OF LIMITATIONS. SEE SECTION 95.03, FLORIDA STATUTES.

C.16 Prohibition of Gratuities:

By submission of a response, a respondent certifies that no elected official or employee of the State of Florida has or shall benefit financially or materially from such response or subsequent Contract in violation of the provisions of Chapter 112, Florida Statutes. Any Contract issued as a result of this ITN may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

C.17 Type of Contract Contemplated:

The Contract resulting from this ITN will be a combination contingency fee and fixed fee Contract.

A copy of the proposed Standard Contract containing all requirements is included as **Attachment H**, Standard Contract. The prospective vendor should closely review the requirements contained in the proposed Standard Contract. Modifications proposed by the prospective vendor may not be considered. This ITN, including all its addenda, the Agency's written response to written inquiries, and the successful vendor's response shall be incorporated by reference in the final Contract document.

C.18 Number of Awards:

The Agency anticipates the issuance of one (1) Contract as a result of this ITN. The Agency, at its sole discretion, shall make this determination.

C.19 Term of Contract:

The anticipated term of the resulting Contract is five (5) years. The Agency anticipates full implementation to be completed by 8:00 a.m. EST or EDT as appropriate on November 1, 2015. The term of the resulting Contract is subject to change based on the actual execution date of the resulting Contract.

In accordance with Section 287.057(13), Florida Statutes, the Contract resulting from this ITN may be renewed for a period that may not exceed three (3) years or the term of the resulting original Contract period whichever is longer. Renewal of the resulting Contract shall be in writing and subject to the same terms and conditions set forth in the resulting original Contract. A renewal Contract may not include any compensation for costs associated with the renewal. Renewals are contingent upon satisfactory performance evaluations by the Agency, are subject to the availability of funds, and optional to the Agency.

It is the Agency's policy to attempt to reduce Contract renewals and re-procurements with the vendor by at least 5 percent (5%), but not to affect the level and quality of services.

C.20 Subcontracting:

The successful vendor shall not enter into any subcontract for any services, including the core TPL services described in this ITN without prior written consent of the Agency. Core TPL services include the following components:

- Casualty recovery;
- Estate recovery;
- Trust and annuity recovery;
- Medicare and other third party payor recovery;
- Cost avoidance;
- Health Insurance Premium Payment Program (HIPP); and
- Other recovery projects.

The successful vendor shall not subcontract, assign, or transfer any work identified under this ITN or the resulting Contract, with the exception of those subcontractors identified in the prospective vendor's response, without prior written consent of the Agency.

The vendor is responsible for all work performed under the Contract resulting from this ITN. No subcontract that the vendor enters into with respect to performance under the resulting Contract shall in any way relieve the vendor of any responsibility for performance of its duties.

The successful vendor shall assure that all tasks related to the subcontract are performed in accordance with the terms of the resulting Contract.

The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this ITN enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Prospective vendors can contact the Office of Supplier Diversity at (850) 487-0915 for information on minority vendors who may be considered for subcontracting opportunities.

C.21 Performance Bond:

A performance bond in the amount of ten percent (10%) of the total amount of the resulting Contract shall be furnished to the Agency by the successful vendor. The bond must be furnished to the Issuing Officer identified in Section C.5 within thirty (30) calendar days after execution of the resulting Contract and prior to commencement of any work under the resulting Contract. The performance bond must not contain any provisions that shorten the time for bringing an action to a time less than that provided by the applicable Florida Statute of Limitations. See section 95.03, Florida Statutes.

No payments will be made to the successful vendor until the performance bond is in place and approved by the Agency in writing. The performance bond shall remain in effect for the full term of the resulting Contract, including any renewal period. The Agency shall be named as the beneficiary of the successful vendor's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by the Agency directly to the Agency.

The cost of the performance bond will be borne by the successful vendor.

Should the successful vendor terminate the resulting Contract prior to the end of the resulting Contract period, an assessment against the bond will be made by the State to cover the costs of issuing a new solicitation and selecting a new vendor. The successful vendor agrees that the Agency's damages in the event of termination by the successful vendor shall be considered to be for the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

C.22 Venue:

The Contract resulting from this ITN shall be delivered in the State of Florida and shall be construed in accordance with the laws of Florida. Wherever possible, each provision of the resulting Contract shall be interpreted in such a manner as to be effective and valid under applicable law, but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of the resulting Contract. Any action hereon or in connection herewith shall be brought in Leon County, Florida.

C.23 Inspection of Records and Work Performed:

The State and its authorized representatives shall, at all reasonable times, have the right to enter the successful vendor's premises, or other places where duties under the resulting Contract are performed. All inspections and evaluations shall be performed in such a manner as not to unduly delay work.

The successful vendor shall retain all financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to

performance under the resulting Contract for a period of six (6) years after termination of the resulting Contract, or if an audit has been initiated and audit findings have not been resolved at the end of six (6) years, the records shall be retained until resolution of the audit findings.

Refusal by the successful vendor to allow access to all records, documents, papers, letters, other materials or on-site activities related to the resulting Contract performance shall constitute a breach of the resulting Contract. The right of the State and its authorized representatives to perform inspections shall continue for as long as the successful vendor is required to maintain records. The successful vendor will be responsible for all storage fees associated with the medical records maintained under the resulting Contract. The successful vendor is also responsible for the shredding of medical records that meet the retention schedule noted above.

Failure to retain records as required may result in cancellation of the resulting Contract. The Agency shall give the successful vendor advance notice of cancellation pursuant to this provision and shall pay the successful vendor only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of the resulting Contract. Performance by the Agency of any of its obligations under a Contract awarded pursuant to this ITN shall be subject to the successful vendor's compliance with this provision.

C.24 Accounting:

The successful vendor shall maintain an accounting system and employ accounting procedures and practices that conform to generally accepted accounting principles and standards. All charges applicable to the resulting Contract shall be readily ascertainable from such records. The successful vendor is required to submit annual financial audits to the Agency within thirty (30) days of receipt.

C.25 Confidentiality of Beneficiary Information:

All personally identifiable beneficiary information obtained by the successful vendor shall be treated as privileged and confidential information and shall be used only as authorized for purposes directly related to the administration of the resulting Contract. The successful vendor must have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of data analysis and other vendor responsibilities under the Contract resulting from this ITN, and is exchanged only for the purpose of conducting a review or other duties outlined in the resulting Contract.

Any patient-specific information received by the successful vendor can be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the successful vendor is retained by the Agency. The successful vendor must have in place written confidentiality policies and procedures to ensure confidentiality and to comply with all Federal and State laws (including the Health Insurance Portability and Accountability Act [HIPAA]) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

The successful vendor's subcontracts must explicitly state expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the successful vendor. If provider-specific data are released to the public, the successful vendor shall have policies and procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, Florida Statutes, are met.

Any releases of information to the media, the public, or other entities require prior approval from the Agency.

C.26 Audits/Monitoring:

The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of analyses performed by the successful vendor to verify the quality of the successful vendor's analyses. Reasonable notice shall be provided for reviews conducted at the successful vendor's place of business.

Reviews may include, but shall not be limited to, reviews of procedures, computer systems, beneficiary records, accounting records, and internal quality control reviews. The successful vendor shall work with any reviewing entity selected by the State.

During the resulting Contract period these records shall be available at the successful vendor's office at all reasonable times. After the resulting Contract period and for six (6) years following, the records shall be available at the successful vendor's chosen location subject to the approval of the Agency. If the records need to be sent to the Agency, the successful vendor shall bear the expense of delivery. Prior approval of the disposition of the successful vendor and subcontractor records must be requested and approved by the Agency if the resulting Contract or subcontract is continuous.

The successful vendor shall comply with 45 CFR, Part 74, with respect to audit requirements of Federal Contracts administered through State and local public agencies. In these instances, audit responsibilities have been delegated to the State and are subject to the on-going audit requirements of the State of Florida and of the Agency.

C.27 EEO Compliance:

A successful vendor awarded a Contract pursuant to this ITN shall not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap except as provided by law.

C.28 Lobbying Disclosure:

The successful vendor shall comply with applicable Federal requirements for the disclosure of information regarding lobbying activities of the successful vendor, subcontractors or any authorized agent. Certification forms shall be filed by the successful vendor and all subcontractors, certifying that no Federal funds have been or shall be used in Federal lobbying activities, and the disclosure forms shall be used by the successful vendor and all subcontractors to disclose lobbying activities in connection with the Medicaid program that have been or shall be paid with non-Federal funds.

The successful vendor shall comply with the provisions of Section 216.347, Florida Statutes, which prohibits the expenditure of Contract funds for the purpose of lobbying the Legislature or a State agency.

C.29 Certification Regarding Debarment and Suspension:

If the Contract to be awarded as a result of this ITN is funded in part by Federal funds that exceed the **$25,000.00** requirement, the successful vendor shall be required to sign a Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion as part of

the contracting process.

C.30 HIPAA Compliance:

The successful vendor must ensure it meets all Federal regulations regarding standards for privacy and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

C.31 Applicable Laws and Regulations:

The successful vendor agrees to comply with all applicable Federal and State laws and regulations, including but not limited to:

Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C; Title 45 CFR, Part 74, General Grants Administration Requirements; Chapter 409, Florida Statutes; all applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 USC 1857, et seq.); Title VI of the Civil Rights Act of 1964 (42 USC 2000d) in regard to persons served; 42 CFR 431, Subpart F; Section 504 of the Rehabilitation Act of 1973, as amended; 29 USC 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from Federal financial assistance; the Age Discrimination Act of 1975, as amended; 42 USC 6101 et. seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from Federal financial assistance; the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from Federal financial assistance; the Medicare-Medicaid Fraud and Abuse Act of 1978; other Federal omnibus budget reconciliation acts; Americans with Disabilities Act (42 USC 12101, et. seq.); and the Balanced Budget Act of 1997. The resulting Contract may be subject to changes in Federal and State law, rules or regulations.

C.32 Patents, Royalties, Copyrights, Right to Data and Sponsorship Statement:

The successful vendor, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the successful vendor. The successful vendor has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the successful vendor or is based solely and exclusively upon the Agency's alteration of the article.

The Agency will provide prompt written notification of a claim of copyright or patent infringement and shall afford the successful vendor full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the successful vendor may, at its option and expense procure for the Agency the right to continue the use of, replace or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the successful vendor and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).

If the successful vendor brings to the performance of the resulting Contract a pre-existing patent, patent-pending and/or copyright, the successful vendor shall retain all rights and entitlements to that pre-existing patent, patent-pending and/or copyright, unless this ITN and the resulting Contract provide otherwise.

If the successful vendor uses any design, device, or materials covered by letter, patent, or

copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under the resulting Contract, the successful vendor shall disclose, in writing, all intellectual properties relevant to the performance of the resulting Contract which the successful vendor knows, or should know, could give rise to a patent or copyright. The successful vendor shall retain all rights and entitlements to any pre-existing intellectual property which is so disclosed. Failure to disclose will indicate that no such property exists. The Agency will then have the right to all patents and copyrights which arise as a result of performance under the resulting Contract as provided in this section.

If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under the resulting Contract, or in any way connected herewith, the successful vendor shall refer the discovery or invention to the Agency for a determination whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of the resulting Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the successful vendor in such a manner as to preserve and protect the legal rights of the Agency.

Where activities supported by the Contract resulting from this ITN produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the Agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to Section 286.021, Florida Statutes, no person, firm, corporation, including parties to the resulting Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

The Agency will have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the successful vendor under any Contract resulting from this ITN.

Pursuant to Section 286.25, Florida Statutes, all non-governmental vendors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the successful vendor shall include the statement: “Sponsored by (name of successful vendor) and the State of Florida, Agency for Health Care Administration.” If the sponsorship reference is in written material, the words, “State of Florida, Agency for Health Care Administration” shall appear in the same size letters or type as the name of the organization.

All rights and title to works for hire under the resulting Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this ITN and the resulting Contract.

The computer programs, materials and other information furnished by the Agency to the successful vendor hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the successful vendor. The services and products listed in this ITN and the resulting Contract shall become the property of the Agency upon the successful vendor’s performance and delivery thereof. The successful

vendor hereby acknowledges that said computer programs, materials and other information provided by the Agency to the successful vendor hereunder, together with the products delivered and services performed by the successful vendor hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, Florida Statutes, and that the successful vendor shall not disclose, publish or use same for any purpose other than the purposes provided in this ITN and the resulting Contract; however, upon the successful vendor first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the successful vendor prior to its receipt from the Agency; (2) became known to the successful vendor from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the successful vendor shall be free to use and disclose same without restriction. Upon completion of the successful vendor's performance or otherwise cancellation or termination of the resulting Contract, the successful vendor shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the successful vendor's possession.

The successful vendor warrants that all materials produced hereunder will be of original development by the successful vendor and will be specifically developed for the fulfillment of this ITN and the resulting Contract and will not knowingly infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the successful vendor shall indemnify and hold the Agency harmless from and against any loss, cost, liability or expense arising out of any breach or claimed breach of this warranty.

The terms and conditions specified in this section shall also apply to any subcontract made under the resulting Contract. The successful vendor shall be responsible for informing the subcontractor of the provisions of this section and obtaining disclosures.

C.33 Work Authorization Program:

The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The successful vendor shall only employ individuals who may legally work in the United States – either U.S. citizens or foreign citizens who are authorized to work in the U.S. The successful vendor shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the successful vendor during the term of the Contract resulting from this ITN and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to the Contract resulting from this ITN.

C.34 Scrutinized Companies List:

The respondent shall complete **Attachment L**, Vendor Certification Regarding Scrutinized Companies Lists, certifying that it is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to section 215.473, Florida Statutes (F.S.). Pursuant to section 287.135(5), F.S., the respondent agrees the Agency may immediately terminate the resulting Contract for cause if the respondent is found to have submitted a false certification or if the respondent is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the resulting Contract.

THE FORM MAY NOT BE RETYPED AND/OR MODIFIED AND MUST BE SUBMITTED IN THE ORIGINAL FORMAT. ANY CAVEAT(S) AND/OR MODIFICATION(S) TO ATTACHMENT

L, VENDOR CERTIFICATION REGARDING SCRUTINIZED COMPANIES LISTS WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. FAILURE TO SUBMIT ATTACHMENT L, VENDOR CERTIFICATION REGARDING SCRUTINIZED COMPANIES LISTS, SIGNED BY AN AUTHORIZED OFFICIAL, WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. ATTACHMENT L, VENDOR CERTIFICATION REGARDING SCRUTINIZED COMPANIES LISTS IS AVAILABLE FOR RESPONDENTS TO DOWNLOAD AT:
http://ahca.myflorida.com/Procurements/index.shtml.

C.35 MyFloridaMarketPlace Vendor Registration and Transaction Fee:

The Contract resulting from this ITN has been exempted by the Florida Department of Management Services from paying the one percent (1%) transaction fee per 60A-1.032(2)(a and b), Florida Administrative Code.

C.36 Florida Department of State:

The successful vendor shall be registered with the Florida Department of State as an entity authorized to transact business in the State of Florida by the effective date of the resulting Contract.

C.37 Insurance:

To the extent required by law, the successful vendor will be self-insured against, or will secure and maintain during the life of the resulting Contract, Worker's Compensation Insurance for all its employees connected with the work of this project and, in case any work is subcontracted, the successful vendor shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under the resulting Contract are covered by the successful vendor's self insurance program. Such self insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the successful vendor under the resulting Contract and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the successful vendor shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of his or her employees not otherwise protected.

The successful vendor shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal and advertising injury and products and completed operations. This insurance will provide coverage for all claims that may arise from the services and/or operations completed under the resulting Contract, whether such services and/or operations are by the successful vendor or anyone directly, or indirectly employed by him. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of the resulting Contract. The successful vendor is responsible for determining the minimum limits of liability necessary to provide reasonable financial protections to the successful vendor and the State of Florida under the resulting Contract.

All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The successful vendor's current insurance policy(ies) shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) days written notice. The successful vendor shall provide thirty (30) day written notice of cancellation to the Agency's Contract Manager.

The successful vendor shall submit insurance certificates evidencing such insurance coverage prior to execution of a Contract with the Agency.

C.38 State Project Plan:

Within thirty (30) calendar days following award of the resulting Contract, the successful vendor shall submit a plan addressing each of the five (5) objectives listed below, to the extent applicable to the services covered by this ITN. **The State reserves the right to direct changes and/or modifications in regard to the below objectives with the respondent selected for award, prior to execution of the resulting Contract.**

1. **Vendor Diversity:** The State supports and encourages supplier diversity and the participation of small and minority business enterprises in State contracting, both as prime contractors and subcontractors. The respondent shall submit as part of this plan, its approach to supporting the State's vendor diversity program, and the intent of Section 287.09451, Florida Statutes.

   Additional assistance may be obtained by contacting the Office of Supplier Diversity at (850) 487-0915 or online at http://osd.dms.state.fl.us/.

2. **Environmental Considerations**: The State supports and encourages initiatives to protect and preserve our environment. The respondent shall submit as part of this plan, the respondent's plan to support the procurement of products and materials with recycled content. The respondent shall also provide a plan for reducing and/or handling of any hazardous waste generated by the respondent company. Reference Rule 62-730.160, Florida Administrative Code. It is a requirement of the Florida Department of Environmental Protection that a generator of hazardous waste materials that exceeds a certain threshold must have a valid and current Hazardous Waste Generator Identification Number. This identification number shall be submitted as part of the respondent's explanation of its company's hazardous waste plan and shall explain in detail its handling and disposal of waste.

3. **Certification of Drug-Free Workplace Program**: The State supports and encourages initiatives to keep the workplace of Florida's suppliers and contractors drug free. Section 287.087, Florida Statutes provides that, where identical tie proposals are received, preference shall be given to a proposal received from a respondent that certifies it has implemented a drug-free workplace program. If applicable, the respondent shall sign and submit the "Certification of Drug-Free Workplace Program" Form, attached hereto and made a part hereof as **Attachment I**, to certify that the respondent has a drug-free workplace program.

4. **Products Available from the Blind or Other Handicapped (RESPECT):** The State supports and encourages the gainful employment of citizens with disabilities. It is expressly understood and agreed that any articles that are the subject of, or required to carry out, the resulting Contract shall be purchased from a nonprofit agency for the blind or for the severely handicapped that is qualified pursuant to Chapter 413, Florida Statutes, in the same manner and under the same procedures set forth in Section 413.036(1) and (2), Florida Statutes; and for purposes of the resulting Contract the person, firm or other business entity carrying out the provisions of the resulting Contract shall be deemed to be substituted for the State agency insofar as dealings with such qualified nonprofit agency are concerned. Additional information about the designated nonprofit agency and the products it offers is available at http://www.respectofflorida.org. The successful vendor shall describe

how it will support the use of RESPECT in providing the services/items being procured under the resulting Contract.

5. **Prison Rehabilitative Industries and Diversified Enterprises, Inc. (PRIDE):** The State supports and encourages the use of Florida Correctional work programs. It is expressly understood and agreed that any articles which are the subject of, or required to carry out, the resulting Contract shall be purchased from the corporation identified under Chapter 946, Florida Statutes, in the same manner and under the same procedures set forth in Section 946.515(2) and (4), Florida Statutes; and for purposes of the resulting Contract the person, firm or other business entity carrying out the provisions of the resulting Contract shall be deemed to be substituted for this agency insofar as dealings with such corporation are concerned. Additional information about PRIDE and the products it offers is available at http://www.pride-enterprises.org/. The successful vendor shall describe how it will support the use of PRIDE in providing the services/items being procured under the resulting Contract.

C.39 General Instructions for Response Preparation and Submission:

Electronic submissions via MyFloridaMarketPlace are not required and will not be accepted for this ITN. This special instruction takes precedence over **Attachment A**, General Instruction #3.

The instructions for this ITN have been designed to help ensure that all responses are reviewed and evaluated in a consistent manner, as well as to minimize costs and response time. Information submitted in variance with these instructions may not be reviewed or evaluated.

An original and five (5) duplicate paper copies, in a sealed package, must be submitted to the Issuing Officer identified in Section C.5 no later than the time indicated in Section C.6, Solicitation Timeline, for receipt of responses. The original sealed response shall be marked as the "original" and contain the transmittal (cover) letter that bears the original signature of the binding authority. **The box that contains the "original" response shall be marked "Contains Original" and shall contain all marked originals.** Responses may be submitted via U.S. Mail, Courier, or hand delivery. Responses sent by fax or email will not be accepted. Responses received after the date and time specified in Section C.6, Solicitation Timeline, will not be considered and returned to the prospective vendor unopened.

Hard copy responses should be bound individually and submitted in three ring binders or secured in a similar fashion to contain pages that turn easily for review. Responses shall be single sided, typed in Arial 11 pt. font, or equivalent, using 1 inch margins and may not exceed two (2) 3-inch binders in length. All pages must be numbered, identify the solicitation number, and include the respondent's name. Graphics, charts, and tables provided in the response may be submitted in a smaller font than Arial 11.

The respondent must also submit an equal number of electronic copies of the response. The electronic format shall be submitted on CD-ROM. The software used to produce the electronic files must be Microsoft Word 97 and/or Excel 97 or greater. These electronic files must be logically named and easily mapped to the hard copy submittal. The electronic media must be clearly labeled in the same manner as the hard copies.

All submittals received by the date and time specified in Section C.6, Solicitation Timeline, become the property of the State of Florida and shall be a matter of record subject to the provisions of Chapter 119, Florida Statutes. The State of Florida shall have the right to use all

ideas, or adaptations of the ideas, contained in any proposal received in response to this ITN. Selection or rejection of the proposal shall not affect this right.

Any portion of the submitted response which is asserted to be exempt from disclosure under Chapter 119, Florida Statutes, shall be set forth on a page or pages separate from the rest of the submission. Each page of the portion(s) asserted to be exempt shall be clearly marked "exempt", "confidential", or "trade secret" (as applicable) and shall also contain the statutory basis for such claim on every page. Pages containing trade secrets shall be marked "trade secret as defined in Section 812.081, Florida Statutes". Failure to segregate and identify such portions shall constitute a waiver of any claimed exemption and the Agency will provide such records in response to public records requests without notifying the respondent. Designating material simply as "proprietary" will not necessarily protect it from disclosure under Chapter 119, Florida Statutes.

All information included in the response (including, without limitation, technical and cost information) and any resulting Contract that incorporates the successful proposal (fully, in part, or by reference) shall be a matter of public record regardless of copyright status. Submission of a response to this ITN shall constitute a waiver of any copyright protection which might otherwise apply to the production, disclosure, inspection and copying of such documentation.

The respondent to the ITN must also submit both a hard and an electronic redacted copy of the response suitable for release to the public. Any confidential or trade secret information covered under Section 812.081, Florida Statutes, should be either redacted or completely removed. The redacted response shall be marked as the "redacted" copy and contain a transmittal (cover) letter authorizing release of the redacted version of the response in the event the Agency receives a public records request.

RESPONDENTS MAY NOT MARK THEIR ENTIRE RESPONSE AS TRADE SECRET. ANY RESPONSE SO MARKED WILL BE REJECTED.

The ITN response shall consist of the following parts:

A. Mandatory Documentation

1. Transmittal (Cover) Letter

This letter is **mandatory** and serves as the document covering transmittal of the response package, as well as verification of vendor name, address, and Federal Employer Identification (FEID) Number. The letter must provide the name, title, address, telephone number, original signature and email address of the official vendor contact and an alternate, if available. These individuals shall have the authority to bind the vendor to a Contract and shall be available to be contacted by telephone and to attend meetings as may be appropriate. If submitting a proposal as a joint venture or legal partnership, both parties must provide the requested information as described in this section (Item 1. Transmittal (Cover) Letter).

2. Original Proposal Guarantee

The original proposal guarantee shall be included with the transmittal (cover) letter in the original response, as specified in Section C.15, Original Proposal Guarantee.

FAILURE TO SUBMIT THE MANDATORY ITEMS 1 AND 2 ABOVE, WILL RESULT IN THE REJECTION OF THE RESPONSE.

B. Past Performance - Client References (Must be provided on pages provided in Attachment F.)

The respondent shall submit a Past Performance – Client Reference Form. See **Attachment F**, Past Performance – Client Reference Form for additional instructions for client reference submission.

The Agency reserves the right to contact sources other than those identified by the respondent to obtain additional information regarding past performance. Any information obtained as a result of such contact may be used to determine whether or not the respondent is a "responsible vendor", as defined in Section 287.012(25), Florida Statutes.

FAILURE TO SUBMIT PAGE 1 OF ATTACHMENT F, PAST PERFORMANCE – CLIENT REFERENCE FORM WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. ATTACHMENT F, PAST PERFORMANCE – CLIENT REFERENCE FORM IS AVAILABLE FOR RESPONDENTS TO DOWNLOAD AT: HTTP://AHCA.MYFLORIDA.COM/PROCUREMENTS/INDEX.SHTML

THE FORM MAY NOT BE RETYPED AND/OR MODIFIED AND MUST BE SUBMITTED IN THE ORIGINAL FORMAT. ANY CAVEAT(S) AND/OR MODIFICATION(S) TO ATTACHMENT F, PAST PERFORMANCE – CLIENT REFERENCE FORM WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE.

C. Financial Information

The respondent shall submit its most recent audited financial statements. If the respondent is a subsidiary of a parent organization, the respondent may submit the most recent audited financial statements of its parent entity; audited financial statements of the parent organization in lieu of the respondent must include an organizational chart representing the relationship between the respondent and the parent entity. If the fiscal year covered by the audit ended within one hundred twenty (120) days prior to the solicitation filing deadline and the audited financial statements are not yet available, then the prior fiscal year will be considered the most recent. Audited financial statements that contain an Adverse Opinion or a Disclaimer of Opinion will not be deemed acceptable for the purposes of meeting the financial requirements set forth in this solicitation. Respondents shall submit the following:

1. A copy of the respondent's audited financial statements (or parent organization's audited financial statements with organizational chart).

2. Audited financial statements must be current; the period covered by the audit cannot be more than one (1) fiscal year and one hundred twenty (120) days old from the solicitation advertisement date.

3. The audit must contain a signed audit statement (Audit Opinion) from a Certified Public Accountant (CPA) and the statement cannot contain an Adverse Opinion or a Disclaimer of Opinion from the CPA.

If audited financial statements are not available, the respondent shall submit its most recent financial information (information cannot be more than one (1) fiscal year old), which shall include at a minimum:

1. Income Statement(s) or Revenue and Expense Statement(s) – Which are statement(s) of profit or loss (for not-for-profits it is the excess of revenues over expenses) during a particular period including all items of revenue income and expenditure.

2. Balance Sheet(s) – Which are statement(s) of total assets, liabilities, and net worth at a given point in time.

3. Cash Flow Statement(s) – Which are statement(s) that reflects the inflow of revenue versus the outflow of expenses resulting from operating, investing, and financing activities during a specific time period.

4. Notes to the financial statements which shall include: a description of the reporting entity, major asset categories, debt, contingency liabilities, transactions with related parties, subsequent events, and a list of significant accounting policies and estimates used.

Financial information will be reviewed by an Agency Certified Public Accountant (CPA) to determine the respondent's financial stability.

The financial information as requested above shall be labeled and tabbed separately.

FAILURE TO SUBMIT FINANCIAL INFORMATION AS REQUIRED WILL RESULT IN REJECTION OF THE RESPONSE.

D. Cost Proposal (Must be submitted on page provided as Attachment J)

THE FORM MAY NOT BE RETYPED AND/OR MODIFIED AND MUST BE SUBMITTED IN THE ORIGINAL FORMAT. ANY CAVEAT(S) AND/OR MODIFICATION(S) TO ATTACHMENT J, COST PROPOSAL WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. FAILURE TO SUBMIT ATTACHMENT J, COST PROPOSAL, SIGNED BY AN AUTHORIZED OFFICIAL, WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. ATTACHMENT J, COST PROPOSAL IS AVAILABLE FOR RESPONDENTS TO DOWNLOAD AT: http://ahca.myflorida.com/Procurements/index.shtml.

E. Technical Response

The Technical Response should be labeled and tabbed separately and should follow the order of the subsections below:

1. Table of Contents

The respondent shall include a Table of Contents in its response. The Table of Contents shall contain section headings and subheadings along with corresponding page numbers.

2. Executive Summary

The respondent shall include an executive summary, no longer than ten (10) single sided pages in length, that demonstrates the respondent's overall understanding of the Scope of Services and describes the significant features of the respondent's technical response.

3. Organizational Structure and History

The respondent shall describe its organizational structure and history. For responses that include a subcontractor, the same description of organizational structure and history shall be provided. The description shall include, at a minimum:

a. A detailed description of the respondent's experience in operating TPL programs;

b. A detailed description of the respondent's experience in designing and developing case tracking systems;

c. A detailed description of the respondent's experience in conducting data mining activities;

d. A detailed description of the respondent's organizational structure, history, legal structure, ownership, affiliations and location(s);

e. A copy of the respondent's organizational chart, including the total number of employees; and

f. A synopsis of the respondent's corporate qualifications, indicating its abilities to provide the level of services described in this ITN.

4. Respondent/Subcontractor Experience and Qualifications

The respondent shall describe, in detail, its qualifications for, and experience in providing services similar in nature to those described in this ITN as well as its proposed subcontractor's experience and qualifications, if applicable. The description shall include, at a minimum:

a. A synopsis of the respondent's experience(s) and, if applicable, its proposed subcontractor's experience(s) with managing or providing services within structured timelines;

b. A summary of the respondent's experience(s) with projects developing case management systems and portals;

c. A summary of the respondent's experience(s) and, if applicable, its proposed subcontractor's experience(s) with Medicaid, including Florida Medicaid;

d. A summary of any professional qualifications that the respondent and, if applicable, its proposed subcontractor's has obtained that would relate to the services described in this ITN; and

e. A summary of the respondent's experience(s) and, if applicable, its proposed subcontractor's experience(s) with data mining activities.

5. Project Timeliness

The respondent shall describe, in detail, its ability and proposed approach to ensuring a smooth and timely Contract implementation. The description shall include, at a minimum:

a. How the respondent intends to manage a Contract with multiple priorities; and

b. How the respondent intends to complete all activities in order to meet required deadlines and achieve the required implementation date as expeditiously as possible.

6. Vendor Systems and Data Requirements

The respondent shall describe, in detail, its capability to meet the systems and data requirements, as stated in Attachment D, Scope of Services, Section D.7, Vendor Systems and Data Requirements. The description shall include, at a minimum:

a. A detailed description of how the respondent intends to cooperate, coordinate and adapt its systems to the requirements of the Florida Medicaid Management Information System (FMMIS);

b. A detailed description of how the respondent intends to use the same operations system software package as the Agency (currently Windows, Office and Internet Explorer) or the most current, up-to-date software and web browser versions available;

c. A detailed description of how the respondent intends to maintain sufficient information technology resources (hardware, software, and personnel) to manage the Contract resulting from this ITN and generate all data including liens, claims, fulfillment of records requests, reports, etc. required for the Contract;

d. The respondent shall demonstrate that it owns, leases or has access to computer facilities in order to be able to accept electronic data, produce electronic billings, data match electronically, generate liens, claims and records requests and produce Medicaid voids, adjustments, accounts receivables, cash receipts, provider expenditures, refunds, reports, etc. through Agency designated electronic or paper media;

e. A detailed description of how the respondent intends to obtain and supply all hardware, software, communication, and equipment necessary to perform the duties associated with the Contract resulting from this ITN and be responsible for any associated programming, equipment, installation of software, maintenance and troubleshooting at no cost to the Agency or fiscal agent;

f. A detailed description of how the respondent intends to have information management processes and information systems that enable it to meet Federal and State reporting requirements, all other Contract requirements resulting from this ITN and any other applicable Federal and State laws, rules and regulations including HIPAA requirements;

g. A detailed description of how the respondent intends to possess capacity sufficient to handle the workload projected for the start of the Contract resulting from this ITN and be scalable and flexible so it can be adapted as needed, within negotiated timeframes, in response to increases in caseload estimates;

h. A detailed description of how the respondent intends to ensure systems contain controls at all appropriate points of processing in order to maintain information integrity;

i. A detailed description of how the respondent intends to ensure systems controls are tested in periodic and spot audits, including SAS-70 audits;

j. A detailed description of how the respondent intends to establish appropriate restrictions and safeguards against unauthorized access to all non-public data entrusted to vendor staff;

k. A detailed description of how the respondent intends to restrict access to information on a "need to know" basis (e.g. users permitted inquiry privileges only shall not be permitted to modify information);

l. A detailed description of how the respondent intends to limit attempts to access system functions to a set number with a system function that automatically prevents further access attempts and records these occurrences;

m. A detailed description of how the respondent intends to put in place measures and technical security to prohibit unauthorized access to the regions of the data communications network inside a respondent’s span of control;

n. A detailed description of how the respondent intends to provide for the physical safeguarding of its data processing facilities and the systems and information housed therein, as well as accountability control to record access attempts, including attempts of unauthorized access;

o. A detailed description of how the respondent intends to be responsible for submitting and managing vendor staff requests for access connectivity to the State’s data communications network, and the relevant information systems attached to this network, in accordance with all applicable State policies, standards and guidelines;

p. A detailed description of how the respondent intends to ensure staff are properly trained to utilize Agency and vendor systems and maintain confidentiality of system passwords;

q. A detailed description of how the respondent intends to allow complete global interactive access to all its systems to specified Agency staff;

r. A detailed description of how the respondent shall fully utilize the data provided by the Agency in order to conduct all Contract requirements resulting from this ITN;

s. A detailed description of how the respondent shall establish a secure environment to provide sufficient storage space to house all documents

including paper and electronic storage media at the respondent's facility until transfer to the Florida State Records Center;

t. A detailed description of how the respondent shall ensure that the operation of all of its systems is performed in accordance with Federal and State regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations;

u. A detailed description of how the respondent shall ensure all staff are trained regarding their regulatory obligations under HIPAA;

v. A detailed description of how the respondent shall ensure any protected health information (PHI) released shall be in accordance with HIPAA requirements as interpreted by the Agency and Agency policy;

w. A detailed description of how the respondent shall ensure a HIPAA compliant medical release or HIPAA Qualified Protective Order is received prior to releasing PHI for the casualty, estate and trust and annuity components of the Contract resulting from this ITN; and

x. A detailed description of how the respondent shall ensure all electronic mail communications that contain PHI are encrypted in accordance with HIPAA requirements and Agency policy.

7. Vendor Subcontracting

The respondent shall describe, in detail, its capability to provide the services described in this ITN by describing its capability to meet the subcontracting requirements as stated in Attachment D, Scope of Services, Section D.8, Vendor Subcontracting.

8. Draft Plans and Manuals

The respondent shall develop and submit the following draft plans/manuals as described in Attachment D, Scope of Services, Sections D.9, Vendor Implementation; D.11, Vendor Policies and Procedures; D.12, Vendor Staffing; and D.13, Vendor Customer Service:

a. Implementation Plan;

b. Risk Management Plan;

c. Disaster Recovery Plan;

d. Operational Policies and Procedures Manual;

e. Training Manual;

f. Quality Assurance Policies and Procedures Manual;

g. Organizational chart that shall include all staff resources that will be assigned to all components of the Contract resulting from this ITN, a justification for the

number of staff, the percentage of time each staff person will devote to the Contract and an estimate of assigned caseloads; and

h. Outreach Plan.

9. Vendor Documents

The respondent shall describe, in detail, its capability to meet the Vendor Documents requirements, as stated in Attachment D, Scope of Services, Section D.10, Vendor Documents. The description shall include, at a minimum:

a. A detailed description of how the respondent shall ensure all correspondence developed and used by the respondent in any format for the purposes of the Contract resulting from this ITN shall be reviewed and approved by the Agency prior to use by the respondent;

b. A detailed description of how the respondent shall ensure all correspondence, written or electronic developed and used by the respondent includes its toll-free telephone number, fax number, e-mail address and website address;

c. A detailed description of how the respondent shall ensure all correspondence used by the respondent shall be written in a professional and efficient manner using plain language;

d. A detailed description of how the respondent shall ensure all written and verbal communication are courteous and prompt, providing accurate and sufficient information;

e. A detailed description of how the respondent shall generate and submit all billing files, recoupment files (electronic and paper), financial adjustment files, cost avoidance files, and refund/expenditure forms necessary to meet the requirements of the Contract resulting from this ITN and at no cost to the Agency; and

f. A detailed description of how the respondent shall ensure all correspondence, billing files, recoupment files, reports and other documents are correct and reflect a high level of professionalism.

10. Vendor Staffing

The respondent shall describe, in detail, its capability to meet the Vendor Staffing requirements, as stated in Attachment D, Scope of Services, Section D.12, Vendor Staffing. The description shall include, at a minimum:

a. Resumes of the following required positions:

- o Contract Manager;
- o Casualty Manager;
- o Estate and Trust and Annuity Manager;
- o Medicare and Other Third Party Payor Manager;

- Other Recovery Projects Manager;
- Quality Assurance Manager;
- Quality Assurance/Training Staff;
- Information Technology Manager;
- Accounting Manager;
- Legal Staff; and
- Legal Support Staff

b. A detailed description of how the respondent intends to ensure the full time dedication of its proposed required staff;

c. A detailed description of how the respondent shall ensure staff communicate all Contract issues resulting from this ITN to the designated Contract Manager as the single point of contact;

d. A detailed description of how the respondent shall be prepared at all times to recruit credentialed, appropriately licensed and highly qualified staff;

e. A detailed description of how the respondent shall ensure staff conduct all components of the Contract resulting from this ITN in a timely, efficient, productive, consistent, courteous and professional manner as representatives of the State;

f. A detailed description of how the respondent shall measure staff productivity and quality;

g. A detailed description of how the respondent shall ensure all staff are familiar with and have a general knowledge of all components of the Contract resulting from this ITN;

h. A detailed description of how the respondent will ensure it employs all required positions and that there are sufficient staff to complete all requirements initially and throughout the duration of the Contract resulting from this ITN;

i. A detailed description of how the respondent will ensure it employs a sufficient number of staff fluent in both English and Spanish;

j. A detailed description of how the respondent will ensure it contracts for interpreter services as required;

k. A detailed description of how the respondent will replace any personnel whose continued presence would be detrimental to the success of the Contract resulting from this ITN;

l. A detailed description of how the respondent will make its staff available to meet with Agency staff on a regular basis, as agreed upon by the Agency to review reports and all other obligations under the Contract resulting from this ITN; and

m. A detailed description of how the respondent will ensure the required positions meet with Agency staff on at least a monthly basis to discuss the status of the Contract resulting from this ITN, vendor performance, reports, planning, etc.

11. Vendor Customer Service

The respondent shall describe, in detail, its capability to meet the Vendor Customer Service requirements, as stated in Attachment D, Scope of Services, Section D.13, Vendor Customer Service. The description shall include, at a minimum:

a. A detailed description of how the respondent will utilize one (1) toll-free telephone system (number) for all Contract components resulting from this ITN;

b. A detailed description of how the respondent will ensure the toll-free telephone number is accessible nationwide;

c. A detailed description of how the respondent will ensure its toll-free number only is used when communicating its telephone contact information;

d. A detailed description of how the respondent will assist all callers in a professional and courteous manner while following all guidelines regarding confidentiality of Medicaid information;

e. A detailed description of how the respondent will ensure the telephone system is staffed at a minimum from the business hours of 8:00 a.m. to 5:00 p.m. EST or EDT, as appropriate, Monday through Friday, excluding State of Florida observed holidays;

f. A detailed description of how the respondent will provide a before and after hours message advising the caller of the days and hours of operation;

g. A detailed description of how the respondent will ensure callers do not encounter a busy signal during the required days and hours of operation;

h. A detailed description of how the respondent will ensure through the use of an interactive voice response system, callers can choose to speak with a “live” person, rather than continue through additional prompts;

i. A detailed description of how the respondent will ensure a “live” person shall be available during the required days and hours of operation;

j. A detailed description of how the respondent will ensure the “live” person is familiar with and has a general knowledge of all components of the Contract resulting from this ITN;

k. A detailed description of how the respondent will ensure all telephone calls are returned within eight (8) business hours;

l. A detailed description of how the respondent will provide the Agency with continuous access to its telephone system from a remote location, for the purpose of monitoring calls in real time;

m. A detailed description of how the respondent will ensure the average caller wait time shall not exceed ninety (90) seconds as measured on a weekly average;

n. A detailed description of how the respondent will ensure the call abandonment/loss rate shall be less than five percent (5%) as measured on a weekly average;

o. A detailed description of how the respondent will ensure the call blockage rate shall be less than one percent (1%) as measured on a weekly average;

p. A detailed description of how the respondent will develop and maintain a website that provides educational information regarding all components of the Contract resulting from this ITN and ways of contacting the respondent (address, telephone, fax, e-mail); and

q. A detailed description of how the respondent will respond to messages sent to its e-mail account within eight (8) business hours of receipt.

12. Vendor Claims Repository

The respondent shall describe, in detail, its capability to meet the Vendor Claims Repository requirements, as stated in Attachment D, Scope of Services, Section D.14, Vendor Claims Repository. The description shall include, at a minimum:

a. A detailed description of how the respondent will ensure that its recovery in one Contract component resulting from this ITN does not overlap its recovery in another Contract component;

b. A detailed description of how the respondent will develop, maintain and use a completely one hundred percent (100%) web based claims repository system;

c. A detailed description of how the respondent will ensure all components of the claims repository system are completely one hundred percent (100%) web based;

d. A detailed description of how the respondent will ensure the claims repository system maintains all claims identified by the respondent for recovery and the status of all claims for all Contract components resulting from this ITN;

e. A detailed description of how the respondent will ensure the claims repository system maintains all claims transferred to the respondent from the prior Vendor;

f. A detailed description of how the respondent will completely and totally utilize the data provided by the Agency as stated in Attachment D, Scope of Services, Section D.5, Data to be Provided to the Vendor by the Agency as a component of its claims repository system;

g. A detailed description of how the respondent will have controls in place to ensure appropriate security and integrity of the claims repository system in accordance with applicable Federal and State laws;

h. A detailed description of how the respondent will ensure that the Agency has complete global interactive access to the claims repository system and training on the system at no cost to the Agency;

i. A detailed description of how the respondent will ensure that the Agency has complete global interactive access to the claims repository system and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

j. A detailed description of how the respondent will ensure that the claims repository system is operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015; and

k. A detailed description of how the respondent will ensure the claims repository can be amended or updated as required by the Agency in accordance with the best interests of the State.

13. Vendor Case Tracking System

The respondent shall describe, in detail, its capability to meet the Vendor Case Tracking System requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System. The description shall include, at a minimum:

a. A detailed description of how the respondent will develop, maintain and use a completely one hundred percent (100%) web based electronic case tracking system;

b. A detailed description of how the respondent will ensure all components of the case tracking system are completely one hundred percent (100%) web based;

c. A detailed description of how the respondent will ensure the case tracking system maintains all of the case files for casualty, estate and trust and annuity recoveries;

d. A detailed description of how the respondent will completely and totally utilize the data provided by the Agency as stated in Attachment D, Scope of Services, Section D.5, Data to be Provided to the Vendor by the Agency, as a component of its case tracking system;

e. A detailed description of how the respondent will have controls in place to ensure appropriate security and integrity of the case tracking system in accordance with applicable Federal and State laws;

f. A detailed description of how the respondent will ensure that the Agency has complete global interactive access to the case tracking system and training on the system at no cost to the Agency;

g. A detailed description of how the respondent will ensure that the Agency has complete global interactive access to the case tracking system and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

h. A detailed description of how the respondent will ensure that the case tracking system is operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

i. A detailed description of how the respondent will ensure the case tracking system can be amended or updated as required by the Agency in accordance with the best interests of the State;

j. A detailed description of how the respondent will meet the Vendor Case Tracking System Requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System, Subsection M.;

k. A detailed description of how the respondent will meet the Vendor Case Tracking System Requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System, Subsection O.; and

l. A detailed description of how the respondent will meet the Vendor Case Tracking System Requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System, Subsection P.

14. Vendor Web Portal

The respondent shall describe, in detail, its capability to meet the Vendor Web Portal requirements, as stated in Attachment D, Scope of Services, Section D.16, Vendor Web Portal. The description shall include, at a minimum:

a. A detailed description of how the respondent will develop, maintain and use a completely one hundred percent (100%) web based portal;

b. A detailed description of how the respondent will ensure all components of the web portal are completely one hundred percent (100%) web based;

c. A detailed description of how the respondent will ensure the web portal maintains information on Medicaid providers pertaining to claims identified, recovered and refunded for the Medicare and other third party payor and other recovery projects components of the Contract resulting from this ITN;

d. A detailed description of how the respondent will ensure the web portal conforms to the requirements of this ITN;

e. A detailed description of how the respondent will completely and totally utilize the data provided by the Agency as stated in Attachment D, Scope of Services, Section D.5, Data to be Provided to the Vendor by the Agency, as a component of its web portal;

f. A detailed description of how the respondent will have controls in place to ensure appropriate security and integrity of the web portal in accordance with applicable Federal and State laws;

g. A detailed description of how the respondent will ensure that the Agency has complete global interactive access to the web portal and training on the system at no cost to the Agency;

h. A detailed description of how the respondent will ensure that the Agency has complete global interactive access to the web portal and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

i. A detailed description of how the respondent will ensure that the web portal is operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

j. A detailed description of how the respondent will ensure the web portal can be amended or updated as required by the Agency in accordance with the best interests of the State;

k. A detailed description of how the respondent will ensure the web portal is made available to Medicaid providers in order for them to review and submit information;

l. A detailed description of how the respondent will provide training to Medicaid providers on the web portal at no cost to the Agency or Medicaid providers;

m. A detailed description of how the respondent will make the web portal available to Medicaid providers by 8:00 a.m. EST or EDT as appropriate on November 1, 2015;

n. A detailed description of how the respondent will meet the web portal requirements, as stated in Attachment D, Scope of Services, Section D.16, Vendor Web Portal, Subsection Q.; and

o. A detailed description of how the respondent will meet the web portal requirements, as stated in Attachment D, Scope of Services, Section D.16, Vendor Web Portal, Subsection R.

15. Vendor Deliverables

The respondent shall describe in detail its capability to meet the Vendor Deliverables requirements, as stated in Attachment D, Scope of Services, Section D.17, Vendor Deliverables.

16. Vendor Accounting

The respondent shall describe, in detail, its capability to meet the Vendor Accounting requirements, as stated in Attachment D, Scope of Services, Section D.18, Vendor Accounting.

17. Vendor Invoicing

The respondent shall describe, in detail, its capability to meet the Vendor Invoicing requirements, as stated in Attachment D, Scope of Services, Section D.20, Invoicing.

18. Vendor Reports

The respondent shall describe, in detail, its capability to meet the Vendor Reports requirements, as stated in Attachment D, Scope of Services, Section D.22, Vendor Reports.

19. Vendor Legal Action Requirements

The respondent shall describe, in detail, its approach to develop and administer the Vendor Legal Action Requirements as specified in Attachment D, Scope of Services, Section D.23, Vendor Legal Action Requirements.

20. Recovery Systems and Management

The respondent shall describe, in detail, its approach to develop and administer the following components as specified in Attachment D, Scope of Services, Sections D.25, Casualty Recovery; D.26, Estate Recovery; D.27, Trust and Annuity Recovery; D.28, Medicare and Other Third Party Payor Recovery; D.29, Cost Avoidance; D.30, Health Insurance Premium Payment (HIPP) Program; and D.31, Other Recovery Projects:

a. Casualty Recovery;

b. Estate Recovery;

c. Trust and Annuity Recovery;

d. Medicare and Other Third Party Payor Recovery;

e. Cost Avoidance;

f. Health Insurance Premium Payment (HIPP) Program; and

g. Other Recovery Projects.

21. Innovative Concepts

Respondents may identify and propose additional services or standards which exceed the minimum requirements of this ITN. Innovative Concepts are negotiable and respondents should have the costs associated with them available at negotiations.

Innovative Concepts should not be included in the respondent's cost proposal. The Agency will not evaluate Innovative Concepts as part of the evaluation process.

C.40 Other Required Documentation:

The following statements contained in **Attachment K**, Required Statements, must be submitted with the response:

1. Certification Statements

a. Certifying that the respondent shall make a documented good faith effort to ensure all services, provided directly or indirectly under the Contract resulting from this ITN, will be performed within the State of Florida.

b. Certifying that the respondent shall ensure all services, provided directly or indirectly under the Contract resulting from this ITN, will be performed within the borders of the United States and its territories and protectorates.

2. Statement of Systems Demonstration

Certifying that the respondent shall provide a demonstration of the following systems/portal at a negotiation meeting held with the Agency:

- Vendor Claims Repository;
- Vendor Claims Tracking System; and
- Vendor Web Portal

THE FORM MAY NOT BE RETYPED AND/OR MODIFIED AND MUST BE SUBMITTED IN THE ORIGINAL FORMAT. ANY CAVEAT(S) AND/OR MODIFICATION(S) TO ATTACHMENT K, REQUIRED STATEMENTS WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. FAILURE TO SUBMIT ATTACHMENT K, REQUIRED STATEMENTS, SIGNED BY AN AUTHORIZED OFFICIAL, WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE. ATTACHMENT K, REQUIRED STATEMENTS IS AVAILABLE FOR RESPONDENTS TO DOWNLOAD AT: http://ahca.myflorida.com/Procurements/index.shtml.

C.41 Conflict of Interest Mitigation Plan:

The standards on organizational conflicts of interest in Chapter 48, Code of Federal Regulations and Section 287.057(17), Florida Statutes apply to this solicitation. A vendor with an actual or potential organizational conflict of interest shall disclose the conflict. If the vendor believes the conflict of interest can be mitigated, neutralized or avoided, the vendor shall include with its submission a Conflict of Interest Mitigation Plan. The plan shall, at a minimum:

- Identify any relationship, financial interest or other activity which may create an actual or potential organizational conflict of interest.
- Describe the actions the vendor intends to take to mitigate, neutralize, or avoid the identified organizational conflicts of interest.
- Identify the official within the vendor's organization responsible for making conflict of interest determinations.

The Conflict of Interest Mitigation Plan will be evaluated as acceptable or not acceptable and will be used to determine vendor responsibility, as defined in Section 287.012(25), Florida Statutes. The Agency reserves the right to request additional information from the vendor or other sources, as deemed necessary, to determine whether or not the plan adequately neutralizes, mitigates, or avoids the identified conflicts.

C.42 Response Clarification:

The Agency reserves the right to seek written clarification from a vendor of any information contained in the vendor's response.

C.43 Joint Ventures and/or Legal Partnerships:

Joint ventures or legal partnerships shall be viewed as one (1) respondent; however, each party to the joint venture/legal partnership shall submit all attachments and/or documentation required by this ITN from respondents, unless otherwise stated.

FAILURE TO SUBMIT ALL REQUIRED ATTACHMENTS AND/OR DOCUMENTATION FROM ALL PARTIES INCLUDED IN A JOINT VENTURE OR LEGAL PARTNERSHIP, SIGNED BY AN AUTHORIZED OFFICIAL, IF APPLICABLE, WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE.

C.44 Posting of Notice of Intent to Award:

Tabulation of Results, with the recommended Contract award, will be posted and will be available for review by interested parties at the time and location specified in Section C.6, Solicitation Timeline, and will remain posted for a period of seventy-two (72) hours, not including weekends or State observed holidays. Any responding vendor desiring to protest the recommended Contract award must file a notice of protest to the Issuing Officer identified in Section C.5, and any formal protest with the Agency for Health Care Administration, Agency Clerk, 2727 Mahan Drive, MS #3, Building 3, Room 3407C, Tallahassee, Florida 32308, within the time prescribed in Section 120.57(3) Florida Statutes and Chapter 28-110, Florida Administrative Code. Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

C.45 Federal Approval:

Approval from the Centers for Medicare and Medicaid Services (CMS) may be required before the Agency will execute a Contract resulting from this ITN. Every effort will be made by the Agency both before and after award to facilitate rapid approval.

ATTACHMENT D
SCOPE OF SERVICES

D.1 Background:

A. The Agency for Health Care Administration (Agency) is the single State agency responsible for administering the Medicaid Program in Florida. General authority for Florida to operate a third party recovery function is provided in 42 Code of Federal Regulations (CFR) sections 433.138 and 433.139, and Chapter 409, Florida Statutes. In accordance with such provision, the State currently contracts with a Vendor. The Contract is administered by the Agency's Division of Operations, Medicaid Third Party Liability (TPL) Unit.

B. The TPL Act (Section 409.910, Florida Statutes) allows for recovery of amounts paid for medical expenses by Medicaid for which there is another liable third party. The definition of liable third party is found in Section 409.901(27), Florida Statutes, which states: "'Third party' means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid. A third party includes a third-party administrator or a pharmacy benefits manager."

C. Under the law, the Medicaid recipient or that person's representative is responsible for notifying Medicaid of the availability of third party resources. It is the role of the Vendor to identify potential third party payors and to recoup from them costs that have been paid by Medicaid.

D. The goal of this Invitation to Negotiate (ITN) is to contract with a Vendor to operate the Florida TPL Program and conduct other recovery projects in accordance with Federal and State laws. The Federal and State laws that pertain to the requirements of this ITN include, at a minimum, the following:

1. 42 Code of Federal Regulations sections 433.138 and 433.139
2. Section 1902 of the Social Security Act
3. Section 1906 of the Social Security Act
4. Section 1917 of the Social Security Act
5. State Medicaid Manual, Part 3 as issued by the Centers for Medicare and Medicaid Services
6. Florida Medicaid State Plan
7. Chapter 409, Florida Statutes
8. Chapter 627, Florida Statutes
9. Chapters 731 through 736, Florida Statutes
10. Florida Medicaid Provider Handbooks
11. Department of Children and Families (DCF) Economic Self-Sufficiency Services, Program Policy Manual, CFOP 165-22

12. 1115 Research and Demonstration Waiver – Florida Medicaid Reform

D.2 Purpose:

The scope of services for this ITN consists of seven (7) components:

1. Casualty recovery;

2. Estate recovery;

3. Trust and annuity recovery;

4. Medicare and other third party payor recovery;

5. Cost avoidance;

6. Health Insurance Premium Payment Program (HIPP); and

7. Other recovery projects.

D.3 Statewide Medicaid Managed Care:

A. During the 2011 Florida Legislative Session, the House and Senate passed HB 7107 and HB 7109, which required the State Medicaid program to implement a Statewide Medicaid Managed Care Program.

B. The Statewide Medicaid Managed Care Program has two (2) key program components:

   1. Long Term Care Managed Care Program; and

   2. Managed Medical Assistance Program.

C. All Medicaid recipients are required to enroll in a managed care plan unless specifically exempted in the legislation.

D. The Managed Care Plan shall have the sole right to subrogation and recovery from a liable third party for one (1) year from when the plan incurred the cost to recover from any third party resource. All recoveries outside this period that were not initiated by the Managed Care Plan will be pursued by the Agency or its Vendor. Managed Care Plan recovery rights exclude all estate, trust and annuity recoveries.

E. One of the key provisions of the legislation includes premium assistance for eligibles with access to other insurance. The successful Vendor shall be responsible for administering this Health Insurance Premium Payment (HIPP) program.

D.4 Services to be Provided by the Agency:

A. Maintain continuing and regular oversight of the Contract requirements resulting from this ITN.

B. Assign and dedicate an Agency Contract Manager to coordinate all Contract activities between the Agency and the Vendor.

C. Provide the Vendor, upon execution of the Contract resulting from this ITN, with a letter on Agency letterhead authorizing the Vendor to conduct the components of the Contract. This letter shall be used and released to entities in pursuit of the State's rights.

D. Provide Vendor staff with access to the Florida Medicaid Management Information System (FMMIS) as determined by the Agency.

E. Provide policy clarification when requested by the Vendor.

F. Provide the Vendor with forms and file layouts necessary to meet the requirements of the Contract resulting from this ITN.

G. Review all documents submitted by the Vendor and respond to each with either an approval, denial, or request for revision.

H. Make all determinations regarding cost-effectiveness of pursuing recovery.

I. Provide a determination of whether the Vendor has violated a contractual obligation and assess liquidated damages as necessary.

J. Amend timelines contained in this ITN and the resulting Contract in accordance with the best interests of the State.

K. Conduct or directly oversee litigation.

D.5 Data to be Provided to the Vendor by the Agency:

A. The Agency shall provide the Vendor with the data necessary to meet the requirements of the Contract resulting from this ITN in a format as determined by the Agency.

B. The frequency with which the data is to be provided shall be arranged between the Agency and the Vendor.

C. The number of years of data to be provided shall be arranged between the Agency and the Vendor.

D. The data provided to the Vendor by the Agency shall be as follows:

1. Medicaid paid claims files;

2. Medicaid Recipient file;

3. Medicaid Provider file;

4. Medicaid Diagnosis file;

5. Medicaid Procedure file;

6. Third Party Carrier file;

7. Third Party Liability Resource file;

8. Leads Letter file; and

9. Medicare files

E. Sample file layouts of the data to be provided to the Vendor are provided in **Exhibit I**, File Layouts.

F. The Vendor shall be responsible for completely and totally utilizing the data provided by the Agency in conducting all Contract components resulting from this ITN.

D.6 Vendor General Requirements:

A. The Vendor shall conduct all Contract components resulting from this ITN in accordance with Agency timeframes and Agency audit protocol standards.

B. The Vendor shall pay for all expenses it incurs as a result of the performance of services under the Contract resulting from this ITN. The Agency shall not be charged for any expenses the Vendor incurs.

C. The Agency shall not be responsible for providing administrative, technical, legal or clerical assistance to the Vendor except as otherwise provided herein.

D. The Agency shall not be charged for any start-up costs for any ITN component.

E. All costs associated with pursuing Medicaid recovery such as filing claims, filing liens, withdrawing claims, withdrawing liens, filing objections, filing motions, filing appeals, litigation participation (with expert witnesses if required), copies of Medicaid paid claims data, copies of legal documents, data validation, etc., shall be the sole responsibility of the Vendor and at no cost to the Agency. If the Agency takes over litigation of a matter, the Vendor remains responsible for these costs.

F. The Vendor shall not charge the State for any travel expenses related to any ITN component.

G. The Vendor shall provide its own office space, furniture, equipment, supplies and staff.

H. All mailing costs associated with the requirements of the Contract resulting from this ITN shall be at the expense of the Vendor and at no cost to the Agency.

I. All correspondence requiring a response from a Medicaid recipient shall include a postage paid return envelope at the expense of the Vendor and at no cost to the Agency or recipient.

J. All payments that are required to be returned to the payor shall be mailed in an Agency approved method to ensure receipt. The return method to be used by the Vendor shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

K. The Vendor shall date stamp all incoming correspondence upon receipt.

L. All outgoing correspondence shall be mailed and documented by the Vendor within one (1) business day after being produced by the Vendor.

M. The Vendor shall process all returned mail by obtaining the correct address and re-mailing the correspondence as appropriate in a timely manner.

N. The Vendor shall cooperate fully with other Vendors, consultants or other parties that may be engaged by the Agency.

O. The Vendor shall respond to all Agency requests promptly and appropriately and in accordance with the timeline provided by the Agency.

P. The Vendor shall follow through on all Agency referrals and assignments in an appropriate, professional and timely manner.

Q. The Vendor shall not use Agency statistics or other information provided by the Agency for publication or for purposes other than the identification of other TPL resources or pursuit of Medicaid overpayments as outlined in this ITN, without written consent of the Agency.

R. Upon discovery of any problem or Vendor error for any component of the Contract resulting from this ITN, that may jeopardize the Vendor's ability to perform any function of the Contract, in accordance with the approved operational policies and procedures, the Vendor shall notify the Agency in person, via telephone or electronic mail, as soon as possible but no later than the close of business if the problem or error is identified during the business day and no later than 9:00 a.m. EST or EDT, as appropriate, the following business day if the problem or error occurs after close of business.

S. Upon discovery of any Vendor backlog for any component of the Contract resulting from this ITN, the Vendor shall notify the Agency in person, via telephone or electronic mail, as soon as possible but no later than the close of business if the backlog is identified during the business day and no later than 9:00 a.m. EST or EDT, as appropriate, the following business day if the backlog is identified after close of business.

T. The Vendor **shall provide** a demonstration of the systems/portal required in this ITN at a negotiation meeting held with the Agency.

U. The Vendor shall provide additional information as requested by the Agency at a negotiation meeting held with the Agency.

V. The Vendor shall make a documented good faith effort to ensure all services, provided directly or indirectly under the Contract resulting from this ITN, are performed within the State of Florida. If the Vendor has made such a documented good faith effort and is unable to perform the Contract components resulting from this ITN within the State of Florida, then all such services must be performed within the borders of the United States and its territories and protectorates. Indirect services include, but shall not be limited to, overhead, administrative and redundant backup services or services that are incidental to the performance of the Contract resulting from this ITN. This provision also applies to subcontractors at all tiers.

    1. The Vendor is prohibited from maintaining any offshore call centers for any ITN component.

2. The Vendor is prohibited from offshoring any work for any ITN component that involves protected health information (PHI) as defined in 42 CFR 431.305(b), which includes:

    a. Names and/or addresses of Medicaid recipients;

    b. Social Security numbers of Medicaid recipients;

    c. Social and economic conditions or circumstances of Medicaid recipients;

    d. Any information received for verifying income eligibility and/or amount of medical assistance payments; and

    e. Any information received in connection with identification of legally liable third party resources under 42 CFR 433.138.

D.7 Vendor Systems and Data Requirements:

A. Systems Requirements

1. The Vendor shall cooperate, coordinate and adapt its systems to the requirements of the FMMIS.

2. The Vendor shall use the same operating system software package as the Agency (currently Windows, Office and Internet Explorer) or the most current, up-to-date software and web browser versions available.

3. The Vendor shall maintain sufficient information technology resources (hardware, software, and personnel) to manage the Contract resulting from this ITN and generate all data including liens, claims, fulfillment of records requests, reports, etc. required for the Contract.

4. The Vendor shall demonstrate that it owns, leases or has access to computer facilities in order to be able to accept electronic data, produce electronic billings, data match electronically, generate liens, claims and records requests and produce Medicaid voids, adjustments, accounts receivables, cash receipts, provider expenditures, refunds, reports, etc. through Agency designated electronic or paper media. Sample file formats and forms are provided in **Exhibit I**, File Layouts.

5. The Vendor shall obtain and supply all hardware, software, communication, and equipment necessary to perform the duties associated with the Contract resulting from this ITN and be responsible for any associated programming, equipment, installation of software, maintenance and troubleshooting at no cost to the Agency or fiscal agent.

6. The Vendor shall have information management processes and information systems that enable it to meet Federal and State reporting requirements, all other Contract requirements resulting from this ITN and any other applicable Federal and State laws, rules and regulations including the Health Insurance Portability and Accountability Act requirements.

7. The Vendor's systems shall possess capacity sufficient to handle the workload projected for the start of the Contract resulting from this ITN and shall be scalable and flexible so it can be adapted as needed, within negotiated timeframes, in response to increases in caseload estimates.

8. The Vendor's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The Vendor shall ensure controls are tested in periodic and spot audits, including SAS-70 audits. Results of SAS-70 audits shall be submitted to the Agency upon request.

9. The Vendor shall establish appropriate restrictions and safeguards against unauthorized access to all non-public data entrusted to Vendor staff.

10. The Vendor shall restrict access to information on a "need to know" basis (e.g. users permitted inquiry privileges only shall not be permitted to modify information).

11. The Vendor shall limit attempts to access system functions to a set number with a system function that automatically prevents further access attempts and records these occurrences.

12. The Vendor shall put in place measures and technical security to prohibit unauthorized access to the regions of the data communications network inside a Vendor's span of control.

13. The Vendor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein, as well as accountability control to record access attempts, including attempts of unauthorized access.

14. The Vendor shall be responsible for submitting and managing Vendor staff requests for access connectivity to the State's data communications network, and the relevant information systems attached to this network, in accordance with all applicable State policies, standards and guidelines.

15. The Vendor shall ensure staff are properly trained to utilize Agency and Vendor systems and maintain confidentiality of system passwords.

16. The Vendor shall allow complete global interactive access to all its systems to specified Agency staff.

B. Data Requirements

1. The Vendor shall fully utilize the data provided by the Agency in order to conduct all Contract requirements resulting from this ITN.

2. The Vendor shall provide the Agency, Federal or State auditors or investigators with access to data facilities as required by the Agency.

3. The Vendor shall have and shall obtain no proprietary interest in any data, data files, documents, papers, records and other information, in any form created, that it acquires in the course of its performance under the Contract resulting from this ITN. All such data and information shall be and remain the property of the State.

4. The Vendor shall establish a secure environment to provide sufficient storage space to house all documents including paper and electronic storage media at the Vendor's facility until transfer to the Florida State Records Center.

5. The Vendor shall follow all applicable requirements for the Agency's Records Retention Scheduling and Disposition established by Florida's records management program as authorized by Section 257.36, Florida Statutes, which applies to public records as defined in Section 119.011(12), Florida Statutes.

6. The Vendor shall report to the Agency within twenty four (24) clock hours of discovery, any security incident of which the Vendor is aware.

C. Health Insurance Portability and Accountability Act (HIPAA) Requirements

1. The Vendor shall ensure that the operation of all of its systems is performed in accordance with Federal and State regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations.

2. The Vendor shall ensure all staff are trained regarding their regulatory obligations under HIPAA. Documentation of this training shall be maintained and provided to the Agency upon request.

3. Any PHI released shall be in accordance with HIPAA requirements as interpreted by the Agency and Agency policy.

4. A HIPAA compliant medical release or HIPAA Qualified Protective Order will be required prior to releasing PHI for the casualty, estate and trust and annuity components of the Contract resulting from this ITN.

5. The Vendor shall report to the Agency's Privacy Officer, within one (1) business day of discovery, any use or disclosure of PHI not provided for in the Contract resulting from this ITN of which the Vendor is aware.

6. The Vendor shall submit to the Agency's Privacy Officer, a monthly report of all incidents whereby PHI may have been released inappropriately.

7. The PHI report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

8. The Agency reserves the right to direct the Vendor to amend or update its PHI Report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D. Encryption

1. The Vendor shall ensure all electronic mail communications that contain PHI are encrypted in accordance with HIPAA requirements and Agency policy.

2. The Vendor shall encrypt all data that is submitted to the Agency in electronic format.

3. The Vendor shall use the Agency's encryption software when corresponding with the Agency via electronic mail.

4. Any costs associated with obtaining the Agency's encryption software shall be at the Vendor's expense and at no cost to the Agency.

D.8 Vendor Subcontracting:

The Vendor shall not enter into any subcontract for any services, including the core TPL services described in this ITN without prior written consent of the Agency. The Vendor shall maintain full responsibility for all work to be performed under the resulting Contract. Each approved subcontractor shall be subject to the same terms and conditions as the Vendor. Core TPL services include the following components:

- Casualty recovery;
- Estate recovery;
- Trust and annuity recovery;
- Medicare and other third party payor recovery;
- Cost avoidance;
- Health Insurance Premium Payment Program (HIPP); and
- Other recovery projects.

D.9 Vendor Implementation:

A. Implementation Date

1. Except as otherwise specified, implementation documents shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

2. A summary of implementation documents required for the Contract resulting from this ITN is included in **Exhibit II**, Implementation Documentation.

3. The Agency shall conduct a readiness review of the awarded Vendor that includes, at a minimum, one (1) on-site review.

4. The readiness review shall be conducted October 1, 2015 through October 4, 2015.

5. The Agency shall provide the Vendor with specific items for each aspect of the Contract resulting from this ITN that will be reviewed prior to the date of the readiness review.

6. The Agency reserves the right to rescind the award should the readiness review indicate substantial deficiencies.

7. The implementation date for the Contract resulting from this ITN shall be November 1, 2015.

8. The Vendor will be considered to have met implementation when all implementation documents are received and approved by the Agency and the Vendor is ready to begin conducting all of the required Contract components resulting from this ITN.

9. If the Vendor is unable to conduct any required Contract component resulting from this ITN at 8:00 a.m. EST or EDT as appropriate on November 1, 2015, the Vendor will have not met implementation.

B. Implementation Plan

1. The Vendor shall develop a final implementation plan to be approved by the Agency prior to implementation by the Vendor outlining the steps necessary for the Vendor to be fully operational by 8:00 a.m. EST or EDT as appropriate on November 1, 2015. At a minimum, the final implementation plan shall include:

    a. Tasks associated with the Vendor's establishment of a "project office" or similar organization with which the Vendor shall manage implementation activities;

    b. An itemization of activities that the Vendor shall undertake during the period between Contract award and the implementation date. These activities shall have established deadlines and timeframes and as needed conform to the timelines established in this ITN;

    c. Identification of staff that shall be responsible for each activity;

    d. An estimate of staff-hours associated with each activity in the implementation plan;

    e. Identification of interdependencies between activities in the implementation plan; and

    f. Identification of Vendor expectations regarding participation by the Agency and/or its Agent(s) in the activities in the implementation plan and dependencies between these activities and implementation activities for which the Agency and/or its Agent(s) shall be responsible.

2. The final implementation plan shall be based upon the draft implementation plan that shall be submitted by the Vendor with its response to this ITN.

3. Finalization of the implementation plan shall be coordinated with the Agency to ensure readiness to complete required tasks by the dates specified in this ITN and the resulting Contract.

4. The final implementation plan shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on July 1, 2015.

5. Any deviation by the Vendor from the Agency approved final implementation plan shall be regarded by the Agency as a material breach, and all remedies provided for hereunder shall become available to the Agency.

6. The Vendor shall participate in both face-to-face meetings and conference calls with the Agency and relevant parties prior to the implementation date of the Contract resulting from this ITN for purposes of coordinating implementation activities.

C. Risk Management Plan

1. The Vendor shall develop and maintain a final risk management plan to be approved by the Agency prior to implementation by the Vendor that shall, at a minimum, address any potential implementation risk including but not limited to the following:

    a. Delays in building the appropriate organization, inclusive of delays in hiring and training of staff required to operate Contract components resulting from this ITN;

    b. Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate Contract components resulting from this ITN;

    c. Delays in the receipt of data from carriers, the Agency and/or its Agent(s);

    d. A problem with the telecommunications infrastructure required for interacting with attorneys, providers, carriers, recipients, etc.; and

    e. Problems with systems required for carrying out the requirements of the Contract resulting from this ITN.

2. For each contingency scenario identified, the risk management plan shall include at a minimum the following:

    a. Risk identification and mitigation strategies;

    b. Implementation plans for the identified risk mitigation strategies; and

    c. Monitoring and tracking tools.

3. The final risk management plan shall be based upon the draft risk management plan that shall be submitted by the Vendor with its response to this ITN.

4. The final risk management plan shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on July 1, 2015.

5. During implementation, the Vendor shall update the risk management plan as required by the Agency.

D. Disaster Recovery Plan

1. The Vendor shall develop and maintain a final disaster recovery plan to be approved by the Agency prior to implementation by the Vendor for the following:

    a. Restoring the application of software and current master files;

    b. Hardware backup in the event the production systems are destroyed; and

    c. Restoring day-to-day operations including alternative locations for the Vendor to conduct all Contract components resulting from this ITN.

2. The disaster recovery plan shall limit service interruption to a period of seventy two (72) clock hours and shall ensure compliance with all Contract requirements resulting from this ITN.

3. The records back-up standards and a comprehensive disaster recovery plan shall be developed and maintained by the Vendor for the entire Contract period resulting from this ITN.

4. The final disaster recovery plan shall be based upon the draft disaster recovery plan that shall be submitted by the Vendor with its response to this ITN.

5. The final disaster recovery plan shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

6. The Agency reserves the right to direct the Vendor to amend or update its disaster recovery plan in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

7. The Agency reserves the right to amend procedures and timelines addressed in this ITN in the event of a natural, technological or man-made disaster.

8. The Vendor shall make all components of the disaster recovery plan available to the Agency at all times.

D.10 Vendor Documents:

A. All correspondence developed and used by the Vendor in any format for the purposes of the Contract resulting from this ITN shall be reviewed and approved by the Agency prior to use by the Vendor.

B. The Vendor shall ensure all correspondence, written or electronic, developed and used by the Vendor includes its toll-free telephone number, fax number, e-mail address and website address.

C. All correspondence used by the Vendor shall be written in a professional and efficient manner using plain language.

D. The Vendor shall ensure all written and verbal communication are courteous and prompt, providing accurate and sufficient information, as determined by the Agency and in accordance with Federal and State laws.

E. The Vendor shall generate and submit all billing files, recoupment files (electronic and paper), financial adjustment files, cost avoidance files, and refund/expenditure forms necessary to meet the requirements of the Contract resulting from this ITN and at no cost to the Agency.

F. The file format for recoupment (void) and financial adjustment files is provided in **Exhibit I**, File Layouts.

G. Prior to submission to the Agency, the Vendor shall ensure all correspondence, billing files, recoupment files, reports and other documents are correct and reflect a high level of professionalism as determined by the Agency.

H. The Vendor shall submit to the Agency for review and approval any and all billing files, recoupment files (electronic and paper), cost avoidance files and refund/expenditure forms.

I. The Vendor shall correct all errors discovered or identified at no cost to the Agency.

J. All correspondence to be used by the Vendor for the purposes of the Contract resulting from this ITN shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

K. The Agency reserves the right to direct the Vendor to make revisions to any correspondence in accordance with the best interests of the State and at no cost to the Agency. Revisions may be required prior to or after implementation.

D.11 Vendor Policies and Procedures:

A. Operational Policies and Procedures Manual

1. The Vendor shall develop and maintain one (1) final operational policies and procedures manual for all components of the Contract resulting from this ITN to be approved by the Agency prior to implementation by the Vendor.

2. The operational policies and procedures manual shall specifically address how the Vendor shall conduct all Contract components resulting from this ITN.

3. The operational policies and procedures manual shall be based on the draft operational policies and procedures manual that shall be submitted by the Vendor with its response to this ITN.

4. The final operational policies and procedures manual shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

5. The Agency reserves the right to direct the Vendor to amend or update its operational policies and procedures manual in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

6. The Vendor shall amend or update its operational policies and procedures in order to adapt to any and all changes to Federal or State law and/or changes in Medicaid policy.

7. The operational policies and procedures manual shall be a guide to assist the Vendor in conducting the requirements of the Contract resulting from this ITN. If situations arise, whereby the Vendor must conduct an activity that is outside the approved operational policies and procedures, the Vendor shall submit a request to the Agency in writing and receive the Agency's approval before any alternative action is taken by the Vendor.

8. The Vendor shall make all components of the operational policies and procedure manual available to the Agency at all times.

B. Training Manual

1. The Vendor shall develop and maintain one (1) final training manual for all Contract components resulting from this ITN to be approved by the Agency prior to implementation by the Vendor.

2. The training manual shall specifically address how the Vendor will conduct training for all Contract components resulting from this ITN.

3. The final training manual shall be based upon the draft training manual that shall be submitted by the Vendor with its response to this ITN.

4. The final training manual shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

5. The Agency reserves the right to direct the Vendor to amend or update its training manual in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

6. The Vendor shall make all components of the training manual available to the Agency at all times.

7. The Vendor shall submit to the Agency a monthly report of its training activities in accordance with the approved training manual.

8. The training report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

9. The Agency reserves the right to direct the Vendor to amend or update its Training Report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

C. Quality Assurance Policies and Procedures Manual

1. The Vendor shall develop and maintain one (1) final quality assurance policies and procedures manual for all Contract components resulting from this ITN to be approved by the Agency prior to implementation by the Vendor.

2. The quality assurance policies and procedures manual shall specifically address how the Vendor will conduct all quality assurance activities for all Contract components resulting from this ITN.

3. The final quality assurance policies and procedures manual shall be based on the draft quality policies and procedures manual that shall be submitted by the Vendor with its response to this ITN.

4. The quality assurance policies and procedures manual shall address at a minimum the following:

    a. Internal review processes;

    b. Quality assurance measures;

c. Process to monitor the performance of staff;

d. Adherence to established due dates of deliverables;

e. Quality assurance measures;

f. Designated staff responsible for evaluating staff performance;

g. Escalation procedures; and

h. Performance improvement processes.

5. The final quality assurance policies and procedures manual shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

6. The Agency reserves the right to direct the Vendor to amend or update its quality assurance policies and procedures manual in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D. Quality Assurance Report

1. The Vendor shall submit to the Agency a monthly report of its quality assurance activities and findings for all components of the Contract resulting from this ITN in accordance with the approved operational policies and procedures manual and the approved quality assurance policies and procedures manual.

2. The monthly report shall include at a minimum the following:

a. Executive summary;

b. Review activity that occurred during the reporting month for all Contract components resulting from this ITN;

c. Review findings;

d. Review accomplishments;

e. Summary of findings of staff performance;

f. Identification of patterns and trends;

g. Recommendations for deficiency improvement; and

h. Any additional information as required by the Agency.

3. The Quality Assurance Report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

4. The Agency reserves the right to direct the Vendor to amend or update its Quality Assurance Report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D.12 Vendor Staffing:

A. Requirements

1. Vendor staff includes all staff employed by the Vendor and by its subcontractors relevant to the Contract resulting from this ITN.

2. Vendor staff shall be responsible for communicating all Contract issues to the designated Vendor Contract Manager as the single point of contact.

3. The Vendor shall be prepared at all times to recruit credentialed, appropriately licensed and highly qualified staff.

4. Vendor staff shall be responsible for conducting all components of the Contract resulting from this ITN in a timely, efficient, productive, consistent, courteous and professional manner as representatives of the State.

5. The Vendor shall be responsible for measuring staff productivity and quality.

6. All Vendor staff shall be familiar with and have a general knowledge of all components of the Contract resulting from this ITN.

7. The Vendor shall provide each staff member orientation and training on all components of the Contract resulting from this ITN prior to working on any component of the Contract. Documentation of this training shall be provided to the Agency upon request.

8. The Vendor shall be required to employ the positions described in this ITN. In addition, the Vendor shall employ sufficient staff to complete all requirements initially and throughout the duration of the Contract resulting from this ITN.

9. The Agency reserves the right to review and approve candidates being considered by the Vendor for employment as the Contract Manager and all other required positions described in this ITN.

10. The Agency at its discretion may request the replacement of the Vendor's Contract Manager within thirty (30) calendar days notice and review and approve any subsequent appointment.

11. If at any time during the term of the Contract resulting from this ITN, any of the required positions described in this ITN become vacant, the Vendor shall submit to the Agency a timeline and process for ensuring the vacant position(s) is filled as soon as possible. The timeline shall be due to the Agency within five (5) calendar days of Vendor notification that a position has become or is becoming vacant.

12. The number of staff employed by the Vendor and its subcontractors shall be sufficient to handle the workload projected for the start of the Contract resulting from this ITN and shall be scalable and flexible so it can be adapted as needed.

13. The Vendor shall employ a sufficient number of staff fluent in both English and Spanish.

14. The Vendor shall contract for interpreter services as required and at no cost to the Agency.

15. The Vendor shall replace any personnel whose continued presence would be detrimental to the success of the Contract resulting from this ITN at the discretion of and as determined by the Agency.

16. The Vendor shall make its staff available to meet with Agency staff on a regular basis, as agreed upon by the Agency, to review reports and all other obligations under the Contract resulting from this ITN as required by the Agency.

17. The required positions of the Contract resulting from this ITN shall meet with Agency staff on at least a monthly basis as determined by the Agency, to discuss the status of the Contract, Vendor performance, reports, planning, etc.

18. The Vendor shall develop and maintain a final organizational chart that includes all staff resources that will be assigned to all components of the Contract resulting from this ITN to be approved by the Agency prior to implementation by the Vendor.

19. The final organizational chart shall include a justification for the number of staff, the percentage of time each staff person will devote to the Contract resulting from this ITN and an estimate of assigned caseloads.

20. The final organizational chart shall be based upon the draft organizational chart that shall be submitted by the Vendor with its response to this ITN.

21. The final organizational chart shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

22. The Vendor shall not modify any of the staff contained on its organizational chart without prior Agency approval.

23. In the event the Agency determines the Vendor's staff or staffing levels are not sufficient to properly complete the services specified in this ITN and the resulting Contract, it shall advise the Vendor in writing. The Vendor shall have thirty (30) calendar days to remedy the identified staffing deficiencies.

B. Contract Manager

1. The Vendor shall employ, at a minimum, one (1) Contract Manager.

2. The Contract Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

3. The Contract Manager shall have experience in operating TPL programs.

4. The Contract Manager shall have experience in operating Medicaid overpayment recovery projects.

5. The responsibilities of the Contract Manager shall include at a minimum:

a. Main point of contact between the Vendor and the Agency;

b. Experienced in TPL processes and capable of overseeing all contracted activities resulting from this ITN;

c. Oversee and be responsible for all Contract components resulting from this ITN and ensure that all Contract requirements are met;

d. Communicate with all Vendor staff regarding Contract issues resulting from this ITN;

e. Manage all staff assigned to the Contract resulting from this ITN;

f. Ensure seamless interaction within the Vendor's organization and any subcontractors;

g. Revise processes and/or procedures and assign additional resources as needed to ensure the maximum efficiency and effectiveness of services required under the Contract resulting from this ITN; and

h. Coordinate all aspects of implementation including coordinating with implementation teams and ensuring all implementation deadlines are met.

C. Casualty Manager

1. The Vendor shall employ, at a minimum one (1) Casualty Manager.

2. The Casualty Manager shall be responsible for managing the casualty component of the Contract resulting from this ITN.

3. The Casualty Manager shall serve as a back-up should another manager be unavailable.

4. The Casualty Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

5. The Casualty Manager shall not be assigned a caseload.

6. The Casualty Manager shall ensure there are sufficient qualified staff to conduct the casualty component of the Contract resulting from this ITN.

7. The Casualty Manager shall ensure staff conduct the casualty component of the Contract resulting from this ITN in a timely, efficient and productive manner.

D. Estate and Trust and Annuity Manager

1. The Vendor shall employ, at a minimum one (1) Estate and Trust and Annuity Manager.

2. The Estate and Trust and Annuity Manager shall be responsible for managing the estate and trust and annuity component of the Contract resulting from this ITN.

3. The Estate and Trust and Annuity Manager shall serve as a back-up should another manager be unavailable.

4. The Estate and Trust and Annuity Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

5. The Estate and Trust and Annuity Manager shall not be assigned a caseload.

6. The Estate and Trust and Annuity Manager shall ensure there are sufficient qualified staff to conduct the estate and trust and annuity component of the Contract resulting from this ITN.

7. The Estate and Trust and Annuity Manager shall ensure staff conduct the estate and trust and annuity components of the Contract resulting from this ITN in a timely, efficient and productive manner.

E. Medicare and Other Third Party Payor Manager

1. The Vendor shall employ, at a minimum one (1) Medicare and Other Third Party Payor Manager.

2. The Medicare and Other Third Party Payor Manager shall be responsible for managing the Medicare and other third party payor, cost avoidance and HIPP components of the Contract resulting from this ITN.

3. The Medicare and Other Third Party Payor Manager shall serve as a back-up should another manager be unavailable.

4. The Medicare and Other Third Party Payor Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

5. The Medicare and Other Third Party Payor Manager shall not be assigned a caseload.

6. The Medicare and Other Third Party Payor Manager shall ensure there are sufficient qualified staff to conduct the Medicare and other third party payor, cost avoidance and HIPP components of the Contract resulting from this ITN.

7. The Medicare and Other Third Party Payor Manager shall ensure staff conduct the Medicare and other third party payor, cost avoidance and HIPP components of the Contract resulting from this ITN in a timely, efficient and productive manner.

F. Other Recovery Projects Manager

1. The Vendor shall employ, at a minimum one (1) Other Recovery Projects Manager.

2. The Other Recovery Projects Manager shall be responsible for managing the other recovery projects component of the Contract resulting from this ITN.

3. The Other Recovery Projects Manager shall serve as a back-up should another manager be unavailable.

4. The Other Recovery Projects Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

5. The Other Recovery Projects Manager shall not be assigned a caseload.

6. The Other Recovery Projects Manager shall ensure there are sufficient qualified staff to conduct the other recovery projects component of the Contract resulting from this ITN.

7. The Other Recovery Projects Manager shall ensure staff conduct the other recovery projects component of the Contract resulting from this ITN in a timely, efficient and productive manner.

G. Quality Assurance Manager

1. The Vendor shall employ, at a minimum, one (1) Quality Assurance Manager.

2. The Quality Assurance Manager shall be responsible for ensuring the quality of all of the components of the Contract resulting from this ITN.

3. The Quality Assurance Manager shall ensure all Vendor staff are trained regarding the Contract requirements resulting from this ITN.

4. The Quality Assurance Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

5. The Quality Assurance Manager shall not be assigned a caseload.

6. The Quality Assurance Manager shall ensure there are sufficient qualified staff to conduct all quality assurance activities for all components of the Contract resulting from this ITN.

H. Quality Assurance/Training Staff

1. The Vendor shall maintain sufficient qualified quality assurance/training staff necessary to train, monitor and review all activities for all components of the Contract resulting from this ITN.

2. The Vendor shall establish and maintain an internal quality assurance and training program that addresses all components of the Contract resulting from this ITN including any components conducted by subcontractors.

3. The Vendor shall designate the quality assurance staff responsible for evaluating performance for each component of the Contract resulting from this ITN on its organizational chart.

I. Information Technology Manager

1. The Vendor shall employ, at a minimum, one (1) Information Technology Manager.

2. The Information Technology Manager shall be responsible for training Agency and Vendor staff on information systems.

3. The Information Technology Manager shall be responsible for maintaining and troubleshooting system issues and ensuring on-going systems operations and supporting the Vendor's technology.

4. The Information Technology Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

5. The Information Technology Manager shall not be assigned a caseload.

6. The Information Technology Manager shall ensure there are sufficient qualified staff to conduct all systems operations for all components of the Contract resulting from this ITN.

J. Accounting Manager

1. The Vendor shall employ, at a minimum, one (1) Accounting Manager.

2. The Accounting Manager shall be responsible for managing the accounting activities of the Contract resulting from this ITN.

3. The Accounting Manager shall be a full-time employee. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

4. The Accounting Manager shall not be assigned a caseload.

5. The Accounting Manager shall ensure there are sufficient qualified staff to conduct all accounting activities for all components of the Contract resulting from this ITN.

K. Legal Staff

1. The Vendor shall employ, at a minimum, two (2) Florida licensed attorneys. The attorneys may be required to work at the direction of the Agency. The Florida Bar Rules of Professional Conduct shall apply to the relationship between the attorneys and the Agency. At all times, the attorneys represent the Agency, have a client-lawyer relationship with the Agency, and owe a duty of loyalty to the Agency.

2. One (1) attorney shall have primary responsibility for the casualty component of the Contract resulting from this ITN and one (1) attorney shall have primary responsibility for the estate and trust and annuity components of the Contract. Each attorney shall have the ability to serve as back-up to the other.

3. Additional attorneys may be required based upon case volume or the Agency's discretion.

4. All attorneys shall have a working knowledge of all components of the Contract resulting from this ITN in the event legal issues arise.

5. All attorneys shall be full-time employees. Full-time means forty (40) hours per week designated to the Contract resulting from this ITN.

6. The Vendor shall support the Agency in any legal proceedings resulting from any of the components of the Contract resulting from this ITN. This support includes, but is not limited to, supplying testimony in trial, including expert testimony; as well as

providing supporting documentation, reports, data and any pertinent information deemed necessary by the Agency.

L. Legal Support Staff

The Vendor shall maintain sufficient qualified legal support staff necessary to conduct all legal activities of the Vendor for all the components of the Contract resulting from this ITN.

D.13 Vendor Customer Service:

A. Telephone

1. Notwithstanding any term or condition of this ITN to the contrary, the Vendor bears sole responsibility for ensuring that its performance of the Contract resulting from this ITN fully complies with all State and Federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, §§ 934.01, et seq., Florida Statutes, and the Electronic Communications Privacy Act, 18 U.S.C. § 2510 et seq. (hereafter, collectively, "Communication Privacy Laws").

2. Prior to intercepting, recording or monitoring any communications which are subject to Communication Privacy Laws, the Vendor must:

   a. Submit a plan which specifies in detail the manner in which the Vendor will ensure that such actions are in full compliance with Communication Privacy Laws (the "Privacy Compliance Plan"); and

   b. Obtain written approval, signed and notarized by the Agency Contract Manager, approving the Privacy Compliance Plan.

   c. No modifications to an approved Privacy Compliance Plan may be implemented by the Vendor unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Privacy Compliance Plan is signed and notarized by the Agency Contract Manager. Agency approval of the Vendor's Privacy Compliance Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Vendor's sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Vendor's performance of the Contract resulting from this ITN. Violation of this term may result in sanctions to include termination of the Contract resulting from this ITN and/or liquidated damages.

   d. The "Privacy Compliance Plan" shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

3. The Vendor shall utilize one (1) toll-free telephone system (number) for all Contract components resulting from this ITN.

4. The toll-free telephone number shall be accessible nationwide.

5. The Vendor shall only use its toll-free number when communicating its telephone contact information.

6. The Vendor shall assist all callers in a professional and courteous manner while following all guidelines regarding confidentiality of Medicaid information.

7. The telephone system shall be staffed at a minimum from the business hours of 8:00 a.m. to 5:00 p.m. EST or EDT, as appropriate, Monday through Friday. The Vendor may be closed for State of Florida observed holidays.

8. The Vendor shall provide a before and after hours message advising the caller of the days and hours of operation.

9. Callers shall not encounter a busy signal during the required days and hours of operation.

10. The Vendor may use an interactive voice response system provided that at each level, the callers can choose to speak with a "live" person, rather than continue through additional prompts. A "live" person shall be available during the required days and hours of operation.

11. The "live" person shall be familiar with and have a general knowledge of all components of the Contract resulting from this ITN.

12. The Vendor shall return all telephone calls within eight (8) business hours.

13. The Vendor shall provide the Agency with continuous access to its telephone system from a remote location, for the purpose of monitoring calls in real time.

14. The average caller wait time shall not exceed ninety (90) seconds as measured on a weekly average.

15. The call abandonment/loss rate shall be less than five percent (5%) as measured on a weekly average.

16. The call blockage rate shall be less than one percent (1%) as measured on a weekly average.

17. The Vendor shall submit to the Agency a weekly telephone report that contains at a minimum the following information:

    a. Number of calls by Contract component resulting from this ITN;

    b. Average caller wait time;

    c. Number of abandoned/lost calls;

    d. Duration of calls; and

    e. Complaints including how the complaint was handled and any procedural action that occurred.

18. The telephone report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

19. The Agency reserves the right to direct the Vendor to amend or update its telephone report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

20. The Vendor shall develop and maintain a telephone script that includes all components of the Contract resulting from this ITN to be approved by the Agency prior to implementation by the Vendor.

21. The telephone script shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

22. The Agency reserves the right to direct the Vendor to amend or update its telephone script in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

B. Website

1. The Vendor shall develop and maintain a website to be approved by the Agency prior to implementation by the Vendor that provides educational information regarding all components of the Contract resulting from this ITN and ways of contacting the Vendor (address, telephone, fax, e-mail).

2. The website shall include a method for interested parties to contact the Vendor through an established e-mail account.

3. The Vendor shall respond to messages sent to its e-mail account within eight (8) business hours of receipt.

4. The website shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

5. The Agency reserves the right to direct the Vendor to amend or update its website in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

6. The Vendor shall submit to the Agency a weekly website report that contains at a minimum the following information:

    a. Web counters;

    b. Number of e-mails received by Contract component resulting from this ITN by date/time; and

    c. Number of e-mails responded to by Contract component resulting from this ITN by date/time.

7. The website report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

8. The Agency reserves the right to direct the Vendor to amend or update its website report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

C. Outreach

1. The Vendor shall conduct initial and continuous outreach activities to attorneys, providers, carriers, recipients, etc., in order to educate and provide information on Federal and State laws pertaining to all Contract components resulting from this ITN.

2. The Vendor shall prepare articles for publication and shall speak at professional organization meetings as authorized by the Agency.

3. Agency staff may accompany Vendor staff at meetings or participate in presentations at the sole discretion of the Agency.

4. The Vendor shall prepare and distribute public education materials in relation to Contract activities resulting from this ITN and at no cost to the Agency.

5. All outreach materials shall be approved by the Agency prior to use by the Vendor.

6. The Vendor contact information shall be included on all outreach materials.

7. The Vendor shall develop a final outreach plan for all components of the Contract resulting from this ITN to be approved by the Agency prior to implementation by the Vendor.

8. The final outreach plan shall be based on a draft outreach plan that shall be submitted by the Vendor with its response to this ITN.

9. The final outreach plan shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

10. The Agency reserves the right to direct the Vendor to amend or update its outreach plan in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

11. The Vendor shall submit to the Agency a quarterly report of its outreach efforts to verify adherence to the approved outreach plan.

12. The outreach report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

13. The Agency reserves the right to direct the Vendor to amend or update its outreach report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D.14 Vendor Claims Repository:

A. The Vendor shall make every reasonable effort to ensure that its recovery in one Contract component resulting from this ITN does not overlap its recovery in another Contract component.

B. The Vendor shall be responsible for the development, maintenance and use of a completely one hundred percent (100%) web based claims repository system.

C. All components of the claims repository system shall be completely one hundred percent (100%) web based.

D. The claims repository system shall maintain all claims identified by the Vendor for recovery and the status of all claims for all Contract components resulting from this ITN.

E. The claims repository system shall conform to the requirements of this ITN.

F. The claims repository system shall maintain all claims transferred to the Vendor from the prior Vendor.

G. The Vendor shall completely and totally utilize the data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency as a component of its claims repository system.

H. The Vendor shall have controls in place to ensure appropriate security and integrity of the claims repository system in accordance with applicable Federal and State laws.

I. The Vendor shall ensure that the Agency has complete global interactive access to the claims repository system and training on the system at no cost to the Agency.

J. The Agency shall have complete global interactive access to the claims repository system and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

K. The claims repository system shall be operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

L. The Agency reserves the right to direct the Vendor to amend or update its claims repository system in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D.15 Vendor Case Tracking System:

A. The Vendor shall be responsible for the development, maintenance and use of a completely one hundred percent (100%) web based electronic case tracking system.

B. All components of the case tracking system shall be completely one hundred (100%) percent web based.

C. The case tracking system shall maintain all of the case files for casualty, estate and trust and annuity recoveries.

D. The case tracking system shall conform to the requirements of this ITN and the resulting Contract.

E. The Vendor shall completely and totally utilize the data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency, as a component of its case tracking system.

F. The Vendor shall have controls in place to ensure appropriate security and integrity of the case tracking system in accordance with applicable Federal and State laws.

G. The Vendor shall ensure that the Agency has complete global interactive access to the case tracking system and training on the system at no cost to the Agency.

H. The Agency shall have complete global interactive access to the case tracking system and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

I. All correspondence including paid claim formats to be used by the Vendor in its case tracking system shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

J. The Agency reserves the right to direct the Vendor to amend or update its correspondence and/or paid claim formats in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

K. The case tracking system shall be operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

L. The Agency reserves the right to direct the Vendor to amend or update its case tracking system in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

M. Each case in the tracking system shall contain, at a minimum, the following identifying information:

1. Unique Case Number;

2. Medicaid Recipient Last Name;

3. Medicaid Recipient First Name;

4. Medicaid Recipient Middle Initial;

5. Medicaid Recipient Date of Birth;

6. Medicaid Recipient Date of Death (if applicable);

7. Medicaid Recipient Date of incident (casualty);

8. Medicaid Recipient Social Security Number;

9. Medicaid Recipient Identification Number;

10. Medicaid Recipient Incident Type (casualty);

11. Medicaid Recipient Specific Injuries (casualty); and

12. Trust start/acceptance date (trust).

N. Restitution cases may contain less information than is described above.

O. The case tracking system shall have at a minimum the following capabilities:

1. Accept all data from the current case tracking system used by the current Vendor (all data includes closed cases data);

2. Capability to conduct a case search using the following criteria and combination thereof:

    a. Unique Case Number;

    b. Medicaid Recipient Last Name;

    c. Medicaid Recipient First Name;

    d. Medicaid Recipient Date of Birth;

    e. Medicaid Recipient Social Security Number; and

    f. Medicaid Recipient Identification Number.

3. Open a case through electronic notification;

4. Scan and associate any and all incoming correspondence and payments to the appropriate case file;

5. Identify and link multiple cases for the same recipient to ensure no duplication or overlapping of recovery occurs;

6. Document the case status;

7. Maintain a chronological order of all events that have occurred in the case;

8. Maintain the date and time of any action taken on the case;

9. Document written and verbal communication including date sent or date of occurrence;

10. Document and maintain contact information for the recipient and the associated attorney, defense attorney, insurance company, personal representative, trustee, court, etc.;

11. Document receipt of a complete and valid HIPAA compliant medical release;

12. Document and maintain tortfeasor information;

13. Document and maintain Medicaid HMO information;

14. Document and maintain benefits paid (claims detail);

15. Document liens filed with the court;

16. Document the litigation settlement date and litigation settlement amount;

17. Document and maintain all payments received;

18. Document and maintain all refunds generated;

19. Add notes and/or comments to the case file;

20. Ensure overriding/deletion of data does not occur;

21. Generate the current and/or final balance of a lien and/or claim using the data directly provided by the Agency described in Section D.5, Data to be Provided to the Vendor by the Agency;

22. Generate a complete listing of all paid claims comprising the lien and/or claim in a user friendly format to document and justify the lien and/or claim amount using the data directly provided by the Agency described in Section D.5, Data to be Provided to the Vendor by the Agency;

23. Generate a complete listing of all paid claims for a recipient in a user friendly format in order to fulfill requests for records using the data directly provided by the Agency described in Section D.5, Data to be Provided to the Vendor by the Agency;

24. Submit correspondence, lien amounts and/or claim amounts to interested parties electronically and track to ensure receipt;

25. Ensure estate claims include dates of service only on or after the recipient turned fifty-five (55) years of age;

26. Generate a case specific release of lien form;

27. Generate a case specific satisfaction of lien or claim form;

28. Generate a case specific withdrawal of lien or claim form;

29. Automatically generate appropriate letters, questionnaires, information requests, follow-up reminders, etc. (Special letters and other case-unique correspondence may be generated from another source. These special letters and case-unique correspondence shall be scanned and associated with the appropriate case);

30. Notify staff when cases require action or follow-up in accordance with the requirements of the Contract resulting from this ITN; and

31. Mechanism to monitor performance and case management.

P. The Vendor's case tracking system shall have the ability to generate, at a minimum, the following reports:

1. Number of cases assigned to staff member by program;

2. Number of cases by attorney or insurance company by program;

3. Number of cases by incident type;

4. Number of cases opened by month by program;

5. Number of cases closed by month and reason for closing by program;

6. Number and description of activity types assigned by staff person;

7. Number of cases that have been filed with the court;

8. Lien balance of open cases;

9. Claim balance of open cases;

10. Source of payment; and

11. Other reports as required by the Agency.

D.16 Vendor Web Portal:

A. The Vendor shall be responsible for the development, maintenance and use of a completely one hundred percent (100%) web based portal.

B. All components of the portal shall be completely one hundred percent (100%) web based.

C. The web portal shall maintain information on Medicaid providers pertaining to claims identified, recovered and refunded for the Medicare and other third party payor and other recovery projects components of the Contract resulting from this ITN.

D. The web portal shall conform to the requirements of this ITN and continually utilize the most up-to-date web browser software version available.

E. The Vendor shall completely and totally utilize the data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency, as a component of its web portal.

F. The Vendor shall have controls in place to ensure appropriate security and integrity of the web portal in accordance with applicable Federal and State laws.

G. The Vendor shall ensure that the Agency has complete global interactive access to the web portal and training on the system at no cost to the Agency.

H. The Agency shall have complete global interactive access to the web portal and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

I. The web portal shall be operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

J. The Agency reserves the right to direct the Vendor to amend or update its web portal in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

K. The web portal shall be made available to Medicaid providers in order for them to review and submit information.

L. The Vendor shall provide training to Medicaid providers on the web portal at no cost to the Agency or Medicaid providers.

M. The Medicaid provider training materials shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

N. The Agency reserves the right to direct the Vendor to amend or update its Medicaid provider training materials in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

O. The Vendor shall make all components of the Medicaid provider training materials available to the Agency at all times.

P. The web portal shall be made available to Medicaid providers at 8:00 a.m. EST or EDT as appropriate on November 1, 2015.

Q. The web portal shall have at a minimum the following capabilities:

1. User friendly navigation for Medicaid providers;

2. Allow Medicaid providers to receive recoupment notices, refund notices and associated claims information through the web portal;

3. Post claims information in a user friendly format for Medicaid providers;

4. Provide notification to Medicaid providers that recoupment notices have been posted to the web portal;

5. Document and maintain contact information for Medicaid providers;

6. Allow Medicaid providers the ability to update their contact information;

7. Allow Medicaid providers the ability to review recoupment determinations;

8. Allow Medicaid providers the ability to agree or disagree with recoupment determinations;

9. Allow Medicaid providers the ability to post comments and/or to upload supporting documentation pertaining to recoupments;

10. Allow Medicaid providers the ability to request a refund of recoupment amounts and to upload supporting documentation pertaining to refunds;

11. Allow Medicaid providers to track the status of recoupment and/or refund;

12. Post recoupment amounts and date(s) of recoupment;

13. Post refund amounts and date(s) of refund;

14. Maintain a chronological history of all activities that have occurred for Medicaid providers;

15. Capability to conduct a search using the following criteria and combination thereof:

    a. Medicaid Provider Identification Number;

b. Medicaid Provider Name;

c. Medicaid Recipient Last Name;

d. Medicaid Recipient First Name;

e. Medicaid Recipient Identification Number; and

f. Project Identification Name and/or Number.

16. Provide Vendor staff contact information to Medicaid providers and offer support; and

17. Post frequently asked questions organized by topic to the web portal.

R. The Vendor's web portal shall have the ability to generate, at a minimum, the following reports:

1. Number of Medicaid providers selecting agree by project;

2. Number of Medicaid providers selecting disagree by project and reason for disagreement;

3. Number of days for Medicaid providers to respond to recoupment data posting by project;

4. Number of Medicaid providers requesting refund by project and reason;

5. Number of days for Vendor to respond to Medicaid provider comments and/or documentation submission by staff member by project; and

6. Other reports as required by the Agency.

D.17 Vendor Deliverables:

A. The Vendor shall submit a monthly deliverables report for each project it conducts as a part of the Contract resulting from this ITN.

B. The deliverables report shall pertain to the Medicare and other third party payor and other recovery projects components of the Contract resulting from this ITN.

C. The deliverables report shall contain at a minimum the following information:

1. Project name/description;

2. Dates of service for project;

3. Copy of provider notice mailed;

4. Listing of providers and overpayment amount identified;

5. Date project mailed;

6. Date project closed;

7. Detail listing of claims identified. The claims listing shall include at a minimum the following information:

    a. Medicaid Provider Number;

    b. Medicaid Recipient Number;

    c. Medicaid Recipient Last Name;

    d. Medicaid Recipient First Name;

    e. First Date of Service;

    f. Last Date of Service;

    g. Internal Control Number (ICN);

    h. Recoupment Amount;

    i. Other Information as Required by the Agency;

    j. Final recoupment amount and date recovered by method (i.e., void, adjustment, etc.); and

    k. Detail listing of claims recouped. The claims listing shall include at a minimum the following information:

        i. Medicaid Provider Number;

        ii. Medicaid Recipient Number;

        iii. Medicaid Recipient Last Name;

        iv. Medicaid Recipient First Name;

        v. First Date of Service;

        vi. Last Date of Service;

        vii. Internal Control Number (ICN);

        viii. Recoupment Amount;

        ix. Method of Recoupment (e.g., void, adjustment, etc.); and

        x. Other Information as Required by the Agency.

8. Overpayment amount outstanding and reason outstanding; and

9. Other information as required by the Agency.

10. The deliverables report shall be updated until all amounts identified for a project have been reconciled.

11. The deliverables report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

12. The Agency reserves the right to direct the Vendor to amend or update its deliverables report in accordance with the best interests of the State. Amendments or updates may be required prior to or after implementation.

D.18 Vendor Accounting:

A. The Vendor shall maintain an accounting system and employ accounting procedures and practices, which conform with generally accepted accounting principles and standards and Agency policy.

B. The Vendor shall instruct all parties that payments related to the Contract resulting from this ITN shall be made payable to the "Agency for Health Care Administration."

C. Payments related to the Contract resulting from this ITN shall not be made payable to the Vendor.

D. The Vendor shall not accept as payment any tender other than check, cashier's check, treasurer's check, bank draft or money order.

E. Any acceptance of installment payments shall be approved in advance by the Agency.

F. The Vendor shall be responsible for all costs for deposit systems at no cost to the Agency.

G. The Vendor shall be responsible for depositing all funds in relation to the Contract resulting from this ITN.

H. The Vendor shall deposit funds only into State approved accounts.

I. The Vendor shall restrictively endorse all payments upon receipt as appropriate.

J. The Vendor shall make every effort to determine if a payment pertains to any Contract component resulting from this ITN and deposit appropriately.

K. The Vendor shall notify the Agency of any payment that does not appear to be related to the Contract resulting from this ITN and proceed as instructed by the Agency.

L. The Vendor shall ensure that payments are deposited within eight (8) business hours of receipt whenever possible.

M. Payments not yet deposited shall be stored in a secure location by the Vendor.

N. The Vendor shall maintain a payment hold log for payments that are not deposited within eight (8) business hours of receipt.

O. The payment hold log shall be submitted to the Agency on a daily basis.

P. The Vendor shall ensure there is continuous and sufficient follow-up on payments contained on the payment hold log.

Q. The payment hold log format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

R. The Agency reserves the right to direct the Vendor to amend or update its payment hold log in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

S. The Vendor shall generate and submit to the Agency all required data files and forms necessary to post payment amounts to the FMMIS.

T. The Vendor shall generate and submit to the Agency all required forms in the event it is necessary to refund monies paid to the Agency.

U. The Vendor shall submit to the Agency a copy of deposit slip(s) on a daily basis.

V. If there is no deposit for a particular business day, the Vendor shall notify the Agency via e-mail.

W. The Vendor shall submit to the Agency a daily report of all accounting activities.

X. The daily accounting report shall include the following information at a minimum:

1. Date Check Received;

2. Deposit Date;

3. Deposit Number;

4. Check Date;

5. Check Number;

6. Check Amount;

7. Payor;

8. Case Number (if applicable);

9. Contract Component/Project resulting from this ITN; and

10. Other information as required by the Agency.

Y. The daily accounting report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

Z. The Agency reserves the right to direct the Vendor to amend or update its daily accounting report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

AA. The Vendor shall submit to the Agency a weekly report of all accounting activities.

BB. The weekly accounting report shall include the following information at a minimum:

1. Date Check Received;
2. Deposit Date;
3. Deposit Number;
4. Check Date;
5. Check Number;
6. Check Amount;
7. Payor;
8. Case Number (if applicable);
9. Medicaid Recipient Last Name;
10. Medicaid Recipient First Name;
11. Medicaid Recipient Number;
12. Explanation of Payment (e.g., full, partial, provider refund, carrier payment, etc.);
13. Contract Component/Project resulting from this ITN; and
14. Other information as required by the Agency.

CC. The weekly accounting report format shall be submitted to the agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

DD. The Agency reserves the right to direct the Vendor to amend or update its weekly accounting report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

EE. The Vendor shall submit to the Agency a monthly report of all accounting activities that includes recovery totals for each project.

FF. The monthly accounting report shall include the following information at a minimum:

1. Date Check Received;
2. Deposit Date;
3. Deposit Number;
4. Check Date;
5. Check Number;

6. Check Amount;

7. Payor;

8. Case Number (if applicable);

9. Medicaid Recipient Last Name;

10. Medicaid Recipient First Name;

11. Medicaid Recipient Number;

12. Explanation of Payment (e.g., full, partial, provider refund, carrier payment, etc.);

13. Contract Component/Project resulting from this ITN;

14. Last Claim Paid Date (if applicable); and

15. Other information as required by the Agency.

GG. The monthly accounting report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

HH. The Agency reserves the right to direct the Vendor to amend or update its monthly accounting report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D.19 Method of Payment:

A. The Contract resulting from this ITN will be a combination contingency fee and fixed fee Contract based on specific rates contained in the successful Vendor's response. No other payment will be made to the Vendor under the Contract resulting from this ITN. No payment will be made for cases or projects that do not result in recovery.

B. The successful Vendor shall be paid a fixed contingency fee for recoveries resulting from casualty recovery, estate recovery, trust and annuity recovery and Medicare and other third party payor recovery.

C. The successful Vendor shall be paid a fixed contingency fee for recoveries resulting from the other recovery projects.

D. Proposed contingency fees shall not exceed eleven percent (11%) for any Contract component resulting from this ITN.

E. Fees will be paid to the Vendor only after recovery has been made. Amounts are considered recovered when they have been correctly posted to the FMMIS and/or release/satisfaction documents have been mailed as appropriate.

F. The Vendor shall be paid a fixed per insurance policy fee for providing new and/or updated verified insurance information that has the potential to increase cost avoidance.

G. The Vendor shall be paid a fixed per enrollee per month fee for individuals enrolled in the HIPP Program. "Enrolled" is defined as a month when a premium payment is

appropriately made on behalf of a recipient. In addition, the Vendor shall be reimbursed by the Agency for any premiums paid on behalf of recipients enrolled in the HIPP Program.

H. The Agency reserves the right to direct the Vendor to cease pursuit of a case or project at any time at the sole discretion of the Agency. No fee will be paid to the Vendor for any case or project for which the Agency directs the Vendor not to pursue regardless of the amount of work performed on the case or project by the Vendor.

D.20 Invoicing:

A. The Vendor shall submit a properly completed invoice with all supporting documents to the Agency's Contract Manager no later than the 15th day of the month following the reporting month. Each invoice shall include, at a minimum the following:

1. Invoice Date;

2. Invoice Number;

3. The Agency's Contract Number;

4. Description of the services rendered;

5. The date(s) on which services were rendered;

6. Payment remittance address;

7. Documentation detailing deliverables completed during the preceding month; and

8. Other supporting documentation as required by the Agency.

B. The Vendor shall submit one (1) invoice per month for each of the seven (7) components.

C. Invoice formats shall be standardized and shall be approved by the Agency prior to use by the Vendor.

D. Invoice formats shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

E. The Agency reserves the right to direct the Vendor to amend or update its invoice(s) format in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D.21 Late Invoicing:

Unless written approval is obtained from the Agency, and at the discretion of the Agency, correct invoices with documentation received forty-six (46) to sixty (60) days after the end of the reporting month will be paid at ninety percent (90%) of the amount of the invoice. Correct invoices with documentation received sixty-one (61) to ninety (90) days after the end of the reporting month will be paid at seventy-five percent (75%) of the invoice. Invoices received ninety-one (91) days or after the end of the reporting month will **not** be paid.

D.22 Vendor Reports:

A. Reports submitted by the Vendor shall be at the expense of the Vendor and at no cost to the Agency.

B. The Vendor shall submit all reports in electronic format (compatible with Agency software) unless otherwise directed by the Agency.

C. Daily reports shall be submitted by 5:00 p.m. EST or EDT, as appropriate, on the business day following the day covered by the report.

D. Weekly reports shall be submitted by 5:00 p.m. EST or EDT, as appropriate, on each Monday for the preceding week.

E. Monthly reports shall be submitted by 5:00 p.m. EST or EDT as appropriate, within fifteen (15) calendar days of the end of each month, for the preceding month.

F. Quarterly reports shall be submitted by 5:00 p.m. EST or EDT as appropriate, within fifteen (15) calendar days of the end of each quarter, for the preceding quarter.

G. Annual reports shall be submitted by 5:00 p.m. EST or EDT as appropriate, within sixty (60) calendar days of the end of each year, for the preceding year.

H. Ad hoc reports required by the Agency shall be submitted by 5:00 p.m. EST or EDT as appropriate, within three (3) business days after the date of the request, unless otherwise specified by the Agency.

I. A summary of reports required for the Contract resulting from this ITN is included in **Exhibit III**, Reports.

J. Report formats shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

K. The Agency reserves the right to direct the Vendor to amend or update any and all of its reports or report formats in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D.23 Vendor Legal Action Requirements:

A. Legal Issues

1. The Vendor shall be responsible for all legal costs associated with the requirements of the Contract resulting from this ITN.

2. The Vendor shall take all legal actions necessary to protect the interests of the State in a timely, efficient and appropriate manner.

3. The Agency reserves the right to direct the Vendor to cease legal action when the Agency determines that such action may not be in the best interests of the State.

4. The Vendor shall ensure that all hearings are scheduled, all notifications are properly served, and there is adequate legal representation on behalf of the Agency at all necessary hearings.

5. The Vendor shall submit to the Agency a weekly report containing scheduled hearings to be attended and outcomes of the hearings that were attended for the previous week.

6. The weekly hearing report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

7. The Agency reserves the right to direct the Vendor to amend or update its weekly hearing report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

8. The Vendor shall submit to the Agency a monthly report of all hearings that were attended and a brief summary of the issue and outcome of each hearing.

9. The monthly hearing report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

10. The Agency reserves the right to direct the Vendor to amend or update its monthly hearing report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

11. Notwithstanding any other provisions herein, the Agency may opt to conduct litigation or perform other legal action, either through contract with private counsel or with in-house resources, that would otherwise be handled by the Vendor, and the Vendor shall coordinate directly with the Agency General Counsel's Office. If the Agency uses in-house personnel, the Vendor shall remain responsible for the costs of the litigation, not including the salaries of the Agency personnel. When the Vendor does not perform litigation, the Vendor's contingency fee shall be reduced by an amount to be negotiated during the negotiation phase of this ITN. At the sole discretion of the Agency, sharing of litigation costs may be subject to negotiation during the negotiation phase.

12. Upon receipt of a request for a hearing, the Vendor shall forward such request to the Agency for review and to determine whether the Agency or the Vendor will conduct litigation or perform other legal action as it relates to the hearing request.

B. Subpoenas/Records Requests

1. The Vendor shall file a Motion to Quash in instances when subpoenas are served to the Vendor or on behalf of the Agency whenever it relates to an identifiable Medicaid recipient.

2. A sample Motion to Quash is provided in **Exhibit IV**, Motion to Quash.

3. In addition to filing a Motion to Quash, the Vendor shall send a letter of response to the attorney issuing the subpoena. The letter shall contain the following information:

a. Advise State and Federal regulations prohibit the release of information regarding Medicaid benefits paid on behalf of a recipient unless it pertains to the administration of the Florida Medicaid State Plan.

b. Advise under what circumstances as described in Section 409.910, Florida Statutes, the Vendor will be able to release information.

c. Advise that all parties are required to submit a HIPAA compliant release in order to obtain any PHI. The letter shall enclose a blank release or provide instructions on how to obtain one. A release will not be required if the court has issued a HIPAA Qualified Protective Order.

d. Identify the type of information the Vendor shall release and offer alternative sources for additional information when requested.

4. The Vendor shall issue a letter of response to both the attorney issuing the subpoena and the records company requesting information, if a subpoena is served by a records collection company.

5. If the Vendor is not able to identify the party referenced in the subpoena as a past or present Medicaid recipient, the Vendor shall issue a letter of response indicating that the party in question cannot be identified as a Medicaid recipient and requesting any additional identifying information.

6. When a subpoena is received, the Vendor shall initiate a case in its case tracking system. The case shall document the subpoena and response.

7. If a subpoena is received accompanied by a check, the check shall be returned to the sender by the Vendor in a method to ensure receipt.

8. The Vendor shall neither request nor accept any fee for providing Agency records to any requester.

D.24 Casualty, Estate and Trust and Annuity Case Initiation and Management:

A. Upon receipt of an initial notice, request or communication, the Vendor shall open the proper case type and make an initial response to the requestor by written, telephone or electronic communication within five (5) business days of receipt and document such response in the case.

B. The Vendor shall promptly and thoroughly review all incoming correspondence and documents to ensure a timely and appropriate response reflecting a high level of professionalism and protecting the interests of the State.

C. The Vendor shall ensure staff assigned to manage cases, know the status of the case, know what documents are present in the case file and know what documents may need to be requested.

D. The Vendor shall ensure that the case file information regarding the contact person, address, telephone number, etc., are correct and current.

E. The Vendor shall submit benefits paid when a HIPAA compliant medical release is received.

F. The Vendor shall ensure that the collections for casualty, estate and trust and annuity and all other Contract components resulting from this ITN do not overlap and that the total amount collected does not exceed the amount that Medicaid paid on the recipient's behalf or the amount that is allowed under any applicable waiver, exception, exemption or reduction.

D.25 Casualty Recovery:

A. General Information

1. Section 409.910, Florida Statutes, provides that the Agency collect all amounts determined available from liable third parties and that recipients or their legal representatives notify the Agency of the existence of any third party benefits.

2. The Vendor shall have no authority to negotiate liens outside of Federal and State laws.

B. Liens

1. Upon receipt of the required information, the Vendor shall notify the recipient's attorney, the defense attorney, or the insurance company of any lien within fourteen (14) calendar days.

2. The required information shall include the following and shall be documented in the case:

    a. Sufficient contact information;

    b. Recipient identifying information;

    c. Date of incident;

    d. Incident type; and

    e. Specific incident-related injuries.

3. The Vendor shall review Medicaid paid claims data to determine any lien amount utilizing the data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency.

4. The Vendor shall ensure the consistency and accuracy of lien calculations.

5. The Vendor shall not be required to assert a lien for less than the threshold amount identified in the Florida Medicaid State Plan (currently **$250.00**).

6. The Vendor shall review each case and update any and all liens no less than every sixty (60) calendar days until the lien is paid in full and the case is closed.

7. The lien shall include any related charges for dates of service up to the date of settlement.

8. The Vendor shall take appropriate action to resolve any dispute regarding the lien amount.

9. The Vendor shall initiate a case and pursue recovery of the court ordered restitution amount when notice or payment is received.

10. The Vendor shall file liens with the appropriate court in the following situations:

    a. The attorney or insurance company requests that the lien be filed with the court;

    b. The total lien amount is thirty thousand dollars **($30,000.00**) or greater;

    c. The attorney or insurance company is uncooperative or unresponsive; and/or

    d. As directed by the Agency.

11. The Vendor shall be responsible for withdrawing liens as appropriate.

C. Case Management

1. The Vendor shall determine whether cases are under the authority of casualty recovery by using the information received in conjunction with the Medicaid data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency.

2. The Vendor shall be responsible for regular and continuous follow-up at a minimum of every sixty (60) calendar days on its current caseload.

3. If the Vendor has not received either written or verbal correspondence from the attorney, insurance company, etc. within sixty (60) calendar days, the Vendor shall diligently pursue information regarding the status of the litigation, settlement, or payment.

4. The Vendor shall submit to the Agency a monthly casualty settlement report of cases for which it receives a notice of settlement or lien payment.

5. The casualty settlement report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

6. The Agency reserves the right to direct the Vendor to amend or update its casualty settlement report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

7. The Vendor shall close cases for the following reasons:

    a. The case was opened in error;

    b. The injured person is determined to not have been eligible for Florida Medicaid;

    c. The total lien calculation is less than the threshold amount identified in the Florida Medicaid State Plan (currently **$250.00**) and the date of incident is more than fifteen (15) months ago;

d. The Vendor has documented that there will be no recovery relating to the injury;

e. The Vendor has documented that the payment received represents all anticipated payment and the release or satisfaction of lien has been issued as appropriate; and/or

f. The Agency has directed the Vendor to close the case.

8. The Vendor shall not send a release or satisfaction of lien prior to physically receiving the entire anticipated payment.

D.26 Estate Recovery:

A. General Information

1. Section 409.9101, Florida Statutes, establishes the authority and sets the parameters for the Florida Medicaid estate recovery program.

2. Probate law, Section 733.2121, Florida Statutes, requires that the estate's personal representative (formal administration) notify the Agency of the opening of the estates of deceased recipients who have reached age fifty-five (55).

3. Section 198.30, Florida Statutes, requires each Clerk of Circuit Court to send a monthly report of probate openings to the Agency.

4. The Vendor shall file a Statement of Claim on behalf of the Agency in the probate estates of Medicaid recipients for medical services or goods with dates of service at age fifty-five (55) years or over in accordance with Federal and State laws.

5. Recovery shall not be pursued if the recipient is survived by a spouse, a minor child, or a disabled child of any age.

B. Case Management

1. Upon notification, the Vendor shall determine whether an estate is under the authority of estate recovery by using the information received in conjunction with the Medicaid data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency.

2. The Vendor shall review all notices and accompanying documents and if the estate is under the authority of estate recovery, the Vendor shall file a claim in the appropriate court by the deadline.

3. The Vendor shall review at a minimum five (5) years of Medicaid paid claims data utilizing the data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency.

4. If the Vendor chooses to review more than five (5) years of Medicaid paid claims data, the Vendor shall review those years of claims data consistently and in accordance with the requirements of the Contract resulting from this ITN.

5. The Vendor shall ensure the consistency and accuracy of Statement of Claim filings.

6. The Vendor is not required to file a Statement of Claim for less than the threshold amount identified in the Florida Medicaid State Plan (currently **$100.00**).

7. The Vendor shall retain cases in a pending status when there is no initial record of Medicaid payments. The Vendor shall periodically check for recent payments prior to closing the case.

8. In addition to all information and format required by probate statute and rules, the Statement of Claim shall include the following:

    a. Reference to Sections 414.28 and 409.9101, Florida Statutes, as the authority to file a claim;

    b. The Tax Identification Number of the Agency for Health Care Administration;

    c. Identification and contact information for the Agency as the claimant and for the Vendor as the Agency's representative;

    d. An emphasis that correspondence shall be sent to the Vendor;

    e. The claim amount;

    f. A statement that this is a Class-3 claim in accordance with Sections 733.707(1)(c), 414.28, and 409.9101, Florida Statutes;

    g. Instructions on making payment;

    h. Reference to HIPAA and instructions on how PHI may be obtained; and

    i. Notification of exclusions and waivers available under Sections 409.9101(6) and 409.9101(8), Florida Statutes.

9. Claims shall only be amended after initial filing as directed by the Agency.

10. If a claim is not filed, the Vendor shall close its case and document in the file why a claim was not filed.

11. The Vendor shall pursue full payment of the Medicaid claim from the estate assets available to a Class-3 creditor.

12. The Vendor shall communicate with the estate and obtain an update on the status of probate for all open cases, regardless of circumstances, at a minimum of every ninety calendar (90) days.

13. The Agency retains the sole authority and right to consider, grant or deny all settlement offers, and/or to authorize the Vendor to negotiate the amount and terms of recovery.

14. The Agency retains the sole authority and right to consider, grant or deny a request for hardship waiver.

15. The Vendor shall close its estate case under the following circumstances:

a. The case was opened in error;

b. The decedent is determined to not have been eligible for Florida Medicaid;

c. The estate claim has been paid in full and the Vendor has mailed a Satisfaction and Release of Claim;

d. The estate claim has been paid in full after consideration of included casualty, trust and/or annuity collections and the Vendor has mailed a Satisfaction and Release of Claim;

e. The amount collected equals the amount agreed upon by the Agency and the Vendor has sent a Satisfaction and Release of Claim;

f. The amount collected equals the amount negotiated by the Vendor under the authority granted by the Agency and the Vendor has sent a Satisfaction and Release of Claim;

g. The Vendor has documented the amount collected is all that is available to Medicaid as a Class-3 creditor and the Vendor has mailed a Satisfaction and Release of Claim;

h. The amount collected is the amount to be paid to Medicaid in accordance with a court order and the Vendor has mailed a Satisfaction and Release of Claim;

i. The Vendor has documented that there are no assets available with which to pay the Medicaid claim;

j. The Vendor has documented that no payment is to be made to Medicaid;

k. The Vendor has documented that the decedent was survived by a spouse, a minor child or a disabled child of any age;

l. The Vendor has documented that the decedent was under the age of fifty-five (55) at the time the Medicaid services were rendered;

m. The Vendor documented that the decedent's date of death was more than two (2) years prior to the time when the claim was filed; and/or

n. The Agency has directed the Vendor to close the case.

16. The Vendor shall not send a Satisfaction and Release of Claim prior to physically receiving the entire anticipated payment.

C. County Probate Reports

1. The Vendor shall track and follow-up with each of the sixty-seven (67) Florida counties to ensure each furnishes its monthly probate report in accordance with Florida Statutes.

2. The Vendor shall maintain and provide the Agency copies of the county probate reports upon request.

D.27 Trust and Annuity Recovery:

A. General Information

1. In accordance with Section 1917 of the Social Security Act, recovery shall be made from the trusts and/or annuities of certain Medicaid recipients.

2. Chapter 736, Florida Statutes, relates to the establishment and administration of trusts.

3. Chapter 627, Florida Statutes, relates to the administration of annuities.

4. There are various types of trusts from which Medicaid may be reimbursed. The reimbursement may be either mandatory or optional depending upon the type of trust. The State Medicaid Manual, Section 3259 – Treatment of Trusts and the Department of Children and Families, Economic Self-Sufficiency Services, ACCESS Florida Program Policy Manual, CFOP 165-22, describe the various trusts.

5. Trust agreements established to qualify a person for Medicaid benefits must include a provision to reimburse the Medicaid program at the time the trust is terminated.

6. Sections 414.28 and 409.9101, Florida Statutes, establish that the acceptance of public assistance (including Medicaid) creates a debt of the person accepting assistance; therefore, voluntary reimbursements shall be accepted.

7. A trust may be under the authority of a guardianship. The guardian would be the "trustee" and also have additional responsibilities and authority including overseeing a separate guardianship account from which Medicaid may receive a voluntary reimbursement.

B. Case Management

1. The Vendor may receive notifications from various sources such as the trustee, an attorney, a family member, a nursing home, the Department of Children and Families, etc.

2. Upon notice, the Vendor shall determine whether the trust or annuity is under the authority of Medicaid recovery and initiate a case as appropriate.

3. The Vendor shall provide applicable payment instructions.

4. The Vendor shall have sufficient information to document that the payment received is either the balance of the account or the full reimbursement due to Medicaid.

5. If the documentation received for review indicates account activity after the date of death (other than payment to Medicaid), the Vendor shall address the appropriateness of that activity.

6. If the person resided in a nursing home for a partial month prior to death, and the full personal responsibility amount was paid, a refund from the nursing home to the trust account may be due Medicaid.

7. The Vendor shall not send a Satisfaction and Release of Claim prior to physically receiving the entire anticipated payment.

D.28 Medicare and Other Third Party Payor Recovery:

A. General Information

1. In accordance with Section 409.910, Florida Statutes, the Agency is required to pursue payment for claims that Medicaid has paid when Medicare or another third party payor may have been liable.

2. The Agency utilizes a matrix maintained in the FMMIS to determine whether a claim shall be paid or denied based upon insurance information contained on the Medicaid recipient's file.

B. Data Matching

1. The Vendor shall perform the following data matches at a minimum:

    a. Tricare/CHAMPUS matches as authorized by CMS/DEERS;

    b. Commercial Insurance Carriers;

    c. Medicare Files;

    d. Workers' Compensation File;

    e. Highway Safety and Motor Vehicles File;

    f. Medical Support Enforcement File/New Hire File (Department of Revenue);

    g. Trauma Diagnosis Code File; and

    h. Vital Statistics Files.

2. The Vendor shall perform data matches with other entities as directed by the Agency. There will be no increase in fees for additional data matches conducted by the Vendor.

3. The Vendor shall obtain copies of insured files from potential TPL sources and match the files with Medicaid files.

4. The Vendor shall use valid computer match criteria, which shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

5. The Agency reserves the right to direct the Vendor to amend or update its computer match criteria in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

6. The Vendor shall submit to the Agency a monthly report of its data matching activities.

7. The data matching report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

8. The Agency reserves the right to direct the Vendor to amend or update its data matching report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

C. Medicare

1. The Vendor shall utilize the data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency, and shall determine claims that could have been paid by Medicare.

2. The Vendor shall notify Medicaid providers as appropriate of claims paid by Medicaid for which Medicare may have been liable and recoup any identified Medicaid overpayments.

3. The Vendor shall generate and submit to the Agency recoupment files and/or accounts receivable/cash receipt forms as appropriate in order to recoup Medicaid overpayments.

4. The Vendor shall generate and submit to the Agency a quarterly report of all verified Medicare entitlement information it discovers not on file or incorrectly on file in the FMMIS.

5. The Medicare entitlement report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

6. The Agency reserves the right to direct the Vendor to amend or update its Medicare entitlement report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D. Other Third Party Payor

1. The Vendor shall utilize the data provided by the Agency in accordance with Section D.5, Data to be Provided to the Vendor by the Agency, and shall determine claims that could have been paid by an insurance carrier.

2. The Vendor shall bill insurance carriers as appropriate for claims paid by Medicaid for which an insurance carrier may have been liable.

3. An insurance carrier may request claim information not on the bill before payment can be remitted. The Vendor shall respond to these requests in a timely and efficient manner.

4. If the claim information is not captured or retained by the Medicaid program, the Vendor shall obtain the information from the servicing provider, responding to the insurance carrier in a timely and efficient manner.

5. The Vendor shall notify Medicaid providers as appropriate of claims paid by Medicaid for which an insurance carrier may have been liable and recoup any identified Medicaid overpayments.

6. The Vendor shall generate and submit to the Agency a financial adjustment file resulting from payments received from insurance carriers.

7. The format for the financial adjustment file to be submitted to the Agency from the Vendor is included in **Exhibit I**, File Layouts.

8. The Vendor shall generate and submit to the Agency recoupment files and/or accounts receivable/cash receipt forms as appropriate in order to recoup Medicaid overpayments.

E. Denials

1. The Vendor shall review Explanation of Benefits for claims that are denied by carriers to determine the reason for no payment.

2. The Vendor shall re-bill claims as appropriate.

3. The Vendor shall submit to the Agency a monthly report of the ten (10) most frequent denial reasons.

4. The denial reasons report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

5. The Agency reserves the right to direct the Vendor to amend or update its denial reasons report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

6. The Vendor shall submit to the Agency a monthly report of the ten (10) carriers that have submitted the most denials with the reason(s) for the denial.

7. The carrier denial report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

8. The Agency reserves the right to direct the Vendor to amend or update its carrier denial report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

F. Providers and Recipients

The Vendor shall pursue and recover payments that were made to either providers or recipients directly from carriers that should have been reimbursed to Medicaid.

D.29 Cost Avoidance:

A. TPL Resource File Maintenance

1. The Vendor shall be responsible for maintaining the accuracy of the TPL Resource File in the FMMIS.

2. The Vendor shall add new and/or updated insurance information to the FMMIS in order to assist in future cost avoidance of claims.

3. The Vendor shall manually update insurance information in the FMMIS as appropriate.

4. The Vendor shall manually update the carrier index file in the FMMIS as appropriate.

5. The Vendor shall perform manual updates in the FMMIS within eight (8) business hours of receipt of request for update.

6. The Vendor shall review the daily TPL Resource Update Report which is an eligibility file received from DCF that contains TPL information added in the FMMIS. The Vendor shall verify the insurance information contained on this report and update the TPL Resource File as appropriate.

7. The Vendor shall submit to the Agency a weekly report of its TPL Resource File maintenance activities.

8. The TPL Resource File report format shall be submitted to the Agency for review and approval by 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

9. The Agency reserves the right to direct the Vendor to amend or update its TPL Resource File report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

10. The Vendor shall generate and submit to the Agency a cost avoidance file in order to electronically post insurance information to the FMMIS.

11. The format for the cost avoidance file to be submitted to the Agency from the Vendor is included in **Exhibit I**, File Layouts.

12. The following fields are the minimum required to add/update insurance information in the FMMIS:

    a. Recipient ID;

    b. Carrier Number;

    c. Policyholder (Policyholder/Recipient);

    d. Policyholder Name;

    e. Policy Number;

    f. Policy Type (Group, Individual, Unknown);

    g. Cost Avoidance (shall always be yes);

    h. Lead Origin (data match);

    i. Suspect Code;

    j. Coverage Code;

    k. Effective Date;

    l. End Date; and

m. Chronological Note (information regarding reason for change/update to file).

B. Vendor Fees

1. The Vendor shall receive a fee for new and/or updated verified comprehensive insurance information under the following circumstances:

   a. The individual is full Medicaid eligible at the time the insurance information is added to the FMMIS.

   b. There is currently no policy in the FMMIS and the Vendor identifies and adds new insurance information to the FMMIS that cost avoids Medicaid claims.

   c. There is currently inactive insurance information in the FMMIS and the Vendor identifies and adds new insurance information to the FMMIS that cost avoids Medicaid claims.

   d. There is currently insurance information in the FMMIS and the insurance information identified and added to the FMMIS will increase cost avoidance of Medicaid claims (e.g., an auto insurance policy is on the file and the Vendor adds a major medical insurance policy).

   e. The Vendor identifies a major medical insurance policy as well as any pharmacy and/or dental policy and adds them to the FMMIS. The Vendor shall include any pharmacy and/or dental insurance coverage with the major medical insurance coverage. The Vendor shall receive one fee for identifying this comprehensive coverage.

2. The Vendor shall not receive a fee for new and/or updated verified insurance information under the following circumstances:

   a. Individuals that are ineligible or not covered by full Medicaid.

   b. The following are the eligibility categories for which the Vendor shall not receive a fee:

      i. SLMB (Special or Specified Low-Income Medicare Beneficiaries): Individuals with income above one hundred percent (100%) but less than one hundred twenty percent (120%) of the Federal Poverty Level, who are entitled to Medicare Part A and who are not otherwise eligible for Medicaid. Medicaid Benefit: payment of the Medicare Part B premium.

      ii. QI 1 (Qualifying Individuals I--formerly PBMO, Part B Medicare Only): Individuals with income of at least one hundred twenty percent (120%) but less than one hundred thirty-five percent (135%) of the Federal poverty level, who are entitled to Medicare Part A and who are not otherwise eligible for Medicaid. Medicaid benefit: payment of the Medicare Part B premium.

   c. Updates only to the current carrier information in the FMMIS (e.g., change in carrier code, address, group number, etc.).

d. Information is supplied by another source (e.g., Medicaid Area Office, other State agencies, Medicaid providers, Medicaid Managed Care Organizations, etc.).

e. A pharmacy insurance policy only is added to the FMMIS, unless the Vendor can demonstrate to the Agency that there is no other coverage available to the Medicaid recipient.

f. Insurance policy information is added to the FMMIS by the Vendor but the policy is removed (terminated) within six months of the initial add by the Vendor (e.g. old insurance policy or bad insurance policy).

C. Leads Letters

1. When Medicaid processes a claim that includes a third party payment for services but the third party information is not in the FMMIS a "leads letter" shall be sent by the Vendor to the Medicaid recipient in order to determine if other insurance is available.

2. The Vendor shall mail leads letters within three (3) business days of receipt of the leads letter information from the Agency.

3. The format for the leads letter information is included in **Exhibit I**, File Layouts.

4. The Vendor shall provide postage paid return envelopes with the mailing.

5. The Vendor shall manually update insurance information in the FMMIS within eight (8) business hours of receipt.

6. The Vendor shall follow-up with recipients who submit incomplete information or who do not return the leads letter.

7. The Vendor shall submit to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015 its proposed method for following-up with recipients who do not return the leads letter.

8. The Agency reserves the right to direct the Vendor to amend or update its leads letter follow-up method in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

9. The Vendor shall submit to the Agency a monthly report of its leads letters activities.

10. The leads letter report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

11. The Agency reserves the right to direct the Vendor to amend or update its leads letter report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D. TPL State Review

1. Providers are required to attach an Explanation of Benefits response to a Medicaid claim when an insurance company denies a Medicaid provider's claim, prior to submission to the fiscal agent for processing.

2. The Vendor shall review and process claims pended for review that contain an Explanation of Benefits in a timely and efficient manner in accordance with Federal and State laws and Agency policy.

3. The Vendor shall ensure no claim remains suspended for TPL review for more than thirty (30) calendar days.

4. The current TPL State Review procedures are provided as **Exhibit V**, TPL State Review Procedures.

D.30 Health Insurance Premium Payment (HIPP) Program:

A. General Information

1. In accordance with the Florida Medicaid State Plan, the Agency shall pay the employee share of employer-sponsored health care coverage when it is cost effective to do so.

B. Cost Effectiveness Criteria

1. When determining cost effectiveness of employer-sponsored health care coverage, the following considerations shall be applied:

   a. The cost of the Medicaid premium that would have been paid to a managed care plan for the recipient;

   b. The employee's share of the employer-sponsored health care coverage;

   c. The average fee-for-service expenditures paid by Medicaid for recipients with other insurance coverage; and

   d. The administrative cost (Vendor's per enrollee per month fee).

2. An example of the cost effectiveness criteria formula is included as **Exhibit VI**, Health Insurance Premium Payment (HIPP) Cost Effectiveness Criteria.

C. Process

1. The Vendor shall be responsible for developing and administering the HIPP program in accordance with Federal and State laws.

2. The Vendor shall be responsible for the development and maintenance of a method to track recipients evaluated for the HIPP program and track recipients enrolled in the program including payment information.

3. The Vendor shall identify recipients eligible for the HIPP program.

4. The Vendor shall ensure all Medicaid recipients are evaluated in order to determine if they are eligible for the HIPP program.

5. The Vendor shall ensure the cost effectiveness of Medicaid paying insurance premiums.

6. The Vendor shall ensure all Medicaid recipients are enrolled in the HIPP program as appropriate.

7. The Vendor shall communicate directly with recipients, employers and ESI plans.

8. The Vendor shall have the ability to generate premium payments within three (3) business days of receipt of a complete and valid reimbursement request.

9. The Vendor shall submit to the Agency a weekly report of its HIPP activities.

10. The HIPP report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

11. The Agency reserves the right to direct the Vendor to amend or update its HIPP report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

D.31 Other Recovery Projects:

A. The Agency may accept or reject other projects suggested by the Vendor during the term of the Contract resulting from this ITN in accordance with the best interests of the State.

B. The Agency may request the Vendor conduct additional projects during the term of the Contract resulting from this ITN in accordance with the best interests of the State.

C. All projects and fees shall be approved by the Agency prior to implementation by the Vendor.

D. The Agency may request the Vendor to program a recovery project and produce an Agency approved report in order for the Agency to conduct the recovery. The Vendor shall be paid an Agency approved percentage of the final recovered amount.

E. The Vendor shall supply the professional staff (according to Agency standards) for approved projects that require medical and/or other types of record reviews.

F. The Vendor shall submit to the Agency a monthly report of its other recovery projects activities.

G. The other recovery projects report format shall be submitted to the Agency for review and approval no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015.

H. The Agency reserves the right to direct the Vendor to amend or update the other recovery projects report in accordance with the best interests of the State and at no cost to the Agency. Amendments or updates may be required prior to or after implementation.

I. The Agency is the sole owner of all software developed as a result of any and all other recovery projects conducted by the Vendor, including, but not limited to, the source code and all supporting documentation.

J. All supporting documentation in the possession of the Vendor, including the source code, shall be delivered to the Agency upon conclusion of the Contract resulting from this ITN.

This shall not apply to any other software or application developed by the Vendor either before or during the term of the Contract resulting from this ITN.

D.32 Performance Standards and Liquidated Damages:

A. The Agency reserves the right to impose liquidated damages upon the Vendor for failure to comply with the performance standard requirements set forth in Table 1, Performance Standards and Liquidated Damages below.

TABLE 1 PERFORMANCE STANDARDS AND LIQUIDATED DAMAGES	
Performance Standard Requirement	**Liquidated Damages To Be Imposed**
The Vendor shall submit all implementation documents as outlined in **Exhibit II**, Implementation Documentation to the Agency no later than August 1, 2015.	**$10,000.00** per calendar day for each calendar day beyond August 1, 2015 by less than two (2) calendar days. **$20,000.00** per calendar day for each calendar day beyond August 1, 2015 by two (2) or more calendar days but less than five (5) calendar days. **$30,000.00** per calendar day for each calendar day beyond August 1, 2015 by five (5) or more calendar days but less than ten (10) calendar days. **$40,000.00** per calendar day for each calendar day beyond August 1, 2015 by ten (10) or more calendar days.
The Vendor shall implement all Contract components resulting from this ITN no later than November 1, 2015.	**$50,000.00** per calendar day for each calendar day beyond November 1, 2015 by less than two (2) calendar days. **$100,000.00** per calendar day for each calendar day beyond November 1, 2015 by two (2) or more calendar days but less than five (5) calendar days. **$200,000.00** per calendar day for each calendar day beyond November 1, 2015 by five (5) or more calendar days but less than ten (10) calendar days. **$400,000.00** per calendar day for each calendar day beyond November 1, 2015 by ten (10) or more calendar days.
Upon discovery of any Vendor backlog for any component of the Contract resulting from this ITN, the Vendor shall notify the Agency in person, via telephone or electronic mail, as	**$50,000.00** per occurrence where a Vendor problem, error and/or backlog is not disclosed to the Agency in accordance with the requirements of

soon as possible but no later than the close of business if the backlog is identified during the business day and no later than 9:00 a.m. EST or EDT, as appropriate, the following business day if the backlog is identified after close of business.	this ITN.
Unscheduled system unavailability shall not exceed one percent (1%) per month on any given month during the hours and days of operation.	**$100,000.00** per month that the unavailability rate exceeds this threshold.
Scheduled system unavailability shall not exceed one-half percent (0.5%) per month on any given month during the same hours/days.	**$100,000.00** per month that the unavailability rate exceeds this threshold.
The Vendor shall not enter into any subcontract for any services, including the core TPL services described in this ITN, without the express written prior consent of the Agency.	**$100,000.00** per occurrence where the Vendor utilizes the services of a subcontractor without prior Agency approval.
The Vendor shall develop and maintain a final disaster recovery plan that contains the requirements outlined in Section D.9, Implementation, Subsection D., Disaster Recovery Plan.	**$100,000.00** per day for each calendar day that the Vendor fails to meet any part of the disaster recovery plan.
All correspondence developed and used by the Vendor in any format for the purposes of the Contract resulting from this ITN shall be reviewed and approved by the Agency prior to use by the Vendor.	**$50,000.00**, for each occurrence, if the Vendor utilizes any correspondence that has not been approved in advance by the Agency. **$50,000.00**, for each occurrence, if the Vendor submits a billing or recovery project to affected parties without prior Agency approval.
Prior to submission to the Agency, the Vendor shall ensure all correspondence, billing files, recoupment files, reports and other documents are correct and reflect a high level of professionalism as determined by the Agency.	**$50,000.00**, for each occurrence, if the Vendor submits a billing or recovery project to affected parties that contains significant errors as determined by the Agency.
The Vendor shall develop and maintain one (1) operational policies and procedures manual for all components of the Contract resulting from this ITN that contains the requirements outlined in Section D.11, Vendor Policies and Procedures.	**$50,000.00** per occurrence if the Vendor utilizes any procedure that has not been approved in advance by the Agency. **$50,000.00** per occurrence for each Agency approved operational procedural timeline that is not adhered to by the Vendor. **$50,000.00**, for each occurrence, if the Vendor does not respond either timely or appropriately to the Agency or other party as required by the Agency.
The Vendor shall not modify any of the staff contained on its organizational chart without	**$50,000.00** per occurrence where the Vendor modifies its Agency approved

prior Agency approval.	organizational chart without prior Agency approval.
The Vendor shall comply with the requirements outlined in Section D.13, Vendor Customer Service.	**$20,000.00** per occurrence where there is a documented occurrence of a caller encountering a busy signal during the required days and hours of operation. **$20,000.00** per occurrence where there is a documented occurrence of no "live" person being available during the days and hours of operation. **$20,000.00** per occurrence where there is a documented occurrence of a telephone call not being returned within eight (8) business hours. **$20,000.00** per occurrence where the Vendor's average caller wait time exceeds ninety (90) seconds as measured on a weekly average. **$20,000.00** per occurrence where the Vendor's average call abandonment/loss rate exceeds five percent (5%) as measured on a weekly average. **$20,000.00** per occurrence where the Vendor's average call blockage rate exceeds one percent (1%) as measured on a weekly average.
The Vendor shall comply with the requirements outlined in Section D.22, Vendor Reports and **Exhibit III**, Reports.	**$25,000.00** per calendar day for each calendar day a report described in **Exhibit III**, Reports is not submitted by the required due date. **$25,000.00** per occurrence if the Vendor submits an incomplete and/or incorrect report or a report in a format not previously approved by the Agency.
The Vendor shall comply with the requirements outlined in Section D.23, Vendor Legal Action Requirements.	**$50,000.00** for each hearing that could potentially impact recovery that is not attended due to the fault of the Vendor. **$50,000.00** for each legal deadline that could potentially impact recovery that is not adhered to due to the fault of the

	Vendor.
The Vendor shall comply with the requirements outlined in Section D.24, Casualty, Estate and Trust and Annuity Case Initiation and Management.	**$25,000.00** per occurrence if the Vendor does not make an initial response within five (5) business days of receipt of initial notice of a casualty, estate recovery or trust and annuity recovery case.
The Vendor shall comply with the requirements outlined in Section D.25, Casualty Recovery.	**$25,000.00** per occurrence if the Vendor does not send notice of a lien for a casualty case within fourteen (14) calendar days of receipt of the required information. **$25,000.00** per occurrence if the Vendor does not review each casualty case and follow-up as appropriate every sixty (60) calendar days.
The Vendor shall comply with the requirements outlined in Section D.26, Estate Recovery.	**$25,000.00** per occurrence if the Vendor does not review each estate case and follow-up as appropriate every ninety (90) calendar days.
The Vendor shall comply with the requirements outlined in Section D.28, Medicare and Other Third Party Payor Recovery.	**$50,000.00** per occurrence if the Vendor does not demonstrate to the satisfaction of the Agency it has conducted a required data match.
The Vendor shall comply with the requirements outlined in Section D.29, Cost Avoidance.	**$25,000.00** per occurrence when manual updates to the TPL Resource File are not completed within eight (8) business hours of receipt of request for update. **$25,000.00** per occurrence when leads letters are not mailed within three (3) business days of receipt of the leads letter information. **$25,000.00** per calendar day for each calendar day that claims remain pending review by the Vendor for more than thirty (30) calendar days.
The Vendor shall comply with public records laws, in accordance with Section 119.0701, Florida Statutes.	**$5,000.00** for each incident in which the Vendor does not comply with a public records request.

The Agency's Contract Manager will monitor the Vendor's performance in accordance with the monitoring requirements of the Contract resulting from this ITN and may determine the level of liquidated damages to be imposed based upon an evaluation of the severity of the deficiency. Failure by the Vendor to meet the established minimum performance standards may result in the Agency, in its sole discretion, finding the Vendor to be out of compliance, and all remedies provided in the Contract resulting from this ITN and under law, shall become available to the Agency.

B. General Liquidated Damages

1. The Agency may impose up to a one percent (1%) reduction of the total, monthly invoice amount for each incident in which the Vendor has failed to meet a deadline as specified in the Contract resulting from this ITN, not to exceed five percent (5%) per month.

2. The Agency will impose upon the Vendor liquidated damages of five hundred dollars (**$500.00**) to five thousand dollars (**$5,000.00**), per incident per occurrence, depending upon the severity, if the Vendor inappropriately releases Protected Health Information. In addition, federal penalties may apply in accordance with the Health Insurance Portability and Accountability Act of 1996.

D.33 Special Provision(s):

A. Performance Bond

A performance bond in the amount of ten percent (10%) of the total amount of the Contract resulting from this ITN shall be furnished to the Agency by the successful vendor.

The performance bond shall be furnished to the Agency's Procurement Office, Building 2, MS#15, 2727 Mahan Drive, Tallahassee, FL 32308, within thirty (30) calendar days after execution of the Contract resulting from this ITN and prior to commencement of any work under the Contract. A copy of all performance bonds shall be submitted to the Agency's Contract Manager.

No payments will be made to the successful vendor until the performance bond is in place and approved by the Agency in writing. The performance bond shall remain in effect for the full term of the Contract resulting from this ITN, including any renewal. The Agency shall be named as the beneficiary of the Vendor's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by the Agency directly to the Agency.

The cost of the performance bond will be borne by the Vendor.

Should the successful vendor terminate the Contract resulting from this ITN prior to the end of the resulting Contract period, an assessment against the bond will be made by the State to cover the costs of issuing a new solicitation and selecting a new vendor. The Vendor agrees that the Agency's damages in the event of termination by the Vendor shall be considered to be for the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

B. Monitoring by Vendor

The Vendor shall ensure that each employee or subcontractor who performs activities related to the services associated with the Contract resulting from this ITN, will report to the Agency areas of concern relative to the operation of any entity covered by the Contract. To report concerns, the Vendor employee or subcontractor may contact the Agency Complaint Hotline by calling 1-888-419-3456 or by completing the online complaint form found at http://apps.ahca.myflorida.com/hcfc. Reports which represent individuals receiving services are at risk for, or have suffered serious harm, impairment or death shall be reported to the Agency immediately and no later than twenty-four (24) hours after the observation is made. Reports that reflect noncompliance that does not rise to the level of

concern noted above shall be reported to the Agency within ten (10) days of the observation.

C. Minority and Certified Minority Subcontractors

The Agency for Health Care Administration encourages the Vendor to use Minority and Certified Minority businesses as subcontractors when procuring commodities or services to meet the requirements of the Contract resulting from this ITN.

A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups: African American (Certified Minority Code H or Non-Certified Minority Code N), Hispanic American (Certified Minority Code I or Non-Certified Minority O), Asian American (Certified Minority Code J or Non-Certified Minority Code P), Native American (Certified Minority Code K or Non-Certified Minority Code Q), or American Woman (Certified Minority Code M or Non-Certified Minority Code R).

D. MyFloridaMarketPlace Vendor Registration

Each Vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in Section 287.012, Florida Statutes, shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.030, Florida Administrative Code, unless exempt under Rule 60A-1.030(3) Florida Administrative Code.

E. MyFloridaMarketPlace Transaction Fee

The Contract resulting from this ITN has been exempted by the Florida Department of Management Services from paying the one percent (1%) transaction fee per Rule 60A-1.032(2)(a and b), Florida Administrative Code.

F. Public Records Requests

In addition to Standard Contract, Section I, Item M., Requirements of Section 287.058, Florida Statutes and other Contract requirements provided by law, the Vendor shall comply with Section 119.0701, Florida Statutes, if applicable, as follows:

1. The Vendor shall keep and maintain public records that ordinarily and necessarily would be required in order to perform services under the Contract resulting from this ITN;

2. The Vendor shall provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in s. 119.0701, F.S., or as otherwise provided by law;

3. The Vendor shall ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law;

4. The Vendor shall meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Vendor upon termination of the Contract resulting from this ITN and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the information technology systems of the Agency; and

5. If the Vendor does not comply with a public records request, the Agency shall enforce the Contract provisions in accordance with the Contract resulting from this ITN.

G. Smartphone Applications

If the Vendor uses smartphone applications (apps) to allow customer direct access to Agency-approved documents and/or content, the Vendor shall comply with the following:

1. The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Vendor or customer; and

2. The Vendor shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines; for example:

   a. OWASP [Open Web Application Security Project] Secure Coding Principles – http://www.owasp.org/index.php/Secure_Coding_Principles;

   b. CERT Security Coding - http://www.cert.org/secure-coding/; and

   c. Top 10 Security coding Practices – https://www.securecoding.cert.org/confluence/display/seccode/Top+10+Secure+Coding+Practices

H. Social Networking

The Vendor shall adhere to the following requirements for policy development, permitted uses of applications and acceptable content for social networking applications/tools in performance of the Contract services resulting from this ITN. These requirements shall apply to all interactions/communications by the Vendor or its subcontractors with enrollees, providers and website requirements, when conducted through social networking applications.

1. General Requirements

a. The Vendor shall establish a social networking administrator, who can hold another position, but is ultimately responsible for the Vendor policy development, implementation and oversight of all social networking activities.

b. The Vendor shall develop and maintain written social networking policies and procedures and a social networking monitoring plan in accordance with the Contract resulting from this ITN. The policies and procedures shall include a statement of purpose/general information stating how the Vendor uses social networking; for example, customer service, community outreach or notifications to enrollees and/or providers. The social networking monitoring plan shall be developed in accordance with Item e., Monitoring, below.

   i. The Vendor shall submit these policies, procedures and monitoring plan, including the intended uses and all initial social networking site static, distributed or broadcast content to the Agency for approval sixty (60) calendar days prior to the launch of any new social networking application.

a) Changes in social networking usage and/or content must be submitted to the Agency for approval sixty (60) calendar days prior to the effective date of the change.

b) The Vendor shall evaluate and annually submit these policies, procedures and monitoring plan, including social networking site content to the Agency on an annual basis, each November 1. However, if the policies, procedures or monitoring plan have been approved by the Agency within six (6) months prior to the annual evaluation/submission above, and are unchanged from the previous Contract year, the Vendor shall submit an attestation to the Agency that the prior year's social networking policies, procedures and monitoring plan are still in place.

ii. The policies and procedures shall include the requirement that, when using social networking applications, the safeguarding of Protected Health Information (PHI) and all HIPAA Privacy Rule-related information must be maintained and monitored. The Vendor shall ensure that social networking records are maintained in accordance with the Contract resulting from this ITN, for the purposes of monitoring of this requirement.

iii. The social networking policies and procedures shall identify management resources, internal teams, external management resources (subcontractors) and human resources needed or used to monitor usage, analyze information trends and prepare responses for the public or private individuals/organizations.

iv. The social networking policies and procedures shall specify record retention requirements in accordance with the Contract resulting from this ITN, and include those records kept of each update and who is responsible for the update as it occurs, interactions/communications or messages posted, with identifying handle or representative code in order to specify which Vendor employee has issued the interaction/communication.

c. The Vendor shall develop and maintain a social networking matrix that identifies staff, subcontractors and volunteers participating in social networking activities on behalf of the Vendor. The Vendor shall provide the Agency with unrestricted access to this matrix upon request. This matrix shall be updated within one (1) business day of any change and include the following information for each person:

i. The social networking application name; for example, MySpace, Twitter, Facebook, Nixle.com, etc.;

ii. First and last name of the individual;

iii. Username (if applicable);

iv. Email address;

v. Password; and

vi. Description of the social networking role, responsibility usage and control.

d. The Vendor shall provide to its staff, subcontractors and volunteers instruction and training on the Contract resulting from this ITN and the Vendor's social networking policies and procedures as outlined in this section, before using social networking applications on behalf of the Vendor.

e. The Vendor shall ensure that, for each social networking application (site) used, there is at least one (1) back-up staff/administrator with knowledge of the login credentials.

f. The Vendor shall ensure that social networking application/site passwords shall be changed immediately when Vendor staff, subcontractors and volunteers, with knowledge of passwords/credentials, are no longer employed by the Vendor or is no longer responsible for social network applications.

g. The Vendor is vicariously liable for any social networking violations of its employees, agents, volunteers, vendors or subcontractors.

   i. In addition to all other liquidated damages and/or sanctions available in the Contract resulting from this ITN, any violations of this section shall subject the Vendor to administrative action by the Agency as determined by the Agency.

   ii. The Vendor shall report to the Agency any Vendor staff who violates any requirements of the social networking policies and procedures or of this Contract within fifteen (15) calendar days of knowledge of such violation.

h. The Vendor shall comply with copyright and intellectual property law and shall reference or cite sources appropriately on all social networking sites.

i. In addition to all other review and monitoring aspects of the Contract resulting from this ITN, the Agency reserves the right to monitor or review the Vendor's monitoring of all social networking activity without notice.

2. Social Networking Applications

a. The following social networking applications or media interactions/communications are permitted by the Agency upon its written approval:

   i. Micro-blogging/Presence applications: Twitter, Plurk, Tumblr, Jaiku, Fmylife;

   ii. Social networking: Bebo, Facebook, LinkedIn, MySpace, Orkut, Skyrock, Hi5, Ning, Elgg;

   iii. Social Network aggregation: NutshellMail, FriendFeed; and

   iv. Events: Upcoming, Eventful, Meetup.com.

b. Unless listed in a. above, the following social networking sites or media are prohibited. Examples of prohibited social networking sites or media include but are not limited to:

   i. Collaboration

      a) Wikis: Wikipedia, PBwiki, wetpaint;

b) Social bookmarking (or social tagging): Delicious, StumbleUpon, Google Reader, CiteULike;

c) Social news: Digg, Mixx, Reddit, NowPublic; and

d) Opinion sites: epinions, Yelp.

ii. Multimedia

a) Photo sharing: Flickr, Zooomr, Photobucket, SmugMug, Picasa;

b) Video sharing: YouTube, Vimeo, sevenload;

c) Livecasting: Ustream.tv, Justin.tv, Stickam; and

d) Audio and Music sharing: imeem, The Hype Machine, Last.fm, ccMixter.

iii. Reviews and Opinions

a) Product Reviews: epinions.com, MouthShut.com; and

b) Community Q&A: Yahoo! Answers, WikiAnswers, Askville, Google Answers.

iv. Entertainment

a) Media and Entertainment Platforms: Cisco Eos;

b) Virtual worlds: Second Life, The Sims Online, Forterra; and

c) Game sharing: Miniclip, Kongregate.

v. Other

a) Information aggregators: Netvibes, Twine (website);

b) Platform providers: Huzu; and

c) Blogs: Blogger, LiveJournal, Open Diary, TypePad, WordPress, Vox, Expresssion Engine.

c. In any invitation, link or information about third party social networking applications or sites presented by the Vendor that requires a user to have a membership, the Vendor shall clearly advise users of the following:

i. That participation will require the user to become a member of the third party host;

ii. Disclaim the Vendor's responsibility for the third party membership;

iii. That the third party controls the membership, privacy, and data exchanged, and may use information for its own marketing purposes (or sell it;) and

iv. Disclaim that despite efforts to keep the Vendor-provided information timely and accurate, users should be aware that the information available through this social media tool may not be timely, accurate, or complete due to the outside dependency on the social media site. The disclaimer should also mention that the social media tool being used is not private and that no protected health information or personally identifying information should be published on this social networking application/site by the Vendor or end user.

3. User Requirements

a. The Vendor's presence on such social networking sites must include an avatar and/or a username that clearly indicates the Vendor that is being represented and cannot use any Agency logo or State of Florida seal. When registering for social networking applications, the Vendor shall use its email address. If the application requires a username, the following syntax shall be used: http://twitter.com/<Vendor_identifier><username>.

b. The Vendor shall personalize its interactions/communications to include an identifying handle or representative code in order to specify which Vendor employee has issued the interaction/communication. The Vendor shall keep social networking records in accordance with social networking record retention requirements specified in Item 1.b.iv. above.

c. All Social Networking interactions/communications must be initiated by the Medicaid enrollee or prospective enrollee, or friend/follower, and not the Vendor.

d. The Vendor's social networking interactions/communications with the public must either be general broadcast messages of information availability or responses to inquiry that contain only referral to authoritative resources such as the Vendor or appropriate state or federal agency websites (including emergency public health advisories). The Vendor shall not reference, cite, or publish information, views or ideas of any third party without the third party's written consent and only as permitted by the Agency for the purpose of conducting business in accordance with the Contract resulting from this ITN.

e. The Vendor may distribute updates, messages and reminders only to registered friends/followers who have chosen to receive these types of interaction/communication whether actively or passively (through a subscription initiated by the external user). Any subscription must be initiated by an opt-in approach from a user. Any communication resulting from such a subscription shall include a link/method to opt-out of the subscription.

f. The Vendor shall not conduct business relating to the Contract resulting from this ITN, that involves the exchange of personally identifying, confidential or sensitive information on a Vendor social network application.

g. The Vendor shall place photographs on pages that are hosted on the site and not linked from outside web pages. The Vendor shall not post

information, photos, links/URLs or other items online that would reflect negatively on any individual(s), its enrollees, the Agency or the State.

h. The Vendor shall not place/embed video on its social networking sites.

i. The Vendor shall not tag photographic or video content and must remove all tags placed by others upon discovery.

j. The Vendor shall not allow advertising, whether targeted or general, on its social networking sites in areas under the Vendor's control.

k. The Vendor shall not use affiliate/referral links or banners on its social networking sites. This includes links to other non-Medicaid lines of business in which the Vendor or a parent company is engaged. The Vendor shall ensure the following:

   i. Any site that automatically generates such linkage, recommendation, or endorsement on side bars or pop-ups must contain a message prominently displayed in the area under the Vendor's control that such items, resources, and companies are NOT endorsed by the Vendor or the Agency; and

   ii. Any external links on any websites controlled by the Vendor shall be clearly identified as external links and must pop up a warning dialog when clicked on informing the user that they are leaving the Vendor's site.

4. Functionalities

a. The following functionalities are permitted:

   i. Search – Finding information through keyword search;

   ii. Links – Guides to other related information; and

   iii. Signals – The use of syndication technology such as RSS to notify users of content changes.

b. The following functionalities are prohibited:

   i. Authoring – The ability to create and update content leads to the collaborative work of many rather than just a few web authors such as in wikis and/or blogs. In wikis, users may extend, undo and redo each other's work. In blogs, posts and the comments of individuals build up over time;

   ii. Tags – Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories;

   iii. Extensions – Software that makes the Web and application platform as well as a document server; and

iv. Forums – Sites hosted by a company that allow users to create topics (threads) and post comments, questions, etc., that are available for public conversation among all members in the forum.

5. Monitoring

The Vendor shall include the following social networking areas in its monitoring:

a. Social networking matrix of users as specified in Item 1.c., above;

b. Social networking content updates and posting;

c. Social networking records retention; and

d. Social networking permitted and prohibited activities and functionalities.

D.34 Vendor Contract Close-Out:

A. The Vendor shall be authorized to continue its collection efforts on cases and projects opened/begun during the Contract resulting from this ITN for a period of six (6) months following the conclusion of the Contract, including all extensions and renewals. After this six (6) month period, the Vendor shall transfer all data in paper and/or electronic format to the Agency.

B. The Vendor shall cooperate fully with the Agency in any transition to a subsequent Vendor, including the transfer of all paper and/or electronic files related to the Contract resulting from this ITN to the Agency.

C. The Agency shall process the Vendor's final invoice only after the Agency has determined that all data has been transferred satisfactorily.

D.35 Definitions:

Abandoned Call - A call in which the caller elects an option and is either not permitted access to that option or disconnects from the system.

Ad Hoc - A report designed for a specific purpose, case, or situation.

Adjustment - A transaction that changes any payment information on a previously paid claim.

After Hours - Hours that extend beyond the business hours of 8:00 a.m. to 5:00 p.m. EST or EDT as appropriate.

Agency for Health Care Administration (Agency) - The agency in Florida responsible for the administration of the Medicaid program, for the licensure and regulation of health facilities and for providing information to Floridians about the quality of the health care they receive in Florida.

Avatar - A small graphic or pseudonym used on a website that identifies the person logging in.

Blocked Call - A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up behind a defined threshold.

Blog (Web Blog) - A type of website, usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order.

Broadcast - Video, audio, text, or email messages transmitted through an internet, cellular or wireless network for display on any device.

Business Day - Traditional workday, including Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded,

Business Hour - The hours of 8:00 a.m. through 5:00 p.m. EST or EDT on business days.

Calendar Day - All seven days of the week. A twenty-four (24) hour period between midnight and midnight, regardless of whether or not it occurs on a weekend or holiday.

Carrier Index File - The file within the FMMIS that contains identifying information for insurance carriers.

CHAMPUS - The former health care program established to provide health coverage for active duty family members and retirees and their family members. TRICARE was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994. Benefits covered under CHAMPUS are now covered under TRICARE Standard.

Claim - A request for Medicaid to pay for health care services.

CMS - Centers for Medicare and Medicaid Services.

Contract - The written agreement between the Agency and the Vendor comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Amendment - Any written alteration in the specifications, delivery point, rate of delivery, Contract period, price, quantity, or other Contract provisions of any existing Contract.

Contract Manager - An individual designated to be responsible for the management of the Contract.

Cost Avoidance - Ensuring Medicaid does not pay for claims for which another third party is liable.

Department of Children and Families (DCF) - The Florida agency that determines Medicaid eligibility in many categories and operates the FLORIDA System to record Medicaid eligibility and eligibility for other State assistance programs.

DEERS - Defense Enrollment Eligibility Reporting System. A computerized database of military sponsors, families and others who are entitled under the law to TRICARE benefits.

Denial - To refuse to pay a claim as submitted.

Deliverable - All software, documentation, reports, manuals, and any other item that the Vendor is required to produce and/or tender to the State under the terms and conditions of the Contract.

EDT - Eastern Daylight Time

EST - Eastern Standard Time

Fee For Service - A method of payment where the provider is paid a fee for each procedure performed and billed within the Medicaid policy limitations.

Fiscal Agent - A private corporation under contract with the Agency to process Medicaid claims.

Florida Medicaid Management Information System (FMMIS) - The information system used to process Florida Medicaid claims, and payments to health plans, and providers, and to produce management information and reports relating to the Florida Medicaid program. This system is used to maintain Medicaid eligibility data and provider enrollment data.

Friends/Followers - Persons that choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - A Federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

Implementation - The period of time after signing of the Contract during which the Vendor is preparing to operate the functions for which it is responsible under the terms of the Contract.

Internal Control Number (ICN) - A unique number assigned to each claim the fiscal agent receives.

Interactions - Conversational exchange of messages.

Matrix - The mechanism within the FMMIS that all claims pass through to determine whether a claim will pay or deny based upon third party insurance coverage.

Medicaid - The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s.1396 et seq., and regulations thereunder, as administered in the State by the Agency under s.409.900 et seq., Florida Statutes.

Medicaid Recipient/Beneficiary - Any individual that DCF or the Social Security Administration, on behalf of DCF, determines is eligible, pursuant to Federal and State law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Must - Indicates a mandatory requirement or a condition to be met.

Overpayment - Any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Paid Claim - A claim that has resulted in the provider being reimbursed for some dollar amount or a zero paid amount.

Protected Health Information (PHI) - For purposes of the Contract resulting from this ITN, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Vendor from, or on behalf of the Agency.

Provider - An entity, facility, person or group who is enrolled in the Medicaid program, renders services to Medicaid recipients and bills Medicaid for services.

Recovery - The overpayment has been satisfied by either receipt of a check, cashier's check, treasurer's check, bank draft or money order, and/or the overpayment has been posted to the FMMIS.

Recoupment - The overpayment has been satisfied by either receipt of a check, cashier's check, treasurer's check, bank draft or money order, and/or the overpayment has been posted to the FMMIS.

Shall - Indicates a mandatory requirement or a condition to be met.

Social Networking Applications - Web-based services that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation and instant messaging services.

State - The State of Florida.

Static Content - Copy written by the Vendor or taken from an outside authoritative source for web posting, for any period of time, shall be defined as Static Content. Static content does not include individualized emails or status messages.

Subcontractor - An entity that performs tasks at the direction of the prime contractor.

Tags/Tagging - Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.

Third Party Liability (TPL) Resource File - The file within the FMMIS that contains any identified insurance coverage for Medicaid recipients.

TRICARE - Health care coverage for medical services, medications, and dental care for military families and retirees and their survivors.

Username - An identifying pseudonym associating the author to messages or content generated.

Vendor - The entity that contracts directly with the Agency for the work specified within this ITN.

Void – A process whereby an original paid claim is refunded to Florida Medicaid.

Web Counter – A method to measure and display the number of visitors a web site has received.

Will - Indicates a mandatory requirement or a condition to be met.

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EXHIBIT I
FILE LAYOUTS

INSTITUTIONAL FILE LAYOUT

Column Name	Description	Type	Length	Precision	Occurrence
SAK_RECIP	The system assigned internal key for a unique recipient.	NUMBER	9	0	
NUM_ICN	Number assigned to a claim processed in the system. This number is used for control purposes.	CHAR	13	0	
NUM_ICN_FORMER	ICN of mother claim when the current claim is a daughter claim due to an adjustment.	CHAR	13	0	
NUM_DTL_TOTAL	Total number of details associated with the claim header.	NUMBER	4	0	
CDE_CLM_STATUS	Code which indicates the header status of the claim in the system.	CHAR	1	0	
CDE_CLM_TXN_TYP	Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.	CHAR	1	0	
CDE_CLM_TYPE	Code that specifies the type of claim record. The valid codes for UB92 claims are I - Inpatient, O - Outpatient, L - Nursing Home, A - Crossover Part A and C - Outpatient Crossover	CHAR	1	0	
NUM_PAT_ACCT	Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).	VARCHAR2	38	0	
CDE_TYPE_OF_BILL	The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do not carry place of service at header.	VARCHAR2	4	0	
DTE_ADMISSION	Date that the recipient was admitted by the provider for inpatient care, outpatient services or start of care.	NUMBER	8	0	
CDE_ADMIT_HOUR	The hour during which the patient was admitted for inpatient or outpatient care.	CHAR	4	0	
CDE_ADMIT_TYPE	Code which indicates the priority of the admission for inpatient or outpatient care.	CHAR	1	0	
CDE_PATIENT_STATUS	Code which indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.	CHAR	2	0	
AMT_PD_PAT_UB92	Amount of money a recipient is responsible for paying for services that were rendered.	NUMBER	9	2	
DTE_BILLED	Date on which the provider or	NUMBER	8	0	

	billing service prepared the claim form to be submitted.				
AMT_BILLED_UB92	Amount of money requested for payment by the provider for services performed.	NUMBER	9	2	
AMT_PAID	The amount of money (check or EFT) we will pay to the submitter of the claim.	NUMBER	9	2	
DTE_FIRST_SVC	Date on which the statement period on the claim began.	NUMBER	8	0	
DTE_LAST_SVC	Date on which the statement period on the claim ended.	NUMBER	8	0	
ID_PROV_ATTEND	The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.	CHAR	15	0	
ID_PROV_OTHER	License number of the physician who performed the principal procedure.	CHAR	15	0	
ID_PROV_OTHER_2	License number of the second physician who performed the principal procedure.	CHAR	15	0	
IND_PROV_SIGN	Indicates whether the paper claim form was signed by the provider who performed the service.	CHAR	1	0	
ID_CLERK	The ID of the clerk who has been assigned to work this claim.	CHAR	8	0	
AMT_REIMBURSEMENT	Percentage that is used to modify the allowed amount.	NUMBER	9	2	
AMT_DISP_SHARE	This field holds the result of the disproportionate share amount multiplied by the total allowed amount.	NUMBER	9	2	
NUM_DAYS_COVD	Indicates the total number of days for the statement period of the claim.	NUMBER	4	0	
IND_ELECT_CLM	Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.	CHAR	1	0	
CDE_CERTIFICATE	This field represents the certification code for Managed Care recipients.	CHAR	2	0	
AMT_OVERHEAD	unused	NUMBER	9	2	
CDE_PROV_SPEC	Code which indicates the scope of practice or operations of the billing provider.	CHAR	3	0	
CDE_PROV_TYPE	Code which indicates the provider type for which a provider is licensed.	CHAR	2	0	
CDE_COUNTY	Numeric (geographical/political) representation of the county in the state in which the provider practices.	VARCHAR2	10	0	

CDE_ADMIT_SOURCE	The source of admission code that is found in block 20 of the UB92 claim form for inpatient and LTC claims.	CHAR	1	0	
Cde_Med_Rec_Num	Medical Record Number	VARCHAR2	30	0	
Cde_Claim_Frequency	CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.	CHAR	1	0	
IND_CARRIER_DENIED	Indicates if other insurance carrier denied the claim	CHAR	1	0	
NUM_DAYS_NCOVD	Indicates the number of days not covered for the statement period of the claim.	NUMBER	4	0	
DTE_FINAL	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.	NUMBER	8	0	
DTE_FINAL_LAST_PAYER	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.	NUMBER	8	0	
CDE_ENC_STATUS	Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.	CHAR	1	0	
IND_ENCOUNTER	This field indicates if the claim is an encounter. Valid values Y or N.	CHAR	1	0	
IND_PR_OVERRIDE	Override Billing Provider calculation	CHAR	1	0	
IND_PR_OVERRIDE_FACILITY	Override Facility Provider calculation	CHAR	1	0	
IND_PR_OVERRIDE_OTHER_2	Override Other Provider 2 calculation	CHAR	1	0	
ID_PROVIDER1	Medicaid id of billing provider	CHAR	15	0	
ID_PROVIDER2	Medicaid id of facility	CHAR	15		
ID_PROVIDER3	Medicaid id of Other provider	CHAR	15		
Number of details	Number of detail records included in file	NUMBER	4		0 - 9999
Number of Occurrences		NUMBER	3		0 -999
Number of Inp Recs		NUMBER	3		0 - 999
Number of Diag X records		NUMBER	3		0 - 999
Number of Value records		NUMBER	3		0 - 999

Number of Condition records		NUMBER	3		0 - 999
Number of Header Key records		NUMBER	3		0 - 999
Number of ICD10 records		NUMBER	3		0 - 999
Number of Payer records		NUMBER	3		0 - 999
Number of Crossover records		NUMBER	3		0 - 999
Number of NH records		NUMBER	3		0 - 999
Number of Treatment records		NUMBER	3		0 - 999
NUM_DTL	The detail number of a claim record.	NUMBER	4	0	**Start of details**
DTE_FIRST_SVC	The first date on which services are rendered for a recipient.	NUMBER	8	0	
DTE_LAST_SVC	Service Line Date. Used to store the service line "To Date" where relevant.	NUMBER	8	0	
CDE_REVENUE	System assigned key used to uniquely identify a revenue code.	NUMBER	4	0	
CDE_PROC	Procedure Code	CHAR	6	0	
QTY_UNITS_BILLED	Number of units of service billed at the detail for a UB92 claim.	NUMBER	9	2	
QTY_UNITS_ALWD	Quantity allowed for payment for services rendered to a recipient.	NUMBER	9	0	
AMT_BILLED_UB92	Amount of money requested by a provider for payment on a UB92 claim form.	NUMBER	9	2	
AMT_ALWD	Amount allowed by the specific program.	NUMBER	9	2	
AMT_PAID	Amount paid for services rendered.	NUMBER	9	2	
AMT_CO_PAY	Amount paid by recipient for services rendered.	NUMBER	7	2	
CDE_CLM_STATUS	Indicates the status of a transaction record in the MMIS system.	CHAR	1	0	
IND_SYS_GENERATE	Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no.	CHAR	1	0	
amt_detail_TPL	This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts inCAS03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount.	NUMBER	9	2	
NUM_DTL_REF	This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original submitted with more than one tooth number. Bundling: When two or more details are bundled into a single NEW detail, then the	NUMBER	4	0	

	original bundled details point to the new bundling detail using a sequence number. The new bundling detail will have the system generated flag on unbundling. This is the reverse of bundling. In this case a detail claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.				
IND_PR_OVERRIDE_OTHER_2	Override Other Provider 2 calculation	CHAR	1	0	
ID_PROVIDER	Medicaid id of second physician who performed the principle procedure	CHAR	15		
CDE_PROC_EXT_KEY	Code which indicates the service that was performed.	CHAR	6	0	
qlf_procedure_id	Product/Service ID (Procedure Code) Qualifier. Code identifying the type/source of the descriptive number used in Product/Service ID (Procedure Code).	CHAR	2	0	
cde_UoM	Unit or Basis for Measurement Code. Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	CHAR	2	0	
amt_unit_rate	Unit Rate. AKA Service Line Rate, Service Line Rate Amount. The rate per unit of associate revenue for hospital accommodation.	NUMBER	10	4	
amt_non_covered	Service Line Non-Covered Charge Amount, Line Item Denied Charge or Non-Covered Charge Amount.	NUMBER	9	2	
qlf_svc_line_dte	Date Time Qualifier for Service Line Date. Code specifying type of date or time, or both date and time.	CHAR	3	0	
qlf_svc_line_dte_fmt	Date Time Period Format Qualifier for Service Line Date. Code indicating the date format, time format, or date and time format.	CHAR	3	0	
id_prov_attend	The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.	CHAR	15	0	
id_prov_other	License number of the physician who performed the procedure.	CHAR	15	0	
id_prov_other_2	License number of the second physician who performed the procedure.	CHAR	15	0	

CDE_PROC_SUB	submitted Procedure Code for HIPAA 835	CHAR	6	0	
CDE_PROC_MOD1_SUB	submitted Procedure Modifier1 for HIPAA 835	CHAR	2	0	
CDE_PROC_MOD2_SUB	submitted Procedure Modifier2 for HIPAA 835	CHAR	2	0	
CDE_PROC_MOD3_SUB	submitted Procedure Modifier3 for HIPAA 835	CHAR	2	0	
CDE_PROC_MOD4_SUB	submitted Procedure Modifier4 for HIPAA 835	CHAR	2	0	
CDE_REV_SUB	submitted Revenue Code for HIPAA 835	NUMBER	4	0	
QTY_BILLED_SUB	submitted units billed for HIPAA 835	NUMBER	9	2	
CDE_OCCURRENCE	Code which defines a significant event relating to a particular UB92 claim that may affect payer processing.	CHAR	2	0	**Start of occurrences**
DTE_OCCURRENCE	The occurrence date of a significant event relating to a particular UB92 claim that may affect payer processing.	NUMBER	8	0	
DTE_OCC_TO	The occurrence to date of a significant event relating to a particular UB92 claim that may affect payer processing. This date is only used for span occurrence codes.	NUMBER	8	0	
QLF_CODE_LIST	This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence	VARCHAR2	3	0	
AMT_BASE_DRG	Base payment amount for an inpatient claim prior to any payment adjustments such as outliers or medical education costs.	NUMBER	9	2	**Start of inp**
AMT_DAY_OUTLIER	Amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the State.	NUMBER	9	2	
AMT_COST_OUTLIER	Costs associated with the capital costs of the facility. Capital costs include, but are not limited to, depreciation, interest, property taxes, and property insurance.	NUMBER	9	2	
CDE_DIAG1	First diagnosis (other than principal) that influenced DRG assignment. This field will be blank if a diagnosis (other than principal) did not influence DRG assignment.	CHAR	7	0	
CDE_DIAG2	Second diagnosis (other than principal) that influenced DRG assignment. This field will be blank if a second diagnosis (other than principal) did not influence DRG assignment.	CHAR	7	0	
CDE_DIAG_CC	Diagnosis that satisfied the complication/cormorbidity (CC)	CHAR	7	0	

	criteria and influenced DRG assignment. This filed will be blank if there is no CC, major CC or non-traumatic major CC.				
CDE_PROC1	First operating room procedure that influenced DRG assignment. This field will be blank if no operating room procedure influenced DRG assignment.	CHAR	6	0	
NUM_VERSION_DRG	Grouper version in use.	VARCHAR2	20	0	
AMT_DISP_SHR	This is the disproportionate share amount that is calculated during the claims pricing process and paid on the claim.	NUMBER	9	2	
CDE_PROC2	Second operating room procedure that influenced DRG assignment. This field will be blank if no operating room procedure influenced DRG assignment.	CHAR	6	0	
CDE_DIAG_SEQ	Indicates whether diagnosis is primary, secondary, third, fourth, fifth, sixth, seventh, eighth, ninth, admitting, or emergency in the header. Values are 1 - 9, A, or E. The admitting diagnosis is sequence A and the emergency diagnosis is sequence E.	CHAR	2	0	**Start of diag x**
QLF_CODE_LIST	This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence	VARCHAR2	3	0	
CDE_DIAG	The diagnosis code that was keyed on the claim.	CHAR	7	0	
CDE_VALUE	Code used to relate values to identified data elements necessary to process a UB92 claim.	CHAR	2	0	**Start of value**
QLF_CODE_LIST	This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence	VARCHAR2	3	0	
AMT_VALUE	Dollar amount of the corresponding value code.	NUMBER	9	2	
CDE_COND	Code used to identify conditions relating to a UB92 claim that may affect payer processing.	CHAR	2	0	**Start of condition**
CDE_COND_SEQ	Sequence number where the condition code was entered on the claim.	CHAR	2	0	
QLF_CODE_LIST	This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence	VARCHAR2	3	0	
ID_PROVIDER	Identification number assigned to a group or individual who provides services to a recipient.	CHAR	15	0	**Start of header key**
ID_MEDICAID	Identification number assigned to a recipient of services.	CHAR	12	0	
CLM_RECIP_FST_NAM	This is the first initial of the	VARCHAR2	35	0	

	recipient's name. It is what is keyed on the claim.				
CLM_LST_NAM_RECIP	This is the first three characters of the recipient's last name. It is what is keyed on the claim.	VARCHAR2	60	0	
cde_Billing_EntityId	Billing Provider Primary ID.	VARCHAR2	15	0	
Cde_Related_Cause_1	CLM - Accident Related Cause	CHAR	2	0	
Cde_Related_Cause_2	CLM - Accident Related Cause	CHAR	2	0	
Cde_Related_Cause_3	CLM - Accident Related Cause	CHAR	2	0	
cde_bill_payto_provider	Code identifying the type of provider. Valid values are: BI - Billing, PT - Pay-To BILLING/PAY-TO	CHAR	3	0	
qlf_sub_dob_fmt	Date Time Period Format Qualifier for Subscriber Date of Birth (DOB). Component of Subscriber Demographic Information.	CHAR	3	0	
dte_subscriber_dob	Subscriber Date of Birth (DOB). AKA Patient Date of Birth. Component of Subscriber Demographic Information.	DATE	8	0	
Cde_Sub_Gender	2000BA - Subscriber Gender	CHAR	1	0	
qlf_facility	Facility Code Qualifier. Code identifying the type of facility referenced. Component of Claim Information.	CHAR	2	0	
cde_med_assignment	Medicare Assignment Code. Code indicating whether the provider accepts Medicare assignment. Component of Claim Information.	CHAR	1	0	
ind_benefits_assignment	Benefits Assignment Certification Indicator. Indicates whether (Yes) or not (No) insured or authorized person authorizes benefits to be assigned to the provider. Component of Claim Information.	CHAR	1	0	
cde_release_of_info	Release of Information Code. Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. Component of Claim Information.	CHAR	1	0	
cde_accident_st	Auto Accident State or Province Code. For Auto Accident Related Causes, the Standard State or Province Code as defined by the appropriate government agency. Component of Claim Information.	CHAR	2	0	
cde_accident_country	Auto Accident Country Code. Code identifying the country where the accident occurred if outside the US. Component of Claim Information.	CHAR	3	0	

cde_special_program	Special Program Code. Code indicating the Special Program under which the services rendered to the patient were performed. Component of Claim Information.	CHAR	3	0	
ind_paper_eob	Explanation of Benefits (EOB) Indicator. Indicates whether (Yes) or not (No) a paper EOB is requested. Component of Claim Information.	CHAR	1	0	
cde_delay_reason	Delay Reason Code. Code indicating the reason why a request (e.g. for information) was delayed. Component of Claim Information.	CHAR	2	0	
qlf_discharge_time	Date Time Qualifier for Discharge Hour. Code specifying type of date or time, or both date and time.	CHAR	3	0	
qlf_discharge_time_fmt	Date Time Period Format Qualifier for Discharge Hour. Code indicating the date format, time format, or date and time format.	CHAR	3	0	
time_discharge	Discharge Hour (HHMM)	NUMBER	4	0	
qlf_statement_dates	Date Time Qualifier for Statement Dates. Code specifying type of date or time, or both date and time.	CHAR	3	0	
qlf_statement_dt_fmt	Date Time Period Format Qualifier for Statement Dates. Code indicating the date format, time format, or date and time format.	CHAR	3	0	
qlf_admit_dt_hour	Date Time Qualifier for Admission Date/Hour. Code specifying type of date or time, or both date and time.	CHAR	3	0	
qlf_admit_dt_tm_fmt	Date Time Period Format Qualifier for Admission Date/Hour. Code indicating the date format, time format, or date and time format.	CHAR	3	0	
amt_TPL_hdr_only	This is the TPL amount for header only services.	NUMBER	9	2	
id_pr_facility	Identification number assigned to the facility provider	CHAR	15	0	
TOB_SUB	submitted Type Of Bill for HIPAA 835	CHAR	3	0	
NUM_PAT_ACCT_SUB	submitted Type Of Bill for HIPAA 835	VARCHAR2	38	0	
CDE_PROC_ICD10	Code which represents the surgical procedure code.	VARCHAR2	4	0	**Start of ICD10**
DTE_ICD_9_CM_PROC	Date on which the surgical procedure code was performed.	NUMBER	8	0	
QLF_CODE_LIST	This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence	VARCHAR2	3	0	

QLF_DT_PERIOD_FORMAT	This code identifies the Date-Time format of the DTE_PROC_ICD10. To be used when creating outbound 837 transaction.	VARCHAR2	3	0	
CDE	Code indicating the payer. A value of 'C' indicates that Medicaid is the payer, 'A' indicates that Medicare is the payer and 'B' indicates that another insurance company was the payer.	CHAR	1	0	**Start of Payer**
AMT_PRIOR_PAYMENT	The amount that the hospital has received toward payment of a UB92 bill prior to the billing on the claim.	NUMBER	9	2	
AMT_DUE_EST	The amount estimated by the hospital to be due from the indicated payer.	NUMBER	9	2	
AMT_DEDUCT	The amount the recipient must pay before Medicare will begin to pay this claim.	NUMBER	8	2	**Start of Crossover**
AMT_COINSURANCE	Dollar amount which represents the recipient's coinsurance payment.	NUMBER	8	2	
AMT_DEDUCT_BLOOD	The amount Medicare has determined that a recipient must pay for blood procedures performed.	NUMBER	8	2	
DTE_MCARE_PAID	The date that Medicare paid the claim.	NUMBER	8	0	
AMT_PAID_MCARE	The dollar amount paid by Medicare for the services provided	NUMBER	10	2	
AMT_ALWD_MCARE	The dollar amount ALLOWED by Medicare for the services provided	NUMBER	10	2	
CDE_LOC	This is the recipient's level of care code.	CHAR	3	0	**Start of NH**
SAK_RECIP	The system assigned internal key for a unique recipient.	NUMBER	9	0	
DTE_FIRST_SVC	This is the first date of service on the claim.	NUMBER	8	0	
DTE_LAST_SVC	This is the last date of service on the claim.	NUMBER	8	0	
IND_SEGMENT_TYPE	This column indicates whether the segment has been created for LTC claims ('L') or for Hospice claims ('S').	CHAR	1	0	
DTE_ADMIT	This is the date of admission.	NUMBER	8	0	
CDE_PATIENT_STATUS	Indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.	CHAR	2	0	
DTE_DISCHARGE	This is the date of discharge.	NUMBER	8	0	
IND_SEGMENT_STATUS	This column indicates whether the segment is active ('A') or inactive ('I').	CHAR	1	0	
DTE_SEGMENT_CREATED	This is the date when segment is created in the database.	NUMBER	8	0	

DTE_SEGMENT_UPDATED	This is the date when segment is updated in the database.	NUMBER	8	0	
IND_SRC_UPDATED	This column indicates the source that created/updated the segment ('C' - Claims, 'A' Adjustments etc.).	CHAR	1	0	
CDE_TREATMENT	Code used to identify conditions relating to a UB92 claim that may affect payer processing.	VARCHAR2	30	0	**Start of treatment**
QLF_CODE_LIST	This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence	VARCHAR2	3	0	

PHARMACY FILE LAYOUT

Column Name	Description	Type	Length	Precision	Occurrence
SAK_RECIP	The system assigned internal key for a unique recipient.	NUMBER	9	0	
AMT_CO_PAY	Amount paid by the recipient for drugs dispensed.	NUMBER	7	2	
AMT_NET_BILLED	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).	NUMBER	8	2	
AMT_TOT_REIMB	Amount reimbursed to provider for drugs dispensed.	NUMBER	10	2	
NUM_ICN	Number assigned to a claim processed in the system used for internal control purposes.	CHAR	13	0	
NUM_ICN_FORMER	ICN of mother claim when the current claim is a daughter claim due to an adjustment.	CHAR	13	0	
TPL_AMT	Amount paid for drugs by a third party.	NUMBER	8	2	
CDE_CLM_TXN_TYP	Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.	CHAR	1	0	
CDE_CLM_STATUS	Indicates the status of a claim.	CHAR	1	0	
DTE_BILLED	Date on which the provider or billing service prepared the claim form to be submitted.	NUMBER	8	0	
DTE_PRESCRIBE	Date physician prescribed drug for a recipient.	NUMBER	8	0	
DTE_DISPENSE	Date pharmacy dispensed drug to recipient.	NUMBER	8	0	
ID_PROV_PRESCRB	License number of the provider who prescribed the drugs be administered to the recipient. This does not have to be an enrolled provider.	CHAR	15	0	
IND_EMERGENCY	Indication (Y/N) of whether drugs were dispensed as a result of an emergency situation.	CHAR	1	0	
NUM_PRSCRIP	Number assigned by a pharmacy to identify the drug dispensed to a	CHAR	7	0	

	recipient.				
QTY_REFILL	This is the refill number for the prescribed drug. This is not the available number of refills. The first time the prescription is filled, this attribute will be 0. The second time is filled - the first refill - this attribute will be 1, and so on.	CHAR	2	0	
NUM_DAY_SUPPLY	Number of days a prescribed drug should last a recipient.	NUMBER	9	0	
CDE_CLM_TYPE	Code that specifies the type of claim record. The code for pharmacy claims is "P", and compound is "Q".	CHAR	1	0	
AMT_BILLED	Amount billed by provider for services rendered.	NUMBER	8	2	
AMT_PATNT_LIAB	Amount that the recipient is responsible to pay for drugs dispensed.	NUMBER	8	2	
CDE_DUR_INTRVNTN	Record of whether a drug utilization and review intervention code was given in response to a ProDUR alert. The intervention code indicates whom the pharmacist consulted with (nobody, physician, recipient) to decide whether to fill the prescription.	CHAR	2	0	
CDE_DUR_OUTCOME	The outcome code returned from the provider in response to a Prospective Drug Utilization Review alert. This code indicates whether the prescription was filled as is, changed, or not filled.	CHAR	2	0	
IND_PREGNANCY	Indicates whether drug is related to the condition of being pregnant.	CHAR	1	0	
IND_NURSE_HOME	Indicates whether the drug was dispensed for a recipient who resides in a nursing home facility.	CHAR	1	0	
IND_PROV_SIGN	Used to indicate whether or not there was a valid provider signature on the original claim.	CHAR	1	0	
ID_CLERK	The ID of the clerk who has been assigned to work this claim.	CHAR	8	0	
AMT_NDC_PROFEE	This is the amount that the provider receives for dispensing a prescription drug. This amount varies by provider type.	NUMBER	7	2	
IND_BRAND_MED_NEC	This field indicates the reason, if any, that a brand name drug was dispensed.	CHAR	1	0	
IND_ELECT_CLM	This field is keyed in to indicate if the provider is a possible electronic biller.	CHAR	1	0	
QTY_DISPENSE	The number of units of a drug dispensed to a recipient.	NUMBER	10	3	
CDE_PROV_SPEC	Code which indicates the scope of practice or operations of the billing provider.	CHAR	3	0	
CDE_PROV_TYPE	Code which indicates the provider type for which a provider is	CHAR	2	0	

	licensed.				
CDE_COUNTY	Numeric (geographical/political) representation of the county in the state of MMIS in which the provider practices.	VARCHAR2	10	0	
IND_CARRIER_DENIED	Indicates if other insurance carrier denied the claim	CHAR	1	0	
DTE_FINAL	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.	NUMBER	8	0	
DTE_FINAL_LAST_PAYER	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.	NUMBER	8	0	
CDE_NCPDP_CONFLICT	Reason for Service Code	CHAR	2	0	
CDE_CLARIFICATION	Submission Clarification Code	CHAR	2	0	
CDE_DISPENSE_STATUS	Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.	CHAR	1	0	
CDE_ENC_STATUS	Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.	CHAR	1	0	
IND_ENCOUNTER	This field indicates if the claim is an encounter. Valid values Y or N.	CHAR	1	0	
IND_PR_OVERRIDE	Override Billing Provider calculation	CHAR	1	0	
IND_PR_OVERRIDE_REND	Override Rendering Provider calculation	CHAR	1	0	
ID_MEDICAID	Medicaid identification number	CHAR	12	0	**Start of header key fields - occurs once per header**
ID_PROVIDER	Provider identification number	CHAR	15	0	
CLM_RECIP_FST_NAM	Recipient's first name on the claim	VARCHAR2	35	0	
CLM_LST_NAM_RECIP	Recipient's last name on the claim	VARCHAR2	60	0	
ID_PROV_RENDERING	Medicaid ID of the provider rendering the service.	CHAR	15	0	
NUM_PRSCRIP_SUB	submitted Prescription Number for HIPAA 835	CHAR	7	0	
CDE_OTHER_COVERAGE	Code indicating whether or not the patient has other insurance coverage.	CHAR	2	0	
CDE_LEVEL_OF_SVC	Code indicating the type of service the provider rendered.	CHAR	2	0	
CDE_PATIENT_LOCATION	Code identifying the location of the patient when receiving pharmacy	CHAR	2	0	

	services.				
AMT_INCENTIVE	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services, such as for returning/rebilling unused patient medications. This amount is included in the 'Gross Amount Due'	NUMBER	8	2	**Start of partial fill fields - occurs once per header**
AMT_OTHER_CLAIMED_SUB	Amount representing the additional incurred costs for a dispensed prescription or service. Used for Copay only billing. This amount is included in the 'Gross Amount Due'.	NUMBER	8	2	
AMT_GROSS_DUE	Total price claimed from all sources. Used for copay only billing.	NUMBER	8	2	
QTY_DISP_INTEND	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status'.	NUMBER	10	3	
QTY_DAYS_INTEND	Days supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status'.	NUMBER	3	0	
NUM_ASSOC_PRSCRIP	Related 'Prescription/Service Reference Number' to which the service is associated. Used for partial fill processing.	CHAR	7	0	
DTE_ASSOC_DISPENSE	Date of the 'Associated Prescription/Service Reference Number'. Used for partial fill processing.	NUMBER	8	0	
CDE_CMPD_RTE_ADMIN	NCPDP Code for the route of administration of the complete compound mixture.	CHAR	2	0	
ID_PROVIDER1	Medicaid ID for billing provider	CHAR	15	0	**Start of provider ID's - occurs once per header**
ID_PROVIDER2	Medicaid ID for rendering provider	CHAR	15	0	
NUM_DTL_TOTAL	Total number of details associated with claim header.	NUMBER	4	0	0 - 9999
cnt_cob	Count of cob records	NUMBER	3	0	0-999
cnt_cobx	Count of cobx records	NUMBER	3	0	0-999
NUM_DTL (Detail) *	Claim Detail Number	NUMBER	4	0	**Start of details**
CDE_DRUG_FORM (Detail)	The basic drug measurement unit (each, milliliter, or grams) for performing price calculations.	CHAR	2	0	
CDE_NDC_STATUS (Detail)	Indicates whether drug code is prescription only or non-legend.	CHAR	1	0	
AMT_BILLED (Detail)	Amount request by provider for payment for services rendered to a recipient.	NUMBER	8	2	
AMT_ALWD (Detail)	Amount allowed for services	NUMBER	9	2	

	rendered.				
AMT_PAID (Detail)	Amount paid for services rendered.	NUMBER	9	2	
AMT_AWP (Detail)	Average wholesale price for drug.	NUMBER	12	5	
AMT_MAC (Detail)	The unit price for a drug under either Federal MAC regulation or state MAC, whichever is lesser or applicable to the NDC on the claim.	NUMBER	12	5	
QTY_DISPENSE (Detail)	Number of units of a drug dispensed to a recipient. The type of unit is expressed in CDE DRUG FORM.	NUMBER	12	3	
AMT_EAC (Detail)	Estimated acquisition cost for drug.	NUMBER	12	5	
CDE_CLM_STATUS (Detail)	Indicates the status of the detail in the MMIS system.	CHAR	1	0	
AMT_DETAIL_TPL (Detail)	Total amount that other insurance paid prior to submission to Medicaid for the service.	NUMBER	9	2	
RATE_PRICE (Detail)	Code used to identify the rate type use to pay the claim.	CHAR	4	0	
CDE_NDC (Detail)	National Drug Code prescribed/dispensed to a recipient.	CHAR	11	0	
CDE_NDC_SUB (Detail)	submitted NDC for HIPAA 835	CHAR	11	0	
QTY_DISPENSE_SUB (Detail)	submitted units billed for HIPAA 835	NUMBER	10	3	
CNT_OTHER_PAYER	This is the other payer sequence count.	NUMBER	4	0	**Start of COB**
CNT_OP_AMT_PAID	Occurrence count of Other Payer information for a particular coverage type and date.	NUMBER	4	0	
CDE_OP_AMT_PAID_QUAL	Code identifying the type of the Other Payer ID.	CHAR	2	0	
AMT_OP_PAID	Amount of any payment known by the pharmacy from other sources.	NUMBER	8	2	
CNT_OTHER_PAYER	This is the other payer sequence count.	NUMBER	4	0	**Start of COBX**
CDE_OP_COV_TYPE	Code identifying the type of the Other Payer ID.	CHAR	2	0	
DTE_OTHER_PAYER	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	NUMBER	8	0	

PHYISICIAN FILE LAYOUT

Column Name	Description	Type	Length	Precision	Occurrence	
SAK_RECIP	The system assigned internal key for a unique recipient.	NUMBER	9	0		
NUM_ICN	Number assigned to a claim processed in the system; used for control purposes.	CHAR	13	0		
NUM_ICN_FORMER	ICN of mother claim when the current claim is a daughter claim due to an adjustment.	CHAR	13	0		
CDE_CLM_STATUS	Indicates the status of a claim in the system. Codes: "P" - paid, "D" - denied, "S" -	CHAR	1	0		

	Suspended, and "R" - Resubmitted.					
CDE_CLM_TXN_TYP	Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.	CHAR	1	0		
CDE_CLM_TYPE	Code that specifies the type of claim record. Physician claims are type M=medical or B=crossover Part B.	CHAR	1	0		
NUM_PAT_ACCT	Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).	VARCHAR2	38	0		
AMT_NET_BILLED	Amount remaining on a claim after payment has been made by all other sources (TPL).	NUMBER	8	2		
TPL_AMT	Amount paid by third party for services rendered.	NUMBER	8	2		
DTE_BILLED	Date on which the provider or billing service prepared the claim form to be submitted.	NUMBER	8	0		
AMT_BILLED	Amount requested by provider for services rendered.	NUMBER	8	2		
AMT_PATNT_LIAB	Amount recipient is responsible to pay for services rendered.	NUMBER	8	2		
AMT_TOT_REIMB	Amount reimbursed to provider.	NUMBER	10	2		
AMT_CO_PAY	Amount paid by recipient for services rendered.	NUMBER	7	2		
DTE_FIRST_SVC	Date on which service was first provided (oldest date of all details).	NUMBER	8	0		
DTE_LAST_SVC	Date on which service was last provided (latest date from all details).	NUMBER	8	0		
DTE_TO_HOSP	Date on which recipient was discharged from an inpatient hospital.	NUMBER	8	0		
DTE_FROM_HOSP	Date on which recipient was admitted to an inpatient hospital.	NUMBER	8	0		
IND_PROV_SIGN	Indicates whether the paper claim form was signed by the provider who performed the service.	CHAR	1	0		
IND_ATTACHMENT	Indicator which is used to identify whether a claim is submitted with or without some type of supporting documentation.	CHAR	1	0		

IND_ACCIDENT	Indicates whether the service performed was as a result of an accident.	CHAR	1	0		
ID_CLERK	The ID of the clerk who has been assigned to work this claim.	CHAR	8	0		
CDE_CERTIFICATE	Certification code that belongs to the primary medical provider (PMP).	CHAR	2	0		
IND_ELECT_CLM	Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.	CHAR	1	0		
CDE_PROV_SPEC	Code which indicates the scope of practice or operations of the billing provider.	CHAR	3	0		
CDE_PROV_TYPE	Code which indicates the provider type for which a provider is licensed.	CHAR	2	0		
CDE_COUNTY	Numeric (geographical/political) representation of the county in the state in which the provider practices.	VARCHAR2	10	0		
DTE_ACCIDENT	Date of accident found in block 14 on the HCFA-1500 claim form	NUMBER	8	0		
Cde_Med_Rec_Num	Medical Record Number	VARCHAR2	30	0		
cde_place_of_service	The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do not carry place of service at header.	CHAR	2	0		
Cde_Claim_Frequency	CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.	CHAR	1	0		
IND_CARRIER_DENIED	Indicates if other insurance carrier denied the claim	CHAR	1	0		
DTE_FINAL	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents CHECK ISSUE date that corresponds with the first financial cycle run for Payers that finalize the claim on that cycle.	NUMBER	8	0		

DTE_FINAL_LAST_PAYER	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents last CHECK ISSUE date CORRESPONDING WITH the last financial cycle run for Payers that finalize the claim.	NUMBER	8	0		
CDE_ENC_STATUS	Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.	CHAR	1	0		
IND_ENCOUNTER	This field indicates if the claim is an encounter. Valid values Y or N.	CHAR	1	0		
IND_PR_OVERRIDE	Override Billing Provider calculation	CHAR	1	0		
IND_PR_OVERRIDE_PERF	Override Performing Provider calculation	CHAR	1	0		
IND_PR_OVERRIDE_REF_1	Override Referring Provider 1 calculation	CHAR	1	0		
IND_PR_OVERRIDE_REF_2	Override Referring Provider 2 calculation	CHAR	1	0		
ID_MEDICAID	Identification number assigned to a recipient of services.	CHAR	12	0	**Start of header key fields - occurs once per header**	
ID_PROVIDER	Identification number assigned to a group or individual that provides medical services to recipients.	CHAR	15	0		
ID_PERF_PROV	Identifies an individual who rendered a service to a recipient.	CHAR	15	0		
ID_PROV_REFER	Number identifying a provider or a case manager who refers recipient to another provider for services.	CHAR	15	0		
CLM_RECIP_FST_NAM	This is the first initial of the recipient's name. It is what is keyed on the claim.	VARCHAR2	35	0		
CLM_LST_NAM_RECIP	This is the first three characters of the recipient's last name. It is what is keyed on the claim.	VARCHAR2	60	0		
cde_Billing_EntityId	Loop: 2010AA BILLING PROVIDER NAME NM109 Identification Code INDUSTRY: Billing Provider Identifier ALIAS: Billing Provider Primary ID	VARCHAR2	15	0		

qlf_sub_dob_fmt	Date Time Period Format Qualifier for Subscriber Date of Birth (DOB). Component of Subscriber Demographic Information.	CHAR	3	0		
Dte_Subscriber_DOB	2000BA - Subscriber Date Of Birth	DATE	8	0		
Cde_Subscriber_Gender	2000BA - Subscriber Gender	CHAR	1	0		
cde_Med_Assignment	CLM07 Loop 2300 Provider Accept Assignment Code. Code indicating whether the provider accepts assignment INDUSTRY: Medicare Assignment Code 2438 NSF Reference: 2438 EA0-36.0, FA0-59.0 CLM07 indicates whether the provider accepts Medicare assignment. The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations. CODE DEFINITION A Assigned B Assignment Accepted on Clinical Lab Services Only C Not Assigned P Patient Refuses to Assign Benefits	CHAR	1	0		
ind_benefits_assignment	Yes/No Condition or Response Code O ID 1/1 Code indicating a Yes or No condition or response INDUSTRY: Benefits Assignment Certification Indicator ALIAS: Assignment of Benefits Indicator CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider. NSF Reference: DA0-15.0 CODE DEFINITION N No Y Yes	CHAR	1	0		
cde_Release_Information	CLM - Release of Information Code	CHAR	1	0		
Cde_Patient_Signature	CLM - Patient Signature Code	CHAR	1	0		
Cde_Related_Cause_1	CLM - Accident Related Cause	CHAR	2	0		
Cde_Related_Cause_2	CLM - Accident Related Cause	CHAR	2	0		
Cde_Related_Cause_3	CLM - Accident Related Cause	CHAR	2	0		
cde_bill_payto_provider	Code identifying the type of provider. Valid values are: BI-Billing; PT- Pay-To	CHAR	3	0		
Cde_Accident_State	CLM - Accident State	CHAR	2	0		

Cde_Accident_Country	CLM - Accident Country	CHAR	2	0		
Cde_Special_Program	CLM - Special Program Code. Code indicating the special program under which the services rendered were performed.	CHAR	3	0		
Cde_Prv_Agreement	CLM - Provider Agreement Code. Code indicating the type of agreement under which the provider is submitting this claim	CHAR	1	0		
Cde_Delay_Reason	CLM - Delay Reason Code. Code indicating the reason why a request was delayed.	CHAR	2	0		
num_lines_submitted	Number of line items submitted on the claim form or transaction.	NUMBER	4	0		
ID_PROV_REFERRING_2	Number identifying a provider or a case manager who refers recipient to another provider for services.	CHAR	15	0		
NUM_PAT_ACCT_SUB	submitted patient account number	VARCHAR2	38	0		
ID_PROVIDER1	Medicaid ID for Billing provider	CHAR	15	0	**Start of provider ID's - occurs once per header**	
ID_PROVIDER2	Medicaid ID for Performing provider	CHAR	15	0		
ID_PROVIDER3	Medicaid ID for Referring provider	CHAR	15	0		
ID_PROVIDER4	Medicaid ID for Second Referring provider	CHAR	15	0		
NUM_DTL_TOTAL	Total number of details associated with claim header.	NUMBER	4	0	0 - 9999	**Detail count**
cnt_other_payer	Count of other payer records	NUMBER	3	0	0 - 999	**Other payer count**
cnt_crossover	Count of crossover records	NUMBER	3	0	0 - 999	**Crossover count**
cnt_diagnosis	Count of diagnosis code records	NUMBER	3			**Diagnosis count**
NUM_DTL (Detail)	The number of the detail on a claim record.	NUMBER	4	0	**Start of details**	
DTE_FIRST_SVC (Detail)	Date on which services were first performed for a recipient.	NUMBER	8	0		
DTE_LAST_SVC (Detail)	Date on which services were last performed for a recipient.	NUMBER	8	0		
QTY_BILLED (Detail)	Number of units of service that were provided.	NUMBER	9	2		
QTY_ALLOWED (Detail)	The number of services that are allowed for the detail.	NUMBER	9	2		
IND_EMERGENCY (Detail)	Indicates whether the service was provided as result of emergency situation.	CHAR	1	0		
IND_PREGNANCY(Detail)	Indicates whether service is related to condition of being pregnant.	CHAR	1	0		

CDE_PROC (Detail)	Code that identifies the service performed for a recipient.	CHAR	6	0		
CDE_PROC_MOD (Detail)	Code used to further define a procedure provided.	CHAR	2	0		
CDE_MODIFIER_2 (Detail)	Code used to further define a procedure provided.	CHAR	2	0		
CDE_MODIFIER_3 (Detail)	Code used to further define a procedure provided.	CHAR	2	0		
AMT_BILLED (Detail)	Amount of money requested for payment by a provider for services rendered to a recipient.	NUMBER	8	2		
AMT_PAID (Detail)	Amount sent to a provider for payment for services rendered to a recipient.	NUMBER	9	2		
AMT_ALWD (Detail)	Amount approved to pay for services provided to a recipient.	NUMBER	9	2		
AMT_CO_PAY (Detail)	Amount paid by recipient for services rendered.	NUMBER	7	2		
CDE_POS (Detail)	Location where service was rendered.	CHAR	2	0		
CDE_DIAG_TREAT_IND (Detail)	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1,2,3,4 for paper claims and 1-8 for electronic claims.	CHAR	8	0		
CDE_CLM_STATUS (Detail)	Indicates the status of the detail in the MMIS system.	CHAR	1	0		
IND_EPSDT_REF (Detail)	Block 24J on the HCFA 1500. Defines EPSDT referral/treatment information. The valid values are as follows: YD - EPSDT, dental referral YV - EPSDT, vision referral YH - EPSDT, hearing referral YO - EPSDT, other referral AT - EPSDT, abnormal not treated AN - EPSDT, abnormal treated AR - EPSDT, abnormal	CHAR	2	0		
CDE_EPSDT_FP (Detail)	A code from the HCFA 1500 claim form block 24 H indicating EPSDT or Family Planning.	CHAR	1	0		
CDE_PROV_SPEC (Detail)	Code which indicates the scope of practice or operations of the rendering provider.	CHAR	3	0		
IND_SYS_GENERATE (Detail)	Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no.	CHAR	1	0		
IND_CLAIM_CHECK(Detail)	This field indicates whether or not the detail has been through the ClaimCheck program.	CHAR	1	0		
CDE_MODIFIER_4 (Detail)	This contains the fourth modifier field on the claim	CHAR	2	0		

	detail.					
amt_detail_TPL (Detail)	This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts inCAS03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount. This is only available for electronic claims.	NUMBER	9	2		
NUM_DTL_REF (Detail)	This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original detail submitted with more than one tooth number. Bundling. When two or more details are bundled into a single NEW detail, then the original bundled details point to the new bundling detail using a sequence number . The new bundling detail will have the system generated flag on Unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.	NUMBER	4	0		
IND_PR_OVERRIDE_REND (detail)	Override Rendering Provider calculation	CHAR	1	0		
IND_PR_OVERRIDE_REF_1 (detail)	Override Referring Provider 1calculation	CHAR	1	0		
IND_PR_OVERRIDE_REF_2 (detail)	Override Referring Provider 2 calculation	CHAR	1	0		
CDE_PROC (Detail)	Five byte code that specifies a service rendered to a recipient.	CHAR	6	0		
ID_PERF_PROV (Detail)	Identifies an individual who rendered a service to a recipient.	CHAR	15	0		
qlf_Approved_Amount (Detail)	Qualifier for Approved Amount	CHAR	3	0		

Amt_Approved (Detail)	Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available. 2. The allowed amount equals the amount for the service line that was approved by the payer sending this 837 to another payer.	NUMBER	9	2		
qlf_Procedure_Qlf (Detail)	Qualifier for the Procedure code	CHAR	2	0		
Cde_Proc_UoM (Detail)	International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors). MJ Minutes UN Unit Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	CHAR	2	0		
Cde_Copay_Status (Detail)	Code indicating whether or not co-payment requirements were met on a line by line basis. Required if patient was exempt from co-pay.	CHAR	1	0		
qty_Med_Necessity_Lnth (Detail)	Lopp 2400 SV502	NUMBER	9	2		
cde_uom_dme (Detail)	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	CHAR	2	0		
amt_Rental_DME (Detail)	loop 2400 SV504	NUMBER	9	2		
amt_Purchase_DME (Detail)	Loop 2400 SV505	NUMBER	9	2		
cde_Bill_Frequency (Detail)	Loop 2400 SV506	CHAR	1	0		
ID_PROV_REFERRING (Detail)	Number identifying a provider or a case manager who refers recipient to another provider for services.	CHAR	15	0		
ID_PROV_REFERRING_2 (Detail)	Number identifying a provider or a case manager who refers recipient to another provider for services.	CHAR	15	0		
qlf_svc_line_dte (Detail)	Date Time Qualifier for Service Line Date. Code specifying type of date or time, or both date and time.	CHAR	3	0		
qlf_svc_line_dte_fmt (Detail)	Date Time Period Format Qualifier for Service Line Date. Code indicating the	CHAR	3	0		

	date format, time format, or date and time format.					
AMT_BILLED_ORIG (Detail)	Original billed amount on the claim detail. Will be NULL if the original billed amount was not changed. If the original billed amount was changed, this column will retain the value of the original billed amount before it was changed.	NUMBER	8	2		
QTY_BILLED_ORIG (Detail)	Original billed quantity on the claim detail. Will be NULL if the original billed quantity was not changed. If the original billed quantity was changed, this column will retain the value of the original billed quantity before it was changed.	NUMBER	9	2		
CDE_PROC_MOD1_ORIG (Detail)	Original procedure modifier 1. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.	CHAR	2	0		
CDE_PROC_MOD2_ORIG (Detail)	Original procedure modifier 2. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.	CHAR	2	0		
CDE_PROC_MOD3_ORIG (Detail)	Original procedure modifier 3. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.	CHAR	2	0		
CDE_PROC_MOD4_ORIG (Detail)	Original procedure modifier 4. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.	CHAR	2	0		
CDE_PROC_SUB (Detail)	submitted Procedure Code for HIPAA 835	CHAR	6	0		
CDE_POS_SUB (Detail)	submitted place of service for HIPAA 835	CHAR	2	0		
QTY_BILLED_SUB (Detail)	submitted units billed for HIPAA 835	NUMBER	9	2		
CDE_PROC_MOD1_SUB (Detail)	submitted Procedure Modifier1 for HIPAA 835	CHAR	2	0		

CDE_PROC_MOD2_SUB (Detail)	submitted Procedure Modifier2 for HIPAA 835	CHAR	2	0		
CDE_PROC_MOD3_SUB (Detail)	submitted Procedure Modifier3 for HIPAA 835	CHAR	2	0		
CDE_PROC_MOD4_SUB (Detail)	submitted Procedure Modifier4 for HIPAA 835	CHAR	2	0		
qlf_othr_sub_DOB_fmt	Date Time Period Format Qualifier for Other Subscriber Date of Birth (DOB). Component of Other Subscriber Demographic Information.	CHAR	3	0	**Start of other payer**	
Dte_Other_Sub_DOB	Other Subscriber Date Of Birth	DATE	8	0		
Cde_Other_Sub_Gender	Other Subscriber Gender	CHAR	1	0		
ind_Ben_Assignment	OI - Assignment of Benefits Indicator	CHAR	1	0		
ind_Release_of_Info	OI - Code identifying whether the provider has on file a signed statement by the patient authorizing release of medical data	CHAR	1	0		
Cde_Pat_Sign_Source	OI - Code identifying how the patient or subscriber authorization signatures were obtained and retained by the provider	CHAR	1	0		
qlf_Claim_Adjud_Dt	Qualifier for Claim Adjudication Date DTP info	CHAR	3	0		
qlf_Clm_Adjud_Dt_Fmt	Format Qualifier for the Claim Adjudication Date	CHAR	3	0		
Dte_Clm_Adjudication	Claim Adjudication Date	DATE	8	0		
NUM_DTL	Detail line number that this crossover record is for	NUMBER	4	0	**Start of crossover**	
AMT_ALWD_MCARE	The dollar amount allowed by Medicare for the services provided.	NUMBER	8	2		
AMT_DEDUCT	The amount the recipient must pay before Medicare will begin to pay this claim.	NUMBER	8	2		
AMT_COINSURANCE	Dollar amount which represents the recipient's coinsurance payment.	NUMBER	8	2		
AMT_PSYCH	Amount Medicare has determined the recipient must pay for psychiatric services received.	NUMBER	9	2		
AMT_PAID_MCARE	The dollar amount paid by Medicare for the services provided.	NUMBER	8	2		
DTE_MCARE_PAID	The date that Medicare paid the claim.	NUMBER	8	0		
cde_diagnosis	Diagnosis code	CHAR	7		**Start of Diagnosis**	
dsc_diagnosis	Short nomenclature for medical condition	CHAR	40			
cde_diag_seq	Indicates sequence of diagnosis code 1-4 for paper, 1-8 for electronic.	CHAR	1			

qlf_code_list	Code identifying a specific industry code list	CHAR	3			

DENTAL FILE LAYOUT

Column Name	Description	Type	Length	Precision	Occurrence
SAK_RECIP	The system assigned internal key for a unique recipient.	NUMBER	9	0	
NUM_ICN	Number assigned to a claim processed in the system. This is used for control purposes.	CHAR	13	0	
NUM_ICN_FORMER	ICN of mother claim when the current claim is a daughter claim due to an adjustment.	CHAR	13	0	
CDE_CLM_STATUS	Indicates the status of a claim in the system.	CHAR	1	0	
CDE_CLM_TXN_TYP	Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.	CHAR	1	0	
CDE_CLM_TYPE	Code that specifies the type of claim record. The code for Dental claims is 'D'.	CHAR	1	0	
NUM_PAT_ACCT	Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).	VARCHAR2	38	0	
AMT_NET_BILLED	Amount remaining on a claim after payment has been made by all other sources (TPL).	NUMBER	8	2	
TPL_AMT	Amount paid by third party for services.	NUMBER	8	2	
DTE_BILLED	Date on which the provider or billing service prepared the claim form to be submitted.	NUMBER	8	0	
AMT_BILLED	Amount requested by provider for services rendered.	NUMBER	8	2	
AMT_PAID	Amount sent to a provider for payment of services rendered to a recipient.	NUMBER	9	2	
DTE_FIRST_SVC	Date on which service was first provided (oldest date of all details).	NUMBER	8	0	
DTE_LAST_SVC	Last date on which service was provided to a recipient (most recent date of all details).	NUMBER	8	0	
AMT_PATNT_LIAB	Amount of money that recipient is responsible for paying for services rendered.	NUMBER	8	2	
CDE_POS	Code that indicates where the dental services were rendered.	CHAR	2	0	
IND_EMERGENCY	Indicates whether the service was provided as a result of an emergency situation.	CHAR	1	0	
IND_ACCIDENT	Indicates whether the service performed was as a result of an	CHAR	1	0	

	accident.				
IND_PROV_SIGN	Indicates whether the paper claim form was signed by the provider who performed the service.	CHAR	1	0	
IND_ANOTHER_PLAN	Indicates whether the recipient on the claim has coverage under another company's insurance plan.	CHAR	1	0	
ID_CLERK	The ID of the clerk who has been assigned to work this claim.	CHAR	8	0	
IND_ELECT_CLM	Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.	CHAR	1	0	
CDE_PROV_SPEC	Code which indicates the scope of practice or operations of the billing provider.	CHAR	3	0	
CDE_PROV_TYPE	Code which indicates the provider type for which a provider is licensed.	CHAR	2	0	
CDE_COUNTY	Numeric (geographical/political) representation of the county in the state in which the provider practices.	VARCHAR2	10	0	
Cde_Claim_Frequency	CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.	CHAR	1	0	
IND_CARRIER_DENIED	Indicates if other insurance carrier denied the claim	CHAR	1	0	
CDE_EPSDT_FP	A code from the ADA 200 claim form indicating EPSDT.	CHAR	1	0	
DTE_FINAL	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.	NUMBER	8	0	
DTE_FINAL_LAST_PAYER	A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.	NUMBER	8	0	
CDE_ENC_STATUS	Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.	CHAR	1	0	
IND_ENCOUNTER	This field indicates if the claim is an encounter. Valid values Y or N.	CHAR	1	0	
IND_PR_OVERRIDE	Override Billing Provider calculation	CHAR	1	0	
IND_PR_OVERRIDE_PERF	Override Performing Provider calculation	CHAR	1	0	

IND_PR_OVERRIDE_REF_1	Override Referring Provider 1 calculation	CHAR	1	0	
IND_PR_OVERRIDE_REF_2	Override Referring Provider 2 calculation	CHAR	1	0	
ID_MEDICAID	Identification number assigned to a recipient of services.	CHAR	12	0	**Start of header key fields - occurs once per header**
ID_PROVIDER	Identification number assigned to a group or individual who provides services to a recipient.	CHAR	15	0	
CLM_RECIP_FST_NAM	This is the first three characters of the recipient's name. It is what is keyed on the claim.	VARCHAR2	35	0	
CLM_LST_NAM_RECIP	This is the first two characters of the recipient's last name. It is what is keyed on the claim.	VARCHAR2	60	0	
ID_PERF_PROV	Rendering provider identifier.	CHARACTER	15	0	
cde_Billing_EntityId	Billing provider name identification code.	VARCHAR2	15	0	
cde_bill_payto_provider	Code identifying the type of provider. CODE DEFINITION BI Billing PT Pay-To	CHAR	3	0	
Dte_Subscriber_DOB	2000BA - Subscriber Date Of Birth	DATE	8	0	
Cde_Sub_Gender	Subscriber Gender. Code indicating the sex of the individual: F, M or U.	CHAR	1	0	
cde_Med_Assignment	CLM07 Loop 2300 Provider Accept Assignment Code. Code indicating whether the provider accepts assignment INDUSTRY: Medicare Assignment Code 2438 NSF Reference: 2438 EA0-36.0, FA0-59.0 CLM07 indicates whether the provider accepts Medicare assignment. The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations. CODE DEFINITION A Assigned B Assignment Accepted on Clinical Lab Services Only C Not Assigned P Patient Refuses to Assign Benefits	CHAR	1	0	
ind_benefits_assignment	Yes/No Condition or Response Code O ID 1/1 Code indicating a Yes or No condition or response INDUSTRY: Benefits Assignment Certification Indicator ALIAS: Assignment of Benefits Indicator CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider. NSF Reference: DA0-15.0 CODE DEFINITION N No Y Yes	CHAR	1	0	
Cde_Release_Info	Release of Information Code.	CHAR	1	0	

Cde_Related_Cause_1	Accident Related Cause.	CHAR	3	0	
Cde_Related_Cause_2	Accident Related Cause.	CHAR	3	0	
Cde_Related_Cause_3	Accident Related Cause.	CHAR	3	0	
Cde_Accident_State	Accident State.	CHAR	2	0	
Cde_Accident_Country	Accident Country.	CHAR	3	0	
Cde_Special_Program	Special Program Code. Code indicating the special program under which the services rendered were performed.	CHAR	3	0	
Cde_Claim_Submit_Rsn	Claims Submission Reason Code. Code identifying reason for claim submission.	CHAR	2	0	
Cde_Delay_Reason	Delay Reason Code. Code indicating the reason why a request was delayed.	CHAR	2	0	
Qty_Ortho_Mths_est	Orthodontic Treatment Months Count. The estimated number of treatment months.	NUMBER	6	0	
Qty_Ortho_Mths_left	Orthodontic Treatment Months Remaining Count. The number of treatment months remaining.	NUMBER	6	0	
Ind_Traction_Device	A code indicating presence of an extra traction device. A 'Y' indicates an extra oral traction device; An 'N' indicates no extra oral traction device.	CHAR	1	0	
num_lines_submitted	Number of line items submitted on the claim form or transaction.	NUMBER	4	0	
ID_PROV_REFERRING	Number identifying a provider or a case manager who refers recipient to another provider for services.	CHAR	15	0	
ID_PROV_REFERRING_2	Number identifying a provider or a case manager who refers recipient to another provider for services.	CHAR	15	0	
qlf_svc_date	Stores the Service Date Qualifier.	VARCHAR2	3	0	
qlf_svc_date_fmt	Stores the service date format qualifier.	VARCHAR2	3	0	
qlf_sub_dob_fmt	Stores Subscriber's Date of Birth qualifier.	VARCHAR2	3	0	
CDE_POS_SUB	submitted place of service for HIPAA 835	CHAR	2	0	
NUM_PAT_ACCT_SUB	submitted patient account number for HIPAA 835	VARCHAR2	38	0	
ID_PROVIDER1	Medicaid ID for Billing provider	CHAR	15	0	**Start of provider ID's - occurs once per header**
ID_PROVIDER2	Medicaid ID for Performing provider	CHAR	15	0	
ID_PROVIDER3	Medicaid ID for Referring provider	CHAR	15	0	
ID_PROVIDER4	Medicaid ID for Second Referring provider	CHAR	15	0	
NUM_DTL_TOTAL	Total number of details associated with the claim header.	NUMBER	4	0	0 - 9999
cnt_other_payer	Count of other payer records	NUMBER	3	0	0 - 999
NUM_DTL (Detail)	The number of the detail on a claim record.	NUMBER	4	0	**Start of details**

CDE_PROC (Detail)	Code used to identify a medical, dental, or DME procedure.	CHAR	6	0	
DTE_FIRST_SVC (Detail)	Date on which services were first performed for a recipient.	NUMBER	8	0	
AMT_BILLED (Detail)	Amount of money requested by a provider for payment for services rendered to a recipient.	NUMBER	8	2	
AMT_ALWD (Detail)	Amount approved to pay for services provided to a recipient.	NUMBER	9	2	
AMT_PAID(Detail)	Amount paid for services rendered.	NUMBER	9	2	
AMT_CO_PAY (Detail)	Amount paid by recipient for services rendered.	NUMBER	7	2	
CDE_CLM_STATUS (Detail)	Indicates the status of the detail in the MMIS system. This can be paid or denied.	CHAR	1	0	
CDE_TOOTH_NBR (Detail)	Code which indicates the tooth on which a particular service was performed.	CHAR	2	0	
QTY_BILLED (Detail)	The number of units billed for the service. All claims will plug a '1' here. Claims converted from the MMIS may have a value greater than '1'.	NUMBER	6	2	
QTY_ALLOWED (Detail)	The number of units allowed for the service.	NUMBER	6	2	
CDE_QUADRANT (Detail)	The quadrant of the mouth that the procedure on the claim is related to.	CHAR	2	0	
CDE_PROV_SPEC (Detail)	Code which indicates the scope of practice or operations of the rendering provider.	CHAR	3	0	
IND_SYS_GENERATE (Detail)	Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no.	CHAR	1	0	
amt_detail_TPL (Detail)	This is the total amount paid by other payers for this detail.	NUMBER	9	2	
NUM_DTL_REF (Detail)	This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original detail submitted with more than one tooth number. Bundling. When two or more details are bundled into a single NEW detail, then the original bundled details point to the new bundling detail using a sequence number . The new bundling detail will have the system generated flag on unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.	NUMBER	4	0	
cde_place_of_service (Detail)	The place of service code representing the location where the dental treatment was rendered.	CHAR	2	0	

CDE_DIAG_TREAT_IND (Detail)	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1,2,3,4,5,6,7,8. One detail can be associated with a minimum of 1 diagnosis in the header or maximum of 8 diagnoses in the header for non-transportation claims only.	CHAR	8	0	
IND_PR_OVERRIDE_PERF (Detail)	Override Performing Provider calculation	CHAR	1	0	
CDE_PROC (Detail)	Code that identifies the service performed for a recipient.	CHAR	6	0	
Cde_Cavity_Desig_1 (Detail)	Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.	VARCHAR2	3	0	
Cde_Cavity_Desig_2 (Detail)	Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.	VARCHAR2	3	0	
Cde_Cavity_Desig_3 (Detail)	Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.	VARCHAR2	3	0	
Cde_Cavity_Desig_4 (Detail)	Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.	VARCHAR2	3	0	
Cde_Cavity_Desig_5 (Detail)	Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.	VARCHAR2	3	0	
Cde_Prosthesis (Detail)	Prosthesis, crown or inlay code. Code specifying the placement status for the dental work	CHAR	1	0	
ID_PROV_PERF (Detail)	The identifier for the performing provider.	CHAR	15	0	
QTY_BILLED_ORIG (Detail)	The original number of units billed for the service.	NUMBER	6	2	
CDE_PROC_old (Detail)	Code that identifies the service performed for a recipient.	CHAR	6	0	
qlf_svc_date (Detail)	Stores the service date qualifier.	VARCHAR2	3	0	
qlf_svc_date_fmt (Detail)	Stores the service date format qualifier.	VARCHAR2	3	0	
qlf_procedure_code (Detail)	Stores sub-element SV301-1	CHAR	2	0	
qlf_tooth_code_list (Detail)	Stores sub-element TOO01	VARCHAR2	3	0	
CDE_PROC_SUB (Detail)	submitted Procedure Code for HIPAA 835	CHAR	6	0	
QTY_BILLED_SUB (Detail)	submitted units billed for HIPAA 835	NUMBER	6	2	
CDE_PROC_MOD1_SUB (Detail)	submitted Procedure Modifier1 for HIPAA 835	CHAR	2	0	
CDE_PROC_MOD2_SUB (Detail)	submitted Procedure Modifier2 for HIPAA 835	CHAR	2	0	
CDE_PROC_MOD3_SUB (Detail)	submitted Procedure Modifier3 for HIPAA 835	CHAR	2	0	
CDE_PROC_MOD4_SUB (Detail)	submitted Procedure Modifier4 for HIPAA 835	CHAR	2	0	

qlf_othr_sub_DOB_fmt	Date Time Period Format Qualifier for Other Subscriber Date of Birth (DOB). Component of Other Subscriber Demographic Information.	CHAR	3	0	**Start of other payer**
Dte_Other_Sub_DOB	Other Subscriber Date Of Birth	DATE	8	0	
Cde_Other_Sub_Gender	Other Subscriber Gender	CHAR	1	0	
ind_Ben_Assignment	OI - Assignment of Benefits Indicator	CHAR	1	0	
ind_Release_of_Info	OI - Code identifying whether the provider has on file a signed statement by the patient authorizing release of medical data	CHAR	1	0	
qlf_Claim_Adjud_Dt	Qualifier for Claim Adjudication Date DTP info	CHAR	3	0	
qlf_Clm_Adjud_Dt_Fmt	Format Qualifier for the Claim Adjudication Date	CHAR	3	0	
Dte_Clm_Adjudication	Claim Adjudication Date	DATE	8	0	

CAPITATION FILE LAYOUT

Column Name	Description	Type	Length	Precision
SAK_CAPITATION	Unique Capitation Identifier, will be sent back to EDS in place of a TCN/ICN	Number	9	0
ID_MEDICAID	Medicaid ID for recipient	Character	12	
ID_PROVIDER	Provider Medicaid ID	Character	9	
NPI	Provider NPI	Character	10	
CDE_PGM_HEALTH	Benefit / Assignment plan code, i.e. MPASS for medipass, HMOMC for non reform HMO etc.	Character	5	
DSC_PGM_HEALTH	Description for cde_pgm_health	Character	50	
DTE_CAPITATION	This is the month that the capitation payment covers. (CCYYMM)	Number	6	0
DTE_CAP_TXN	This is the date that the capitation payment was made. If the payment is being made for a retro month the date is still the current month, i.e., payment in April of February admin fee, this date would have the April payment date. (CCYYMMDD)	Number	8	0
CDE_MC_REGION	This is the code that identifies a region (or Managed Care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.	Character	5	
DSC_MC_REGION	This is a description or name of the region within the state.	Character	50	
CDE_RATE_CELL	Each managed care rate cell has a code.	Character	5	
DSC_CAP_CATEGORY	Description of the managed care rate cell.	Character	35	
CDE_CAP_REASON	This is the code of the reason the capitation is being done.	Character	2	
DSC_CAP_REASON	Description of the capitation reason code	Character	50	
AMT_CAP_PAID	The amount of money (check or EFT) we will pay to an external entity for recipient's capitation.	Number	10	2
DTE_PAYMENT_BEGIN	First date during the payment month that this payment covers. (CCYYMMDD)	Number	8	0
DTE_PAYMENT_END	Last date during the payment month that this payment covers. (CCYYMMDD)	Number	8	0
NUM_CAP_DAYS	This is the number of days out of the month that the capitation payment covers.	Number	2	
CDE_AID_CATEGORY	Identifies the type of aid for which a recipient is eligible. The code represents a concatenation of the Assistance Category, the Aged/Blind/Disabled, the Refugee and the Poverty codes.	Character	7	

DSC_AID_CATEGORY	Describes the type of aid for which a recipient is eligible.	Character	80	
IND_MEDICARE	Yes or No to indicate if the member had Medicare insurance at the time the capitation was created.	Character	1	
DTE_PAYMENT_ISSUE	This is the date that Financial issued/processed the payment. (CCYYMMDD)	Number	8	0

DRUG FILE LAYOUT

Column Name	Description	Type	Length	Precision
CDE_NDC	National Drug Code is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and a 2 byte numeric package code. Used to uniquely identify a drug, its labeler & package size of a product for pricing and service/prior authorization.	CHAR	11	0
CDE_DEA	The Drug Enforcement Administration (DEA) code denotes the degree of potential abuse and Federal control of a drug. This code is subject to change by Federal regulation.	CHAR	1	0
CDE_DRUG_CLASS	Classifies a drug by its availability to the consumer according to federal specifications. Values may change even after the NDC has become obsolete. Valid Values are: O = Over-the-Counter. A prescription is not required per the product labeling. F = Prescription required per the product labeling.	CHAR	1	0
CDE_DRUG_FORM	The Drug Form Code indicates the basic drug measurement unit for performing price calculations. The current codes are: EA - (tables,kits,etc.) ML - (liquids) GM - (solids).	CHAR	2	0
CDE_THERA_CLS_FDA	The HCFA FDA Therapeutic Equivalency Code (HCFA_FDA) indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent. The HCFA_FDA is provided on the Health Care Financing Administration's quarterly tape.	CHAR	2	0
CDE_THERA_CLS_AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	CHAR	10	0
DSC_NDC	Contains the name that appears on the package label provided by the manufacturer. This column is populated for all products, brand and generic.	VARCHAR2	35	0
DTE_DRUG_OBSOLETE	The date on which the drug product was no longer available in the market place as per the manufacturer's notification, or the best estimate of that date.	NUMBER	8	0
IND_UNIT_DOSE	Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the mfr. This indicator does not apply to injectable products, suppositories, or powder packets. Current codes are: 1=Unit Dose & 0=All other.	CHAR	1	0

QTY_DRUG_PACK_SZ	This field contains the metric quantity used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, etc.	NUMBER	11	3
IND_MAINT	A one-character alphanumeric column that identifies a drug as a maintenance drug. Blank = Not a maintenance drug 1 = Maintenance drug	CHAR	1	0
NAM_DRUG_GENERIC	The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.	CHAR	63	0
CDE_ROUTE_ADMIN	This field contains a meaningful abbreviation of the normal method by which a drug is administered. Some abbreviations include: IV = Intravenous (only), DT = Dental and NS = Nasal. GCRT on NDDF.	CHAR	2	0
CDE_DOSAGE_FORM	An abbreviated two-byte code (GCDF on NDDF update) is available for applications. Users may request the code in addition to or instead of the description.	CHAR	2	0
DSC_STRENGTH	The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.	CHAR	10	0
CDE_THERA_CLS_STD	The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.	CHAR	3	0
DTE_EFFECTIVE	This is the date that the drug limitations take effect.	NUMBER	8	0
DTE_END	This is the date that the drug limitations no longer are in effect.	NUMBER	8	0
NAM_DRUG_MANUF	This is the name of the distributor as listed on the drug label or as indicated by the NDC code. It does not necessarily identify the actual drug fabricator.	CHAR	15	0
There can be zero to many of the following four field segments for each drug row. The type field differentiates each four field segment.				
DTE_EFFECTIVE	The first day of service that the associated percentage or price is effective.	NUMBER	8	0

DTE_END	The last day of service that the associated percentage or price is effective.	NUMBER	8	0
PRICE	The associated percentage (EAC) or price (AWP, MAC, SMAC). Multiplied by 1000 for the EAC percentage, and 100000 for the prices.	NUMBER	12	5
TYPE	EAC - Estimated Acquisition Cost, AWP - Average Wholesale Price, MAC - Maximum Allowable Cost, SMAC - State Maximum Allowable Cost	CHAR	4	0

RECIPIENT ELIGIBILITY FILE LAYOUT

Column Name	Description	Type	Length	Precision	Occurrence		
SAK_RECIP	The system assigned internal key for a unique recipient.	NUMBER	9	0		0	9
ID_MEDICAID	Unique identifier for the recipient.	CHAR	12	0		9	21
NAM_LAST	The last name of a recipient.	CHAR	20	0		21	41
NAM_FIRST	The first name of a recipient.	CHAR	15	0		41	56
NAM_MID_INIT	The middle initial of the recipient.	CHAR	1	0		56	57
NAM_TITLE	The title of the recipient. (Mr., Mrs., Miss)	CHAR	5	0		57	62
ADR_STREET_1	The first line of the recipient's street address.	CHAR	60	0		62	122
ADR_STREET_2	The second line of a recipient's street address.	CHAR	60	0		122	182
ADR_STREET_3	The third line of a recipient's street address.	CHAR	30	0		182	212
ADR_CITY	The city where the recipient resides.	CHAR	30	0		212	242
ADR_STATE	The state where the recipient resides.	CHAR	2	0		242	244
ADR_ZIP_CODE	The five character zip code for the recipient.	CHAR	5	0		244	249
ADR_ZIP_CODE_4	The zip plus four of the recipient.	CHAR	4	0		249	253
CDE_SOURCE_ADDR	This is the source of the address updates and information.	CHAR	5	0		253	258
NUM_LATITUDE	Geographical Latitude of recipient's address.	NUMBER	11	6		258	269
NUM_LONGITUDE	Geographical Longitude of recipient's address.	NUMBER	11	6		269	280
CDE_GIS_QUALITY	This is the code that stores the precision of the address match for the latitude and longitude lookup.	CHAR	4	0		280	284
NUM_SSN	The social security number for a recipient.	CHAR	9	0		284	293
DTE_BIRTH	The date of birth for the recipient.	NUMBER	8	0		293	301
DTE_DEATH	The date of death for the recipient.	NUMBER	8	0		301	309
CDE_SEX	Indicates the sex of the recipient.	CHAR	1	0		309	310
CDE_RACE	Code that will map to a specific race or combination	CHAR	2	0		310	312

	of races.						
CDE_ETHNIC	The ethnicity of the recipient. Value of 01 means Hispanic. Value of 00 means not Hispanic.	CHAR	2	0		312	314
CDE_MARITAL	Indicates the marital status of a recipient.	CHAR	1	0		314	315
CDE_COUNTY	The county code used to identify a geographical/political area in the state.	VARCHAR2	10	0		315	325
CDE_OFFICE	County office that the recipient lives near.	CHAR	1	0		325	326
CDE_LANGUAGE	Code that will map to a specific language preferred by the recipient	CHAR	3	0		326	329
CDE_LANG_CORRESP	This is the language that the recipient uses for written correspondence.	CHAR	3	0		329	332
NUM_PHONE	Recipient Phone number	CHAR	10	0		332	342
NUM_ADD_PHONE	This an additional phone number for contacting the recipient.	CHAR	10	0		342	352
IND_SPEC_HLTH	Indicates if the recipient has any special health needs.	CHAR	1	0		352	353
CDE_SOUNDEX	Identifies the Oracle Soundex phonetic value.	CHAR	4	0		353	357
IND_ACTIVE	Indicates if the recipient Medicaid ID is active or inactive because of a link. When two Medicaid IDs are linked one of them is no longer valid and will have an IND ACTIVE of 'N'. All others are active and will have a 'Y', which means active.	CHAR	1	0		357	358
CDE_SOURCE	This is the source of the recipient updates and information.	CHAR	5	0		358	363
DTE_ADDED	The date that the recipient was added to the system.	NUMBER	8	0		363	371
DTE_LAST_UPDATE	The date that the recipient was last updated.	NUMBER	8	0		371	379
CDE_SOURCE_SSN	Indicate the last source of the SSN update.	CHAR	5	0		379	384
CDE_AREA	This is to indicate the state office responsible for the recipient. The area code is derived from the recipient's residence county using the Area/County/District Cross Reference and Area Office tables.	CHAR	3	0		384	387
CDE_COUNTY_CASEWORKER	The county code of the caseworker responsible for this recipient. If no caseworker is assigned to the recipient, then this is defaulted to the recipient's residence county code	VARCHAR2	10	0		387	397

CDE_DISTRICT	This is to indicate the Department of Children and Family office responsible for the recipient. The district code is derived from the caseworker's county using the Area/County/District Cross Reference and District Office tables.	CHAR	2	0		397	399
TXT_UNIT	The unit code within the recipient's district. Free form text with no validation.	CHAR	5	0		399	404
CDE_STATE_EVACUEE	The state code of which the recipient evacuated from due to special circumstances (e.g., hurricane).	CHAR	2	0		404	406
CDE_PHI	An indicator denoting the level of restrictions, based on policy, of the uses and disclosures of the recipient's protected health information (PHI). Valid values are 'Y', 'N' or blank.	CHAR	1	0		406	407
IND_SPI	A special print indicator (SPI) for special recipient designation. Valid values are 'Y' and 'N', default is 'N'. (Available only to superuser security access.)	CHAR	1	0		407	408
CDE_SOURCE_LANG	Indicate the last source of the language update.	CHAR	5	0		408	413
CDE_SOURCE_DOD	Indicate the last source of the date of death update.	CHAR	5	0		413	418
CDE_MK_PEND_CHOICE	This is a flag to note if the recipient is currently a MediKids pending choice counseling. Valid values are 'Y', 'N' or blank.	CHAR	1	0		418	419
CDE_CHCUP	A flag to note if a recipient is participating in the CHCUP program. Valid values are: 'Y'-Eligible; 'N'-Eligible but Refused; blank-Not Eligible.	CHAR	1	0		419	420
CDE_SOURCE_CHCUP	Indicate the last source of the CHCUP flag update.	CHAR	5	0		420	425
NUM_RE_ELIG	Number of eligibility records	NUMBER	3	0	0 - 999	0	0
CDE_PGM_HEALTH	Recipient plan associated to this eligibility	CHAR	5	0		0	5
DSC_PGM_HEALTH	Description of the recipient plan associated to this eligibility	CHAR	50	0		5	55
DTE_EFFECTIVE	The date that the recipient becomes eligible for the corresponding Medical Assistance program.	NUMBER	8	0		55	63
DTE_END	The date that the recipient is no longer eligible for the corresponding Medical Assistance program.	NUMBER	8	0		63	71

CDE_STATUS1	The status code for the program eligibility segment. A blank means the segment is active and an 'H' means that the segment is history and no longer valid.	CHAR	1	0		71	72
DTE_ADDED	Date the eligibility segment was last updated.	NUMBER	8	0		72	80
DTE_LAST_UPDATE	Identifies the source of last update.	NUMBER	8	0		80	88
NUM_RE_PLAN	Number of Assignment plan records	NUMBER	3		0 -999		
CDE_PGM_HEALTH	Recipient plan associated to this assignment plan	CHAR	5			0	5
DSC_PGM_HEALTH	Description of the recipient plan associated to this assignment plan	CHAR	50			5	55
DTE_EFFECTIVE	The effective date for the assignment plan.	NUMBER	8	0		55	63
DTE_END	The end date for the assignment plan.	NUMBER	8	0		63	71
CDE_STATUS	This will be a space for active records and an 'H' for history and inactive records.	CHAR	1	0		71	72
CDE_SOURCE	This is the source of the recipient updates and information.	CHAR	5	0		72	77
DTE_LAST_UPDATE	This is the date that the record was last updated.	NUMBER	8	0		77	85
NUM_RE_HIB	Number of Medicare ID Records	NUMBER	3		0 - 999		
ID_MEDICARE	The recipient's current or previous Medicare ID (HIB).	CHAR	12	0		0	12
IND_SOURCE	Source of last update. Values include "BENDX" for Bendex, "EDB" for EDB, "BUYIN" for Buy-In, "ONL" for online.	CHAR	5	0		12	17
DTE_EFFECTIVE	The date the new Medicare ID was added and became effective.	NUMBER	8	0		17	25
ID_PSEUDO_SSA	Pseudo-SSA number for RRB (Railroad Retirement Board) recipients	CHAR	12	0		25	37
IND_RRB	RRB indicator. "Y" means the ID_MEDICARE is a Railroad Retirement Board issued number.	CHAR	1	0		37	38
NUM_RE_LIAB	Number of patient financial liability records	NUMBER	3	0	0 - 999		
CDE_TYPE	Indicate which program to apply patient obligation to. N = Nursing Home; P = Personal Care	CHAR	1	0		0	1
DTE_EFFECTIVE	The date that the patient financial liability amount becomes effective for the recipient in a long term care facility.	NUMBER	8	0		1	9
DTE_END	The date that the patient financial liability amount is no	NUMBER	8	0		9	17

	longer effective for the recipient in a long term care facility.						
AMT_PATNT_LIAB	The patient financial liability amount that must be paid by the recipient before Medicaid will make payment on the claim. This is a monthly amount.	NUMBER	8	2		17	25
NUM_RE_PMP	Number of PMP assignment records	NUMBER	3	0	0 - 999		
CDE_PGM_HEALTH	Recipient plan associated to this PMP assignment record	CHAR	5	0		9	14
DSC_PGM_HEALTH	Description of the recipient plan associated to this PMP assignment record	CHAR	50	0		14	64
DTE_EFFECTIVE	This is the date that the assignment became effective.	NUMBER	8	0		64	72
DTE_END	This is the date that the assignment is no longer effective.	NUMBER	8	0		72	80
CDE_STATUS1	Specifies if the assignment is valid (space) or if the assignment has been historied ('H').	CHAR	1	0		80	81
IND_PRIMARY	Indicates if this is the primary assignment for the given program. In order to allow multiple assignments to the same program, (i.e. the recipient is assigned to an OB/GYN and assignment to a Family Practitioner at the same time) a single assignment MUST be designated as the primary assignment so that enrollment counts for a program are not exaggerated, etc... The assignment that gets marked as primary is determined by the focus of the PMP.	CHAR	1	0		81	82
CDE_MC_REGION	This is the code that identifies a region (or Managed Care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.	CHAR	5	0		82	87
CDE_RSN_MC_START	This indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change.	CHAR	2	0		87	89

CDE_RSN_MC_STOP	This indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change.	CHAR	2	0		89	91
DTE_ADDED	Date that the PMP assignment was created/inserted.	NUMBER	8	0		91	99
DTE_PROV_MBR_ADD	This is the date that the MCO's PCP (the group member) was associated with the recipient.	NUMBER	8	0		99	107
DTE_CHANGED	This is the date that the PMP assignment was last updated.	NUMBER	8	0		107	115
DTE_TERMED	This is the actual date that the PMP assignment was end dated. It is not necessarily the date that the PMP assignment is no longer effective (the end_date).	NUMBER	8	0		115	123
CDE_ENRL_TYPE	This is type of enrollment. Valid values are 'M' (Mandatory), 'V' (Voluntary), and 'S' (System).	char	1	0		123	124
PROVIDER_ID	Medicaid ID for provider associated to assignment record	char	9	0		124	133
NUM_NEWBORN	Number of newborn records	NUMBER	3	0	0 - 999		
ID_MEDICAID_NEWBORN	Medicaid ID for newborn associated to main recipient record	CHAR	12	0			
filler	filler	char	1	0			

PROVIDER FILE LAYOUT

Column Name	Description	Type	Length	Precision	Occurrence
NAME	This is the name associated with an organization or person.	CHAR	50	0	
IND_NAME_TYPE	This is an indicator of whether a name is that of a person or an organization. The current valid values are: B - Business P - Personal Name	CHAR	1	0	
NAM_TITLE	This field indicates the professional title of an individual.	CHAR	15	0	
CDE_SOUNDEX	Identify the Oracle Soundex phonetic value.	CHAR	4	0	
ADR_MAIL_STRT1	Mailing address street 1. This is the street address for a provider.	CHAR	60	0	
ADR_MAIL_STRT2	Mailing address street 2. This is the mailing address for a provider.	CHAR	60	0	

ADR_MAIL_CITY	Mailing address city. This is the city where a provider would receive business mail.	CHAR	30	0	
ADR_MAIL_STATE	Mailing address state. This is the state where a provider would receive business mail.	CHAR	2	0	
ADR_MAIL_ZIP	Mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.	CHAR	5	0	
ADR_MAIL_ZIP_4	Mailing address zip code + 4. This is the last 4 digits of a zip code.	CHAR	4	0	
NUM_PHONE	This is a phone number in the format area code + prefix + suffix.	CHAR	10	0	
NUM_PHO_EXT	A phone number extension.	CHAR	4	0	
NUM_LATITUDE	Latitude to the providers address	NUMBER	11	6	
NUM_LONGITUDE	Longitude to the providers address.	NUMBER	11	6	
CDE_HANDICAP_ACC	Identify whether the providers service location has handicap access. Valid values: Y = Yes N = No	CHAR	1	0	
NUM_PHONE_FAX	This is fax number of the provider's office.	CHAR	10	0	
CDE_GIS_QUALITY	This is the code that stores the precision of the address match for the latitude and longitude lookup.	CHAR	4	0	
ADR_EMAIL	Email address of the provider.	VARCHAR2	50	0	
CDE_COUNTRY	Two character ISO country abbreviation.	CHAR	2	0	
ADR_MAIL_INT	The international address line. This will contain the international equivalent of City, State, and Zip.	VARCHAR2	50	0	
NUM_PHONE_INT	International phone number.	VARCHAR2	15	0	
NUM_PHONE_EXT_INT	International phone number extension.	CHAR	5	0	
NUM_PHONE_FAX_INT	International fax number.	VARCHAR2	15	0	
DTE_CHG_OF_ADR	The date when the provider address change occurred.	NUMBER	8	0	
CDE_CHG_ADR	The change of address status code indicating the reason for the address change.	CHAR	1	0	
TXT_CHG_ADR_COMMENTS	Change of address comment used to capture any additional information regarding the address change.	VARCHAR2	150	0	
IND_REPORT	Report status indicator is used to determine if something is wrong the Provider Application and if is incomplete. Valid values are "Y" and "N". The default value will be "N" and set within the application.	CHAR	1	0	

IND_MAIL_RETURN	This is an indicator that indicates returned mail.. Values are 'Y' and 'N'.	CHAR	1	0	
NUM_UPIN	This is the universal provider identification number.	CHAR	6	0	
IND_ON_REVIEW	This field indicates whether a provider is on review.	CHAR	1	0	
IND_OWNER_INTEREST	This indicator denotes whether a provider has an ownership interest in another provider's business.	CHAR	1	0	
CDE_GENDER	This identifies the gender of the provider. Current Valid Values: M = Male F = Female O = Organization N = N/A	CHAR	1	0	
NUM_PROV_SSN	The Social Security Number of the Provider.	CHAR	9	0	
DTE_BIRTH	The date of birth of the Provider.	NUMBER	8	0	
CDE_PROV_TYPE	Type that a provider is licensed for.	CHAR	2	0	
NUM_PROV_LIC	A provider license number.	CHAR	11	0	changed to 11
CDE_PROV_SPEC_PRIM	This field contains the provider specialty which is the main focus of the provider's practice. Each provider type must have a primary specialty and the primary specialty must be one of the provider's existing specialties.	CHAR	3	0	
ID_PROVIDER	Provider ID value	CHAR	15	0	
CDE_PROV_ID_TYPE	Type of Provider ID	CHAR	3	0	
DTE_PR_ID_EFF	Effective start date	NUMBER	8	0	
DTE_PR_ID_END	Effective end date	NUMBER	8	0	
CDE_PR_ID_END_RSN	Reason code for end dating the t_pr_identifier segment	CHAR	3	0	
IND_DFLT_NPI_LOC	For NPI entries, indicates that this is the default service location for this NPI.	CHAR	1	0	
IND_NPI_VERIFY	For NPI entries, indicates if this NPI has been validated with NPPES.	CHAR	1	0	
DTE_EFFECTIVE	Effective date for an object. Used to signify the start of a span or period.	NUMBER	8	0	
DTE_END	The date that something is no longer in effect.	NUMBER	8	0	
NUM_TAX_ID	This is the tax identification number assigned to a provider by the Internal Revenue Service.	CHAR	9	0	
IND_TAX_ID_TYPE	This field indicates whether the tax ID is a social security number or an FEIN.	CHAR	1	0	
IND_TAX_ID_EXEMPT	This field indicates whether the corresponding tax id field contains an EXEMPT number or not. The valid values are Y = Tax Exempt and N = Not Tax	CHAR	1	0	

	Exempt.				
CDE_COUNTY	Numeric representation of county in the state.	VARCHAR2	10	0	
DTE_ARA_EFF	This field indicates the date that a provider became eligible to receive an automated remittance advice.	NUMBER	8	0	
DTE_END_PAPER_RA	This date indicates when a provider stops receiving paper copies of the RA.	NUMBER	8	0	
DTE_SUPPRESS_CHECK	This field indicates whether a provider is having their check suppressed or not.	NUMBER	8	0	
DTE_ECC_EFF	This is the date that a provider became eligible to submit claims electronically.	NUMBER	8	0	
CDE_ORGANIZ	This code identifies the proprietary nature of a provider's practice. (1-Individual, 2-Partnership, 3-Corporation, etc.)	CHAR	2	0	
CDE_PEER_GROUP	This field indicates the peer group for a provider's service location.	CHAR	1	0	
CDE_INDIAN_PROV	This identifies the type of Indian provider.	CHAR	1	0	
IND_INDIAN_MGDCARE	This is a Yes/No indicator to specify whether this provider is eligible to be an Indian Managed Care provider.	CHAR	1	0	
IND_MASS_RATE_UPD	This is a Yes/No indicator to specify whether this provider receives mass rate updates.	CHAR	1	0	
IND_SUPPRESS_RA	Indicates whether the RA should be suppressed if the only thing there is to report on the RA is account receivables.	CHAR	1	0	
IND_FICA	Indicates whether this service location should have FICA computed on it or not. The default will be "No".	CHAR	1	0	
CDE_PUB_PRIV	This indicator will identify whether a provider is a private or public organization/practice. Valid values are: B: Public V: Private	CHAR	1	0	
IND_BILLER	Tells whether the service location can be used for billing claims. Valid value are Y = YES and N = No.	CHAR	1	0	
IND_HEALTHCARE	Indicates if item is healthcare related	CHAR	1	0	
CDE_RECEIVE_ALERTS	This code will be used to determine if the provider will receive alerts. Valid values are 'F' = Fax, 'E' = Email, 'P' = Portal Mailbox, and a blank space as the default value.	CHAR	1	0	

IND_ACCEPT_NEW_PATIENTS	This indicator will be used to determine if the provider is accepting new patients. Valid values are "Y" and "N".	CHAR	1	0	
IND_INCLUDE_DIR_SEARCH	This indicator will be used to determine if the provider's name will appear in the directory search. Valid values are "Y" and "N".	CHAR	1	0	
IND_OUT_STATE	Out of State Indicator to specify that the Provider is out of state. Valid values are "Y" and "N". The default value will be "N" and set within the application.	CHAR	1	0	
CDE_AREA	This is used to indicate the area associated with the provider. The area code is derived from the provider's county using the Area/County/District Cross Reference and Area Office tables.	CHAR	3	0	
CDE_SITE_VISIT	This code will be used to classify what type of site visit was performed at the Provider's location. Valid values are BLANK = default value, M = Mandatory, R = Random, E = Exempt, or C = Complete.	CHAR	1	0	
DTE_SITE_VISIT_COMP	This represents the date the site visit was completed.	NUMBER	8	0	
TXT_ONSITE_REVIEW_MEMO	This column allows comments to be stored about an onsite visit.	VARCHAR2	30	0	
IND_NEW_PATIENT_EXEMPT	This indicates that a physician can bill an initial office visit for the same patient more than once. Values are 'Y' and 'N'.	CHAR	1	0	
cnt_pr_comment	record count	NUMBER	3	0	0 - 999
DTE_COMMENT	The date of the note or comment relating to the provider.	NUMBER	8	0	
DSC_COMMENT	The text of the note or comment relating to the provider.	VARCHAR2	500	0	
cnt_pr_svc_lang	record count	NUMBER	3	0	0 - 999
CDE_LANGUAGE	This is the unique two character code for each language that the system tracks.	CHAR	3	0	
DTE_EFFECTIVE	This is the effective date of the language segment for a specific provider service location.	NUMBER	8	0	
DTE_END	This is the end date of the language segment for a specific provider service location.	NUMBER	8	0	
cnt_fin_eft_acct	record count	NUMBER	3	0	0 - 999
CDE_PAYEE_TYPE	Unique char value for payee types defined within financial.	CHAR	1	0	
CDE_TXN_TYPE	This indicates how the EFT account will be used. The valid values are "W" - Withdrawals or "D" Deposits.	CHAR	1	0	

CDE_STATUS_EFT	Code indicating the status of a provider's electronic funds transfer (EFT) account. The valid values are the following: Pending (0),Pre-notification (1), Active (2), Canceled (3), Interrupt (4), Failed (5), Expired (6)	CHAR	1	0	
NUM_ABA	A unique number assigned to individual financial institutions for identification.	CHAR	9	0	
NUM_EFT_ACCT	This is the bank account number for the payees in which the payments are electronically transferred.	CHAR	17	0	
IND_ACCT_TYPE	This one byte indicator identifies the type of the bank account that a payee is using for Electronic Funds Transfers. The valid values are 'Checking, 'S'avings, 'T'ransfer (State Transfer).	CHAR	1	0	
DTE_EFFECTIVE	Effective date for an object. Used to signify the start of a span or period.	NUMBER	8	0	
DTE_END	The date that this EFT segment is no longer in effect.	NUMBER	8	0	
DTE_LAST_CHANGE	This is the date the EFT information was last changed.	NUMBER	8	0	
NAM_SIGNEE_1	This name represents the name of the first authorized signer on the EFT account.	VARCHAR2	50	0	
NAM_SIGNEE_2	This name represents the name of the second authorized signer on the EFT account.	VARCHAR2	50	0	
NAM_SIGNEE_3	This name represents the name of the third authorized signer on the EFT account.	VARCHAR2	50	0	
NAM_SIGNEE_4	This name represents the name of the fourth authorized signer on the EFT account.	VARCHAR2	50	0	
NAM_ACCOUNT_OWNER	This name represents the name of the owner of the EFT account.	VARCHAR2	50	0	
cnt_pr_dea	record count	NUMBER	3	0	0 - 999
NUM_DEA	Drug Enforcement Administration identification number for a provider.	CHAR	9	0	
DTE_EFFECTIVE	Effective date for an object. Used to signify the start of a span or period.	NUMBER	8	0	
DTE_END	The date that something is no longer in effect.	NUMBER	8	0	
cnt_acct_rec_max	record count	NUMBER	3	0	0 - 999
DTE_EFFECTIVE	This is the effective date when the maximum recoupment amount takes effect.	NUMBER	8	0	
DTE_END	This is the end date when the maximum recoupment amount ends.	NUMBER	8	0	

AMT_MAX_RECOUP	This is the maximum amount that can be recovered for a specific provider service location in one cycle.	NUMBER	10	2	
PCT_PAYMENT_RECOUP	This is the percentage of the provider's total payment amount that may be recouped from a payment cycle.	NUMBER	5	4	
TXT_RECOUP_COMMENT	This is the comment associated with the recoupment payment percentage.	VARCHAR2	30	0	
cnt_pr_appln	record count	NUMBER	3	0	0 - 999
CDE_APPL_TYPE	This code indicates the type of enrollment for which a provider is applying.	CHAR	3	0	
DTE_LAST_STATUS	The last time the status was changed for the application	NUMBER	8	0	
CDE_STATUS1	This is a description of possible statuses.	CHAR	1	0	
DTE_RECEIVED	A date that the object was received.	NUMBER	8	0	
CDE_REQUEST_TYPE	This code represents the media in which the application request was received.	CHAR	1	0	
DTE_FINALIZED	This is the date the object was finalized.	NUMBER	8	0	
DTE_RTP	A date that the object was returned to the provider.	NUMBER	8	0	
QTY_RTN_TO_PROV	This is an accumulator of the number of times something has been returned to a provider.	NUMBER	4	0	
DTE_RTP_REC	A date that the RTP object was returned to OHCA.	NUMBER	8	0	
QTY_RTN_FRM_PRV	This is an accumulator of the number of times something has been returned from a provider.	NUMBER	4	0	
IND_NAME_TYPE	This is an indicator of whether a name is of a person or an organization.	CHAR	1	0	
NAME	This is the name associated with an organization or person.	CHAR	50	0	
ADR_STREET_1	This is the first street line in an address.	CHAR	60	0	
ADR_STREET_2	This is the second street line in an address.	CHAR	60	0	
ADR_CITY	This is the city field in an address.	CHAR	15	0	
ADR_STATE	This is the abbreviated 2 character state code.	CHAR	2	0	
ADR_ZIP_CODE	The five digit zip code prefix in an address.	CHAR	5	0	
ADR_ZIP_CODE_4	The four digit zip code suffix in an address.	CHAR	4	0	
NUM_PHONE	This is a phone number in the format area code + prefix + suffix.	CHAR	10	0	
NUM_PHO_EXT	A phone number extension.	CHAR	4	0	
NAM_CONTACT	Contact name. This is the person you will contact if you	CHAR	40	0	

	have questions concerning an application.				
IND_TAX_ID_TYPE	This is the Tax ID indicator, SSN or FEIN.	CHAR	1	0	
NUM_TAX_ID	This is the tax identification number assigned to a provider by the Internal Revenue Service.	CHAR	9	0	
NUM_PROV_LIC	The provider's license or certification number.	CHAR	11	0	changed to 11
CDE_LIC_STATE	The state the provider is licensed or certified in.	CHAR	2	0	
CDE_LIC_TYPE	The license type, typically a licensing agency or board.	CHAR	1	0	
DTE_LIC_CERT	The provider's license certification date.	NUMBER	8	0	
DTE_LIC_CERT_END	The provider's license certification end date if applicable.	NUMBER	8	0	
ID_CLERK	This is the clerk identification code of a system user who is assigned to the application.	CHAR	8	0	
NPI	National Provider ID	CHAR	10	0	
NAM_DOING_BUSINESS_AS	The name is the Provider's Doing Business As name.	VARCHAR2	50	0	
NUM_DRIVERS_LICENSE	This is the provider driver's license number.	CHAR	12	0	
IND_MEDICAID_AGREMNT	This field indicates whether or not a signed Medicaid Agreement with the provider is on file. Value are 'Y' and 'N'.	CHAR	1	0	
cnt_appln_comment	record count	NUMBER	3	0	0 - 999
DTE_COMMENT	The date on which the comment was entered	NUMBER	8	0	
COMMENT1	The comment related to a specific provider application	VARCHAR2	250	0	
cnt_appln_rtp	record count	NUMBER	3	0	0 - 999
DSC_RTP_REAS	This is free form text description stating the reason that a provider application was returned to a provider applicant.	VARCHAR2	250	0	
cnt_pr_spec	record count	NUMBER	3	0	0 - 999
CDE_PROV_TYPE	This is the provider type that a provider is licensed for.	CHAR	2	0	
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	
DTE_EFFECTIVE	The date the specialty of a provider becomes valid (effective).	NUMBER	8	0	
DTE_END	The date the specialty of a provider is no longer valid.	NUMBER	8	0	
CDE_PROV_SUBSPEC	A designation indicating the scope of practice or operations of the provider within a provider specialty.	CHAR	3	0	
cnt_loc_rate	record count	NUMBER	3	0	0 - 999

CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	
DTE_EFFECTIVE	The first date in which the level of care rate became active.	NUMBER	8	0	
DTE_END	The date in which the level of care rate became inactive.	NUMBER	8	0	
AMT_RATE_PERCENT	A daily room rate or percentage of charge value depending on the pricing indicator.	NUMBER	7	2	
AMT_LOC_2_BED_RATE	A daily room rate or percentage of charge value depending on the pricing indicator that may be additional.	NUMBER	7	2	
AMT_LOC_ADD_RATE	A daily room rate or percentage of charge value depending on the pricing indicator that may be additional.	NUMBER	7	2	
NUM_TOTAL_BEDS	The number of beds available in an institutional facility.	NUMBER	9	0	
NUM_MCARE_BEDS	The number of beds available in an institutional facility which are designated for Medicare recipients.	NUMBER	9	0	
NUM_MCAID_BEDS	The number of beds available in an institutional facility which are designated for Medicaid recipients.	NUMBER	9	0	
DTE_LTC_CERT	This field indicates the date of LTC certification for a category of service.	NUMBER	8	0	
DTE_SDH_INSPECT	This field indicates the date of State Department of Health inspection.	NUMBER	8	0	
cnt_hb_lic	record count	NUMBER	3	0	0 - 999
NUM_PROV_LIC	A provider license number.	CHAR	11	0	changed to 11
CDE_LIC_TYPE	This identifies the licensure. The current valid values are: P = Prescriber H = Health Board	CHAR	1	0	
DTE_EFFECTIVE	This is the effective date of the provider's license that Medicaid has on file.	NUMBER	8	0	
DTE_END	This is the date that the provider's license is no longer valid for Medicaid.	NUMBER	8	0	
NAME	This is the name associated with an organization or person.	CHAR	50	0	
ADR_STREET_1	Address street 1. This is the street address for a provider where the license is valid.	CHAR	30	0	
ADR_STREET_2	Address street 2. This is the street address for a provider where the license is valid.	CHAR	30	0	
ADR_CITY	This is the city for a provider where the license is valid.	CHAR	23	0	
ADR_STATE	This is the state for a provider where the license is valid.	CHAR	2	0	
ADR_ZIP_CODE	This is the zip code for a provider where the license is valid.	CHAR	5	0	

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ADR_ZIP_4	This is the zip code extension for a provider where the license is valid.	CHAR	4	0	
CDE_COUNTY	This is the county for a provider where the license is valid.	VARCHAR2	10	0	
NUM_SSN	This is the SSN or FEIN for a provider where the license is valid.	CHAR	9	0	
CDE_STATUS1	Status code which indicates the status of the license. 'A' is for an active status.	CHAR	2	0	changed to 2
CDE_LIC_STATUS	This is the License status of the license assigned by DOH or HQA.	CHAR	2	0	
CDE_SOURCE_TYPE	The is the source of the license information. Valid values are: DOH - Department of Health, HQA - Health Quality Assurance, DCF - Department of Family, DOT - Department of Transportation, EMS - Emergency Medical Services	CHAR	3	0	
CDE_PROFESSIONAL	This is the Professional code assigned by the originator of the license.	CHAR	4	0	
CDE_MODIFIER	This is the modifier code assigned by the originator of the license.	CHAR	4	0	
cnt_php_elig	record count	NUMBER	3	0	0 - 999
DTE_EFFECTIVE	This is the effective date when the maximum recoupment amount takes effect.	NUMBER	8	0	
DTE_END	This is the end date when the maximum recoupment amount ends.	NUMBER	8	0	
DTE_INACTIVE		DATE	8	0	
CDE_ENROLL_STATUS	This is the letter assigned to the enrollment status description to uniquely identify it. Examples of valid values are: R=Retired, D=Deceased, M=Return Mail, I=Term by IFSSA, H=Term by HCFA, B=Term by HPB, and A=Active.	CHAR	2	0	
CDE_PROV_PGM	Identifies the medical assistance programs that a provider can enroll in.	CHAR	5	0	
DSC_PROV_PGM	This is the short description to the provider enrollment program.	CHAR	20	0	
DSC_PROV_PGM_LONG	This is the long description to the provider enrollment program.	VARCHAR2	500	0	

IND_CT_EDITING	The IND_CT_EDITING attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	CHAR	1	0	
DTE_EFFECTIVE	The date the claim type to program restriction becomes effective for use in claims editing.	NUMBER	8	0	
DTE_END	The last date the claim type to program restriction is effective for use in claims editing.	NUMBER	8	0	
DTE_INACTIVE		DATE	8	0	
cnt_review	record count	NUMBER	3	0	0 - 999
CDE_REVIEW_TYPE	Code depicting the type of review or agency conducting the review.	CHAR	1	0	
DTE_EFFECTIVE	The date the review began.	NUMBER	8	0	
DTE_END	The date the review ends.	NUMBER	8	0	
cnt_grp_mbr	record count	NUMBER	3	0	0 - 999
DTE_EFFECTIVE	Date that the provider is effective with this group.	NUMBER	8	0	
DTE_END	Date that the provider is no longer effective with this group.	NUMBER	8	0	

DIAGNOSIS FILE LAYOUT

Column Name	Description	Type	Length	Occurrence
CDE_DIAG	A code for the condition requiring medical attention.	CHAR	7	
DSC_25	The short nomenclature for a medical condition.	CHAR	40	
DIAG_TYPE	Describes the diagnosis type.	CHAR	50	
DTE_LAST_UPDATE	Last update date	NUMBER	8	
CDE_DIAG_CNTRL	Diagnosis control code	CHAR	1	
Number of Limit Records	Number of limit records (dte_effective to ind_sub_class)	NUMBER	3	0 - 999
DTE_EFFECTIVE	The date that the limitations for the diagnosis code became effective.	NUMBER	8	
DTE_END	The date that the limitations for the diagnosis code stopped being effective.	NUMBER	8	
CDE_SEX	Code that identifies the sex for which the diagnosis is limited. If a diagnosis is valid for both sexes, the value in this field will be 'B'.	CHAR	1	
QTY_AGE_MAX	The maximum age that is valid for the diagnosis.	NUMBER	4	
QTY_AGE_MIN	The minimum age that is valid for the diagnosis.	NUMBER	4	
IND_FAM_PLAN	The indicator for determining whether or not this diagnosis is a Family Planning diagnosis.	CHAR	1	

IND_PREGNANCY	Indicates if the diagnosis is for a pregnancy.	CHAR	1	
IND_EMERGENCY	Indicates whether the diagnosis is for an emergency ASC condition. Valid values are 'Y' - yes and 'N' - no.	CHAR	1	
IND_ATTACHMENT	Indicates whether documentation is required for the diagnosis.	CHAR	1	
IND_PRIMARY	Indicates primary diagnosis codes cannot be billed. The valid values are Y/N.	CHAR	1	
IND_SUB_CLASS	Indicates whether the diagnosis requires further specification.	CHAR	1	
Rules based data records, can have 0 to many repetitions				0 - 20
CDE_PGM_HEATLH	Plan or contract code that rule is under	CHAR	5	
DSC_PGM_HEATLH	Plan or contract description	CHAR	50	
MIN_AGE	Minimum Age	NUMBER	3	
MAX_AGE	Maximum Age	NUMBER	3	
MIN_QTY	Minimum Quantity	NUMBER	5	
MAX_QTY	Maximum Quantity	NUMBER	5	
IND_GENDER	Gender Indicator, (M)ale, (F)emale, (B)oth	CHAR	1	
IND_PA	Prior Authorization Indicator	CHAR	1	

PROCEDURE FILE LAYOUT

Column Name	Description	Type	Length	Precision	
CDE_PROC	Code used to identify a medical, dental, or DME procedure.	CHAR	6	0	
DSC_PROCEDURE	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	CHAR	40	0	
DSC_EOMB	Explanation of Medical Benefits description used on Recipient EOMB.	CHAR	30	0	
DTE_HCFA_ADD	Defined by HCFA as the date the HCPCS code was added to the HCFA common procedure coding system.	NUMBER	8	0	
DTE_HCFA_TERM	Defined by HCFA as the last date for which a procedure code may be used by Medicare providers.	NUMBER	8	0	
CDE_MC_SVC_CLASS	The service class indicates the type of services provided.	CHAR	2	0	
DSC_LAY	Description of the code in layman terms.	VARCHAR2	100	0	
CDE_CMS_TOS	The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code	CHAR	1	0	
CDE_MCAR_COVRG	A code denoting Medicare coverage status	CHAR	1	0	
Number of Tooth Records	(CDE_TOOTH_NBR to DTE_END)	NUMBER	3	0	0 - 999
CDE_TOOTH_NBR	The code of the particular tooth that the procedure is restricted to.	CHAR	2	0	
DTE_EFFECTIVE	The date that signifies that the procedure's tooth number restriction is in effect.	NUMBER	8	0	

DTE_END	The date that signifies that the procedure's tooth number restriction is no longer in effect.	NUMBER	8	0	
Number of Tooth Quad Records (CDE_TOOTH_QUAD to QUAD_DTE_END)		NUMBER	3	0	0 - 999
CDE_TOOTH_QUAD	Code identifying the tooth quadrant.	CHAR	3	0	
DTE_EFFECTIVE	The date that signifies that the procedure's tooth quadrant restriction is in effect.	NUMBER	8	0	
DTE_END	The date that signifies that the procedure's tooth quadrant restriction is no longer in effect.	NUMBER	8	0	
Number of ASC Records	(CDE_ASC to DTE_END	NUMBER	3	0	0 - 999
CDE_ASC	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.	CHAR	1	0	
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	
DTE_EFFECTIVE	The date a ASC payment group code assignment for a procedure becomes effective for claims processing.	NUMBER	8	0	
DTE_END	The date an ASC payment group code is no longer in effect for claims processing.	NUMBER	8	0	
Number of Notes Records		NUMBER	3	0	0 - 999
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	
Number of Limits Records	(DTE_EFFECTIVE to CDE_DIAG_CMPT_EDIT)	NUMBER	3	0	0 - 999
DTE_EFFECTIVE	The date procedure limitations become effective for claims processing.	NUMBER	8	0	
DTE_END	The date procedure limitations become invalid (no longer active) for claims processing.	NUMBER	8	0	
IND_LIFETIME	Indicates if a procedure can only occur once in the lifetime of a recipient.	CHAR	1	0	
IND_FAM_PLAN	Indicates if a medical procedure is related to family planning.	CHAR	1	0	
IND_PREGNANCY	Indicates if a medical procedure is related to a pregnancy.	CHAR	1	0	
IND_CLIA	Indicates if a procedure requires CLIA certification.	CHAR	1	0	
IND_ATTACHMENT	Indicates whether attachments are required for the procedure.	CHAR	1	0	
CDE_SEX	The recipient gender that a procedure may be valid for. Valid values are M, F, or blank.	CHAR	1	0	
QTY_AGE_MIN	The minimum age a recipient may be to receive the procedure.	NUMBER	4	0	
QTY_AGE_MAX	The maximum age a recipient may be to receive the procedure.	NUMBER	4	0	
QTY_UNITS_MIN	The minimum number of units that may be billed for the procedure.	NUMBER	9	0	

QTY_UNITS_MAX	The maximum number of units that may be billed for the procedure	NUMBER	9	0	
IND_CONFIDENTIAL	Indicates a confidential procedure. Confidential procedures will not be printed on a recipient EOMB.	CHAR	1	0	
QTY_FOLLOWUP	This field represents the number of days before an E&M (visit) procedure can be paid, since it was included as part of the original surgery that was performed. This field is 3 bytes in length.	NUMBER	4	0	
CDE_PROV_SPEC_EDIT	Indicates whether and what type of provider specialty editing is to be performed for the procedure during claims processing. An 'N' indicates not editing is to be performed. An 'I' (Include) indicates only the provider specialty listed are acceptable. An 'E' (Exclude) indicates the listed provider specialties cannot bill the procedure. Provider Specialties for editing are listed on the T_PROV_SPEC_LIM entity.	CHAR	1	0	
IND_DIAG_REQ	A Yes/No indicator used in claims processing to determine if a diagnosis is required for the given procedure.	CHAR	1	0	
IND_FROM_THRU_OK	Yes/No indicator used in claims process to determine if the procedure may be billed with From and Through dates of service.	CHAR	1	0	
CDE_DIAG_CMPT_EDIT	Code that indicates whether and what type of editing is to be performed in claims processing on the procedure/diagnosis compatibility groupings. An 'N' indicates not editing is to be performed. An 'I' (Include) indicates only diagnosis codes on the diagnosis compatibility groups listed are acceptable. An 'E' (Exclude) indicates the diagnosis codes in the listed diagnosis compatibility groups cannot be billed with the procedure. Valid Diagnosis Compatibility groups for editing are listed on the T_PROC_DIAG_LIM entity.	CHAR	1	0	
Number of Rate Records				0	0 - 20
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	
CDE_PROC_MOD2	Pricing modifier used to identify the appropriate max fee for a procedure modifier combination.	CHAR	2	0	
CDE_PROC_MOD3	The modifier code used to further describe a procedure.	CHAR	2	0	
CDE_PROC_MOD4	The modifier code used to further describe a procedure.	CHAR	2	0	
DTE_EFFECTIVE	The date a max fee rate for a procedure/modifier combination becomes effective for claims processing.	NUMBER	8	0	
DTE_END	The date a max fee rate for a procedure/modifier combination is no longer in effect for claims processing.	NUMBER	8	0	

AMT	The maximum fee amount that may be paid for a procedure.	NUMBER	9	2	
NUM_REL_VALUE	Relative value unit is a grading of the relative difficulty of all medical services and procedures and is used in determining claims payment.	NUMBER	4	0	
DTE_INACTIVE	This is the date this row becomes inactive.	NUMBER	8	0	
Rules based data records, can have 0 to Many repetitions				0	0 - 20
CDE_PGM_HEATLH	Plan or contract code that rule is under	CHAR	5	0	
DSC_PGM_HEATLH	Plan or contract description	CHAR	50	0	
MIN_AGE	Minimum Age	NUMBER	3	0	
MAX_AGE	Maximum Age	NUMBER	3	0	
MIN_QTY	Minimum Quantity	NUMBER	5	0	
MAX_QTY	Maximum Quantity	NUMBER	5	0	
IND_GENDER	Gender Indicator, (M)ale, (F)emale, (B)oth	CHAR	1	0	
IND_PA	Prior Authorization Indicator	CHAR	1	0	
Number of Modifier Set Records		NUMBER	3	0	0 - 999
MOD_MIN	Minimum for modifier set	NUMBER	3	0	
MOD_MIN	Maximum for modifier set	NUMBER	3	0	
IND_INC_EX	Include / Exclude indicator for modifier set, I or E	CHAR	1	0	
Number of Modifiers in Current Set		NUMBER	3	0	0 - 999
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	
DTE_EFFECTIVE	The date that the modifier and its type are to become effective for claims processing.	NUMBER	8	0	
DTE_END	The date that the modifier and its type are no longer in effect for claims processing.	NUMBER	8	0	
DSC_MODIFIER	Short text that describes the modifier.	VARCHAR2	40	0	
CDE	Describes the usage/type of the modifier. Valid values are Pricing (1), Processing (2), Information (3), and Suspend for Manual Review (4).	CHAR	1	0	
CDE_CATEGORY	Indicates whether the modifier is a HCPCS or Ambulance Modifier. Valid values are A(Ambulance) and H(HCPCS)	CHAR	1	0	
DTE_CMS_ADD	Date that CMS added the Modifier	NUMBER	8	0	
DTE_CMS_TERM	Date that CMS terminated the Modifier.	NUMBER	8	0	
Number of POS Records		NUMBER	3	0	0 - 999
IND_INC_EX	Include / Exclude indicator for POS set, I or E	CHAR	1	0	
CDE_POS	Place of medical assistance service code.	CHAR	2	0	
DSC_POS	Description of place where medical assistance service is performed.	CHAR	50	0	
Number of Claim Type Records		NUMBER	3	0	0 - 999
IND_INC_EX	Include / Exclude indicator for POS set, I or E	CHAR	1	0	
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	2	0	
DSC_CLM_TYPE	Description of the value assigned to a specific claim type.	CHAR	50	0	
Number of Billing Provider Type		NUMBER	3	0	0 - 999

/ Spec Records					
IND_INC_EX	Include / Exclude indicator for POS set, I or E	CHAR	1	0	
BILL_PROV_TYPE	Billing provider type	CHAR	2	0	
BILL_PROV_SPEC	Billing provider specialty	CHAR	3	0	
Number of Performing Provider Type / Spec Records		NUMBER	3	0	0 - 999
IND_INC_EX	Include / Exclude indicator for POS set, I or E	CHAR	1	0	
PERF_PROV_TYPE	Performing provider type	CHAR	2	0	
PERF_PROV_SPEC	Performing provider specialty	CHAR	3	0	
Number of Referring Provider Type / Spec Records		NUMBER	3	0	0 - 999
IND_INC_EX	Include / Exclude indicator for POS set, I or E	CHAR	1	0	
REF_PROV_TYPE	Referring provider type	CHAR	2	0	
REF_PROV_SPEC	Referring provider specialty	CHAR	3	0	

CARRIER FILE LAYOUT

Column Name	Description	Type	Length
SAK_CARRIER	This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.	NUMBER	9
CDE_CARRIER	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	CHAR	7
NAM_BUS	This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.	CHAR	45
ADR_MAIL_STRT1	This is the street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	CHAR	55
ADR_MAIL_STRT2	This is the second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	CHAR	55
ADR_MAIL_CITY	This is the city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	CHAR	30
ADR_MAIL_STATE	This is the state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	CHAR	2
ADR_MAIL_ZIP	This is the first 5 digits of the zip code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	CHAR	15
ADR_MAIL_ZIP_4	This is the last 4 digits of the zip code of a claim submission address for a carrier. It is used for mailing TPL claim facsimiles.	CHAR	4
NAM_CONTACT	This is the name of the carrier contact when there are questions about a policy or the carrier.	CHAR	40
NUM_PHONE	This is the telephone number of the carrier contact.	CHAR	15
NUM_PHO_EXT	This is the telephone extension of the carrier contact.	CHAR	6
CDE_HMO_PPO	This code identifies whether this carrier is an HMO or PPO.	CHAR	1
EIN	This is the FEIN for the Carrier.	CHAR	9
NUM_FAX	The fax number for the carrier in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.	CHAR	15
CDE_COUNTRY	Two character ISO country abbreviation.	CHAR	2
CDE_CARRIER_TYPE	This is the code for the carrier type.	CHAR	2

CDE_CARRIER_STAT	This is the code for the carrier status.	CHAR	2
dte_effective	This is the carriers beginning effective date.	NUMBER	8
dte_end	This is the carriers ending effective date.	NUMBER	8
ind_ins_disclosure	This shows whether the carrier participates in the Insurance Disclosure program.	CHAR	1
filler	filler	char	1

RESOURCE FILE LAYOUT

Column Name	Description	Type	Length	Occurrence
CDE_POLICY_TYPE	This code identifies whether the recipient's resource is private pay insurance or state paid insurance.	CHAR	1	
CDE_BILL_TO	This code describes who TPL claim facsimiles are billed to: the employer of the policyholder or the carrier.	CHAR	1	
SAK_RECIP	The system assigned internal key for a unique recipient.	NUMBER	9	
CDE_POLICY_OWNR	This code identifies whether the policy owner is a Recipient or a Policyholder.	CHAR	1	
NUM_TPL_POLICY	Policy number for this TPL policy.	CHAR	16	
NUM_GROUP	Policy group number. If present, gives the group number of the policy.	CHAR	16	
DTE_COST_AVOID	This is the date the cost avoidance indicator was last updated.	NUMBER	8	
DTE_SUSPECT	This is the date the suspect code was last updated.	NUMBER	8	
DTE_ADDED	This is the date the resource was originally added to the system.	NUMBER	8	
CDE_INIT_ORG	This is who told us about the coverage the very first time.	CHAR	1	
CDE_RELATION	This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.	CHAR	1	
CDE_COURT_ORDER	This code identifies the type of court-ordered insurance that must be provided by an absent parent.	CHAR	1	
CDE_SUSPECT	This code identifies whether a TPL resource is active or suspect and, if suspect, who marked it as suspect (the system or the user).	CHAR	1	
IND_COST_AVOID	Indicates if this is to bypass cost avoidance or not.	CHAR	1	
CDE_ORIGIN	This tells who is gave us the information for the latest change to this resource.	CHAR	1	
DTE_LAST_CHANGE	Contains the date that this record was last changed to help support audit trail research	NUMBER	8	
IND_HIPP	Indicates whether or not the recipient participates in HIPP	CHAR	1	
CDE_CARRIER	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	CHAR	7	
num_ac_parents	count of how many ac parent records there are	NUMBER	3	0 - 999
CDE_SEX	This is the code describing the gender of an individual.	CHAR	1	
CDE	This field is used to describe the type of absent parent. Recommended values are as follows: 'A' = ABSENT PARENT; 'C' = CUSTODIAL PARENT	CHAR	1	
DTE_ADDED	This is the date the record was added to the table.	NUMBER	8	

NAM_LAST	This is the last name of the recipient's absent or custodial parent.	CHAR	15	
NAM_FIRST	This is the first name of the recipient's absent or custodial parent.	CHAR	13	
NAM_MID_INIT	This is the middle initial of the recipient's absent or custodial parent.	CHAR	1	
NUM_SSN	This is the parent's social security number.	CHAR	9	
CDE_COUNTRY	Two character ISO country abbreviation.	CHAR	2	
DTE_BIRTH	Absent parents date of birth	NUMBER	8	
CDE_MILITARY_BRANCH	The absent parent's branch of service code.	CHAR	1	
CDE_MILITARY_STATUS	This is the Military status of the absent parent. Recommended values are 'A' - Active, 'D' - 100% DAV, 'E' - MEPCOM Enlistee, 'N' - National Guard, 'R' - Retired, 'V' - Reserve, 'X' - Other, 'Z' - Unknown, Space - Not Military	CHAR	1	
ADR_STATE	This is the state abbreviation for the state in which the absent parent resides.	CHAR	2	
NUM_PHONE	The US or international phone number of the absent or custodial parent.	CHAR	15	
NUM_PHONE_EXT	The US or international phone extension number for the absent or custodial parent.	CHAR	6	
NUM_FAX	The fax number for the absent or custodial parent in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.	CHAR	15	
ADR_CITY	This is the absent parent's city where the correspondence is sent to. Could be an out of country city if country code is not US.	CHAR	30	
ADR_STREET_1	The first address line of the absent parent used for correspondence. Could be an international address if country code is not US.	CHAR	55	
ADR_STREET_2	The second address line of the absent parent used for correspondence. Could be an international address if country code is not US.	CHAR	55	
ADR_ZIP	This is the first five digits of the absent parent's zip code used for correspondence. Could also be an out of country zip code if country code is not US.	CHAR	15	
ADR_ZIP_4	This is the last four digits of the zip code for correspondence of an absent parent if within the US.	CHAR	4	
DTE_LAST_UPDATED	Contains the date that this record was last changed to help support audit trail research	NUMBER	8	
NAM_LAST	This is the last name of the policyholder. It is used to send correspondence to the policyholder.	CHAR	15	
NAM_FIRST	This is the first name of the policyholder. It is used to send correspondence to the policyholder.	CHAR	13	
NAM_MID_INIT	This is the middle initial of the policyholder. It is used to send correspondence to the policyholder.	CHAR	1	
ADR_MAIL_STRT1	This is the street address of the policyholder. It is used to send correspondence to the policyholder.	CHAR	55	

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ADR_MAIL_STRT2	This is the second street address of the policyholder. It is used to send correspondence to the policyholder.	CHAR	55	
ADR_MAIL_CITY	This is the city of the policyholder. It is used to send correspondence to the policyholder.	CHAR	30	
ADR_MAIL_STATE	This is the state of the policyholder. It is used to send correspondence to the policyholder.	CHAR	2	
ADR_MAIL_ZIP	This is the first 5 digits of the zip code of the policyholder. It is used to send correspondence to the policyholder.	CHAR	15	
ADR_MAIL_ZIP_4	This is the last 4 digits of the zip code of the policyholder. It is used to send correspondence to the policyholder.	CHAR	4	
NUM_SSN	This is the social security number of the policyholder.	CHAR	9	
dte_birth	This is the birth date of the policyholder.	NUMBER	8	
NUM_PHONE	The US or international phone number of the policyholder.	CHAR	15	
NUM_PHO_EXT	The US or international phone extension number for the policyholder.	CHAR	6	
NUM_FAX	The fax number for the policyholder in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.	CHAR	15	
CDE_COUNTRY	Two character ISO country abbreviation.	CHAR	2	
CDE_EMPLOYER	This field is the unique, user-defined employer ID which is used on all screens and reports to identify the employer.	CHAR	15	
NAM_BUS	This is the business name of an employer.	CHAR	39	
ADR_MAIL_STRT1	This is the street address of an employer.	CHAR	55	
ADR_MAIL_STRT2	This is the second street address of an employer	CHAR	55	
ADR_MAIL_CITY	This is the city of an employer.	CHAR	30	
ADR_MAIL_STATE	This is the state of an employer.	CHAR	2	
ADR_MAIL_ZIP	This is the first 5 digits of the zip code of an employer.	CHAR	15	
ADR_MAIL_ZIP_4	This is the last 4 digits of the zip code of an employer.	CHAR	4	
ADR_EMAIL	This is the email address of the employer.	CHAR	50	
NAM_CONTACT	This is the employer contact name.	CHAR	40	
NUM_PHONE	This is the employer contact telephone number.	CHAR	15	
NUM_PHO_EXT	This is the employer contact telephone extension.	CHAR	6	
EIN	This is the FEIN for the Employer.	CHAR	9	
NUM_FAX	The fax number of the employer.	CHAR	15	
DTE_START_ENROLL	The employer's enrollment period start date.	NUMBER	8	
DTE_END_ENROLL	The employer's enrollment period end date.	NUMBER	8	
DTE_ACTIVE	The date the employer started business.	NUMBER	8	
DTE_INACTIVE	The date the employer ended business.	NUMBER	8	
CDE_COUNTRY	Two character ISO country abbreviation.	CHAR	2	
num_notes	count of how many note records there are	NUMBER	3	0 - 999
CDE_CHRONO	This code identifies the type of chrono note.	CHAR	1	
DTE_ADDED	This identifies the date a particular chrono note was added to the case.	NUMBER	8	
DSC_TEXT_LINE	This is used for free form text in the chrono notes.	VARCHAR2	500	
num_coverage	count of how many coverage records there are	NUMBER	3	0 - 999
CDE_COVERAGE	This code identifies the type of coverage that a TPL policy provides.	CHAR	2	

DTE_EFFECTIVE	The effective begin date of this coverage code.	NUMBER	8	
DTE_END	The effective ending date of this coverage code.	NUMBER	8	

LEADS LETTER FILE LAYOUT

Column Name	Description	Type	Length
ID_MEDICAID	Unique identifier for the beneficiary.	CHAR	12
NAM_LAST	The last name of a beneficiary.	CHAR	20
NAM_FIRST	The first name of a beneficiary.	CHAR	15
NAM_MID_INIT	The middle initial of the beneficiary.	CHAR	1
ADR_STREET_1	The first line of the beneficiary's street address.	CHAR	30
ADR_STREET_2	The second line of a beneficiary's street address.	CHAR	30
ADR_CITY	The city where the beneficiary resides.	CHAR	18
ADR_STATE	The state where the beneficiary resides.	CHAR	2
ADR_ZIP_CODE	The five character zip code for the beneficiary.	CHAR	5
ADR_ZIP_CODE_4	The zip plus four of the beneficiary.	CHAR	4
NAME	Provider Name	CHAR	50
DTE-FIRST-SVC	Date on which service was first provided (oldest date of all details).	MMDDCCYY	8

MEDICARE ELECTRONIC DATABASE FILE LAYOUT

FIELD NAME	LOC	SIZE	TYPE	OCC	FORMAT/VALUES
---	---	---	---		---
*** STATE FINDER RECORD ***	1	80	CHAR		
STATE-SSN-NUM	1	9	CHAR		
STATE-REQ-ID		8	CHAR		
STATE-BENE-ID-NUM		25	CHAR		
STATE-BIRTH-DT		8	CHAR		
STATE-SEX-CD		1	CHAR		
STATE-GVN-NAME		6	CHAR		
STATE-SUR-NAME		6	CHAR		
STATE-CREATE-YYMM		4	CHAR		
STATE-MISC-DATA		13	CHAR		
*** FINDER STATUS ***	81	1	CHAR		
FINDER STATUS CODE:	81	1	NUM		012345
					0 = NOT ON FILE
					1 = BENE_CLM_NUM: EXACT MATCH
					3 = BENE_CLM_NUM: EQUATABLE BIC MATCH
					2 = XREF_CLM_NUM: EXACT MATCH
					4 = XREF_CLM_NUM: EQUATABLE BIC MATCH
					5 = BENE_SSN_NUM MATCH (USING PRIMARY BIC)
*** BENEFICIARY IDENTIFICATION	82	209	CHAR		
BENE_IDENT_REL	82	209	CHAR		

BENE_CLM_NUM	82	11	CHAR		
BENE_CLM_ACNT_NUM	82	9	CHAR		
BENE_IDENT_CD	91	2	CHAR		
BENE_BIRTH_DT	93	8	DATE		YYYYMMDD
BENE_DEATH_DT	101	8	DATE		YYYYMMDD
BENE_SEX_IDENT_CD	109	1	NUM		012
					1=MALE
					2=FEMALE
					0=UNKNOWN
BENE_GVN_NAME	110	15	CHAR		
BENE_MDL_NAME	125	1	CHAR		
BENE_SRNM_NAME	126	24	CHAR		
BENE_MLG_CNTCT_ADR_CNT	150	2	NUM		0 THRU 6
BENE_MLG_CNTCT_ADR_MAX	152	2	NUM		6
BENE_MLG_CNTCT_ADR	154	22	CHAR	6	
BENE_RPRSNTV_PYE_SW	286	1	CHAR		YN
					Y=REPAYEE
					N=NO REPPAYEE
EDB_BENE_PTA_PRM_PYR_CD	287	1	CHAR		017
					0=PREVIOUSLY INVOLVED IN
					PART A THIRD PARTY BILLING
					1=STATE BILLING
					7=PRIVATE THIRD PARTY
					BILLING
EDB_BENE_PTB_PRM_PYR_CD	288	1	CHAR		0123456789
					0=PREVIOUSLY INVOLVED IN
					PART B THIRD PARTY BILLING
					1=STATE BILLING
					2=PRIVATE GROUP
					AND PENALTY ONLY GROUP
					3=CIVIL SERVICE
					AND PENALTY ONLY GROUP
					4=PENALTY ONLY GROUP
					5=CIVIL SERVICE
					6=CLOSED CIVIL SERVICE
					AND OPEN PENALTY ONLY GROUP
					7=PRIVATE THIRD PARTY BILLING
					8=OPEN CIVIL SERVICE
					AND CLOSED PENALTY ONLY
					GROUP
					9=POTENTIAL CIVIL SERVICE WITH
					A FUTURE PART B START DATE
BENE_PTA_NENTLMT_STUS_CD	289	1	CHAR		DFHNR
					THE FOLLOWING CODES OCCUR WHEN
					THERE IS NO PART A ENTITLEMENT
					DATE
					D=COVERAGE WAS DENIED
					F=TERMINATED DUE TO INVALID

					ENROLLMENT OR ENROLLMENT
					VOIDED
					H=NOT ELIGIBLE FOR FREE
					PART A, OR DID NOT ENROLL
					FOR PREMIUM PART A
					N=NOT A VALID SSA HOC, BUT
					USED BY CMS'S THIRD PARTY
					SYSTEM TO INDICATE A
					'POTENTIAL' PTA ENTITLEMENT
					DATE
					R=REFUSED BENEFITS
BENE_PTB_NENTLMT_STUS_CD	290	1	CHAR		DNR
					THE FOLLOWING CODES OCCUR WHEN
					THERE IS NO PART B ENTITLEMENT
					DATE
					D=COVERAGE WAS DENIED
					N=NO (FOREIGN/PUERTO RICAN
					BENEFICIARY NOT ENTITLED TO
					SMI. ALSO DUALLY/TECHNICALLY
					BENEFICIARY IS NOT ENTITLED
					TO SMI).
					R=REFUSED BENEFITS
*** CROSS-REFERENCE NUMBERS ***	291	114	CHAR		
XREF_BENE_CLM_ACNT_CNT	291	2	NUM		0 THRU 99
XREF_BENE_CLM_ACNT_MAX	293	2	NUM		10
XREF_BENE_CLM_ACNT_REL	295	11	CHAR	10	
XREF_BENE_CLM_NUM	295	11	CHAR		
XREF_BENE_CLM_ACNT_NUM	295	9	CHAR		
XREF_BENE_IDENT_CD	304	2	CHAR		
*** SOCIAL SECURITY NUMBERS ***	405	49	CHAR		
BENE_SSN_NUM_CNT	405	2	NUM		0 THRU 99
BENE_SSN_NUM_MAX	407	2	NUM		5
BENE_SSN_NUM_REL	409	9	CHAR	5	
BENE_SSN_NUM	409	9	NUM		
*** PART A ENTITLEMENT ***	454	18	CHAR		
BENE_PTA_ENTLMT_REL	454	18	CHAR		
BENE_PTA_ENTLMT_STRT_DT	454	8	DATE		YYYYMMDD
BENE_PTA_ENTLMT_TRMNTN_DT	462	8	DATE		YYYYMMDD
BENE_PTA_ENRLMT_RSN_CD	470	1	CHAR		
BENE_PTA_ENTLMT_STUS_CD	471	1	CHAR		CEGSTWXY
*** PART B ENTITLEMENT ***	472	18	CHAR		
BENE_PTB_ENTLMT_REL	472	18	CHAR		
BENE_PTB_ENTLMT_STRT_DT	472	8	DATE		YYYYMMDD
BENE_PTB_ENTLMT_TRMNTN_DT	480	8	DATE		YYYYMMDD

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BENE_PTB_ENRLMT_RSN_CD	488	1	CHAR		
BENE_PTB_ENTLMT_STUS_CD	489	1	CHAR		CFGSTWY
*** HOSPICE COVERAGE ***	490	124	CHAR		
BENE_HOSPC_CVRG_CNT	490	2	NUM		0 THRU 99
BENE_HOSPC_CVRG_MAX	492	2	NUM		5
BENE_HOSPC_CVRG_REL	494	24	CHAR	5	
BENE_HOSPC_CVRG_STRT_DT	494	8	DATE		YYYYMMDD
BENE_HOSPC_CVRG_TRMNTN_DT	502	8	DATE		YYYYMMDD
BENE_HOSPC_CVRG_PRCSG_DT	510	8	DATE		YYYYMMDD
*** ENTITLEMENT REASON ***	614	9	CHAR		
BENE_ENTLMT_RSN_CD_REL	614	9	CHAR		
BENE_ENTLMT_RSN_CD_CHG_DT	614	8	DATE		YYYYMMDD
BENE_ENTLMT_RSN_CD	622	1	NUM		0123
					0=INSURED DUE TO AGE (OASI)
					1=INSURED DUE TO DIB
					2=INSURED DUE TO ESRD
					3=INSURED DUE TO DIB+ESRD
*** RESIDENCE ***	623	17	CHAR		
BENE_RSDNC_REL	623	17	CHAR		
BENE_RSDNC_CHG_DT	623	8	DATE		YYYYMMDD
BENE_MLG_CNTCT_ZIP_CD	631	9	CHAR		
*** DISABILITY INSURANCE ***	640	17	CHAR		
BENE_HCFA_DIB_ENTLMT_REL	640	17	CHAR		
BENE_HCFA_DIB_ENTLMT_STRT_DT	640	8	DATE		YYYYMMDD
BENE_HCFA_DIB_ENTLMT_END_DT	648	8	DATE		YYYYMMDD
BENE_DIB_ENTLMT_DT_JSTFCTN_CD	656	1	NUM		1A
					1=ENTITLED TO MEDICARE DUE TO PRIOR DIB
					A=ENTITLED TO MEDICARE BASED ON SSA DIB
					AND THE 24-MONTH WAITING PERIOD WAIVED
*** GROUP HEALTH ORGANIZATION *	657	214	CHAR		
BENE_GHO_ENRLMT_CNT	657	2	NUM		0 THRU 99
BENE_GHO_ENRLMT_MAX	659	2	NUM		10
BENE_GHO_ENRLMT_REL	661	21	CHAR	10	
BENE_GHO_ENRLMT_STRT_DT	661	8	DATE		YYYYMMDD
BENE_GHO_DISENRLMT_DT	669	8	DATE		YYYYMMDD
BENE_GHO_CNTRCT_NUM	677	5	CHAR		
*** END STAGE RENAL DISEASE	871	17	CHAR		
COVERAGE					
BENE_ESRD_CVRG_REL	871	17	CHAR		
BENE_ESRD_CVRG_STRT_DT	871	8	DATE		YYYYMMDD
BENE_ESRD_CVRG_TRMNTN_DT	879	8	DATE		YYYYMMDD

BENE_ESRD_TRMNTN_DT_RSN_CD	887	1	CHAR		ABCDE
*** END STAGE RENAL DISEASE	888	16	CHAR		
DIALYSIS					
BENE_ESRD_DLYS_REL	888	16	CHAR		
BENE_ESRD_DLYS_STRT_DT	888	8	DATE		YYYYMMDD
BENE_ESRD_DLYS_STOP_DT	896	8	DATE		YYYYMMDD
*** END STAGE RENAL DISEASE	904	16	CHAR		
TRANSPLANT					
BENE_ESRD_TRNSPLNT_REL	904	16	CHAR		
BENE_ESRD_TRNSPLNT_STRT_DT	904	8	DATE		YYYYMMDD
BENE_ESRD_TRNSPLNT_STOP_DT	912	8	DATE		YYYYMMDD
*** THIRD PARTY PART A HISTORY	920	43	CHAR		
BENE_TP_PTA_HSTRY_REL	920	43	CHAR		
BENE_PTA_TP_STRT_DT	920	8	DATE		YYYYMMDD
BENE_PTA_TP_PRM_PYR_CD	928	3	CHAR		
BENE_PTA_TP_ACRTN_TRANS_CD	931	4	CHAR		
FILLER	935	1	CHAR		
BENE_PTA_TP_ACRTN_BLG_MO_DT	936	6	NUM		YYYYMM
BENE_PTA_TP_TRMNTN_DT	942	8	DATE		YYYYMMDD
BENE_PTA_TP_DLTN_TRANS_CD	950	4	CHAR		
FILLER	954	1	CHAR		
BENE_PTA_TP_DLTN_BLG_MO_DT	955	6	NUM		YYYYMM
BENE_PTA_TP_BUYIN_ELGBLTY_CD	961	1	CHAR		
FILLER	962	1	CHAR		
*** THIRD PARTY PART B HISTORY	963	43	CHAR		
BENE_TP_PTB_HSTRY_REL	963	43	CHAR		
BENE_PTB_TP_STRT_DT	963	8	DATE		YYYYMMDD
BENE_PTB_TP_PRM_PYR_CD	971	3	CHAR		
BENE_PTB_TP_ACRTN_TRANS_CD	974	4	CHAR		
FILLER	978	1	CHAR		
BENE_PTB_TP_ACRTN_BLG_MO_DT	979	6	NUM		YYYYMM
BENE_PTB_TP_TRMNTN_DT	985	8	DATE		YYYYMMDD
BENE_PTB_TP_DLTN_TRANS_CD	993	4	CHAR		
FILLER	997	1	CHAR		
BENE_PTB_TP_DLTN_BLG_MO_DT	998	6	NUM		YYYYMM
BENE_PTB_TP_BUYIN_ELGBLTY_CD	1004	1	CHAR		
FILLER	1005	1	CHAR		
*** MBD PERSONAL BENEFITS					
PACKAGE ELECTION	1006	29	CHAR		
MBD_PBP_ELCT_REL	1006	29	CHAR		
MBD_GHP_ENRL_EFCTV_DT	1006	8	DATE		YYYYMMDD
MBD_PBP_STRT_DT	1014	8	DATE		YYYYMMDD
MBD_PBP_END_DT	1022	8	DATE		YYYYMMDD

MBD_PBP_NUM	1030	3	CHAR		
MBD_PBP_CVRG_TYPE_CD	1033	2	CHAR		3,5,6,8,10
					3=COORDINATED CARE PLAN (CCP)
					5=PRIVATE FEE FOR SERVICE (PFFS)
					6=PROGRAM OF ALL INCLUSIVE CARE
					FOR THE ELDERLY (PACE)
					8=DEMONSTRATION
					10=COST/HEALTH CARE PREPAYMENT PLAN (HCPP)

MEDICARE PROVIDER FILE LAYOUT

Column Name	Description	Type	Length
NUM_MEDICARE	Medicare number assigned by the government to the provider.	CHAR	10
ID_PROVIDER	Provider ID value	CHAR	15
DTE_EFFECTIVE	The first date in which the Medicare number became effective.	NUMBER	8
DTE_END	The last date in which the Medicare number will expire.	NUMBER	8
NPI	National Provider ID	CHAR	10

MEDICARE PART D FILE LAYOUT

Fields Received by the State on monthly MMA Response File:

• MEDICARE PART D FINDER CODE

(Part D Payment Switch or MARx Payment Switch)

- Value will be '0' for dual eligibles who are enrolled in a Part D plan during eligibility month/year
- Value will be '1' for dual eligibles who are not enrolled in a Part D Plan during eligibility month/year
- As of the March Response Files, rare occurrences have been observed whereby the Finder Code is set to "1" (not enrolled) yet a beneficiary is enrolled in an MA PD
  (H Plan # can be found as an MA PD on the latest Spreadsheet of Part D plans) receiving Part D benefits- this situation will be corrected promptly and only affects information in the response file, not the beneficiary's actual benefit
- PACE programs and Demonstrations had not been required to submit individual PBP data prior to onset of PART D, thus for beneficiaries enrolled in either type of program, this indicator was erroneously set to a '1', although beneficiary had Part D drug coverage. Situation will be ameliorated as of 03/2006, with PACE and Demonstration programs submitting PART D identifiable PBP information to the MARx enrollment system and allowing correct Part D enrollment information to be shared.

• GROUP HEALTH ORGANIZATION: GHO (10 OCCURRENCES)
(Prior to the onset of Part D benefits, this part of this part of the record only contained Part C MA Organizations

(This area of the response file contains both Medicare Advantage Plans, PACE and Demo Enrollments offering and not offering Part D drug benefits. The information represents the overall contract/organization within which a beneficiary may have a choice of plans (PBPs). If a rollover from a non drug covering plan into one that did occurs, the enrollment effective date of the GHO/GHP would not change but the enrollment periods of the effected PBPs would be updated)

- The first occurrence is the active (current or future) or most recent Medicare Group Health Organization coverage (i.e. plan enrollment). Presently, this section is populated with Medicare Part C and Medicare Part D Organizations enrollments. The organizations can be distinguished by the first position of 'BENE GHO CNTRCT NUM':
  - H# is for local MA and MA-PDs; PACE, Cost Plans, and Demos
  - S# is for STAND ALONE PDP'S
  - R# is for Regional MA and MA-PDs

- o [9 in the first position may denote a Demo Plan; or a Chronic Care Improvement Pilot]
- o E# -- Starting with contract year 2007, a contract number starting with E indicates an employer sponsored prescription drug plan.

• MBD PLAN BENEFIT PACKAGE ELECTION (10 OCCURRENCES)

(This area of the response file describes the various PBP (plan) enrollments within the given GHO periods mentioned above)

- The most active plan enrollment will reside in occurrence 1, followed by historical enrollments.
- Presently, this section is populated with Medicare Part C offering no drug overage as well as offering drug coverage and Part D standalone plans
- It is possible for a beneficiary to have two open enrollment periods, one signifying a managed care plan offering no drug coverage and a PDP standalone. In that case, the GHP contract numbers will be different.
- Updated list of values for the

MBD PBP CVRG TYPE CD:

NF=pay bill option was not found for the contract
3 =CCP - COORDINATED CARE PLAN
5 = PFFS - PRIVATE FEE FOR SERVICE
6 = PACE - PACE PGM OF ALL INCLSVE CARE FOR THE ELDERLY
8 =DEMO - DEMONSTRATION
9 = FFS - FEE FOR SERVICE
10 = Cost/HCPP -COST/HEALTH CARE PREPAYMENT PLAN
11=PDP - Part D Drug Plan ELECTION

• PART D PLAN BENEFIT PACKAGE (10 Occurrences)

(This portion of the record will list the Part D Plans which also trigger the MEDICARE PART D FINDER CODE to reflect a '0', denoting "Part D Enrollment found"

(This area of the response file describes the various PBP (plan) enrollments within the given PDP only periods)

- The most active plan enrollment will reside in occurrence 1, followed by historical enrollments.
- **Presently, this section is populated with Medicare Part C offering drug coverage as well as Part D standalone plans**
- It is possible for a beneficiary to have two open enrollment periods, one signifying a managed care plan offering no drug coverage and a PDP standalone. In that case, the GHP contract numbers will be different.
- Updated list of values coverage type code:

-Values for Enrollment Type Code:

A - Beneficiary was auto-enrolled thru CMS (full duals)
B - Beneficiary elected plan (overrides auto enrolled plan)
C - Facilitated enrollment: CMS facilitates enrollment of partial duals into a PDP (eff. 3/2006)
D - System (plan's) generated enrollment: the beneficiary is in a plan and either the contract or PBP # is changing and they are rolled over automatically into the new number. This usually occurs at the end of the calendar year (which coincides with contract year), when contracts/plans may transition to new numbers.

File and Record Specifications

Data Types:

9(x) = Numeric characters; where "9" indicates a numeric data type and "x" is the field length
X(x) = Alphanumeric characters with field length (x)
DATES = ALL DATES WILL BE IN MMDDCCYY FORMAT (month, day, century, year)

NOTE: Entries of numeric data fields will be right-justified within the field and entries alphanumeric data fields will be left-justified within the field.

File Format:

File naming standard – **P#DDP.#DDP3.CMS.IN.ELIGIBLE.ss**

Where "ss" represents the FIPS State abbreviation, see table below:

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Mainframe EBCDIC file format, FB
Record Lengths:
HEADER LRECL= 180, (40 + 140 space filled),
DETAIL LRECL=180,
TRAILER LRECL=180, (40 + 140 space filled).

-Where “FB” = Fixed Block, and “LRECL” = Record Length

STATE CODE ABRREVIATIONS TABLE

State Code - Valid Code	
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV

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Wisconsin	WI
Wyoming	WY

This file will be automatically returned to the state through the Connect:Direct file transfer process upon the successful processing of a State Enrollment File. There may be a delay in sending the response file based upon other scheduling issues.

The return data set name will be the same data set name that was used to return the Drug Card Return File, unless the state notifies CMS of an alternative name. This will ensure that CMS returns a file that complies with state system data set naming conventions. States that prefer to differentiate by the use of a different data set name must provide that name to CMS at least 2 weeks prior to Enrollment File submittal. . Please forward requests for data set name changes to the following e-mail address and include "Request for MMA Dataset Name Change" in your Subject Line:

StateMMAdatafeed@cms.hhs.gov

Note that this file will have a much longer record length than the return file for the Drug Card File. The content of this file will include the following:

1. Header Record with identifying information, record count summaries, and a copy of the incoming header record
2. Detail Record
   a. Copy of the incoming state detail record
   b. Series of edit error return codes
   c. Large section of data from the Medicare Beneficiary Database including enrollment and plan information
3. File summary including record validation and matching outcomes
4. Summary enrollment count record by month for each month of enrollment information on the incoming file, and
5. Trailer Record with identifying information and a copy of the incoming trailer record.

Each Section is identified by a Record-Identifier code in the first three positions of the record. The physical record layouts and field descriptions for these sections are provided below.

Header Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
RECORD IDENT CODE	X(03)	0001	0003
FILE PROCESS TIMESTAMP	X(26)	0004	0029
FILE ACCEPT IND	X(01)	0030	0030
FILLER	X(01)	0031	0031
RECORDS TOTAL	9(08)	0032	0039
RECORDS DUPLICATE	9(08)	0040	0047
RECORDS NONDUP	9(08)	0048	0055
RECORDS VALID	9(08)	0056	0063
RECORDS INVALID	9(08)	0064	0071
RECORDS MATCHED	9(08)	0072	0079
RECORDS NOT MATCHED	9(08)	0080	0087
FILE CREATE MONTH	9(02)	0088	0089
FILE CREATE YEAR	9(04)	0090	0093
FILLER	X(22)	0094	0115
***********ORIG STATE HEADER REC 180 characters ******************************			
RECORD IDENT CODE	X(03)	0116	0118
STATE CODE	X(02)	0119	0120
CREATE MONTH	9(02)	0121	0122
CREATE YEAR	9(04)	0123	0126
FILLER	X(169)	0127	0295
***********REMAINDER OF RECORD**			
FILLER	X(2666)	0296	2961

Person-Level Detail Record Physical Layout

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FIELD NAME	FORMAT	<------POSITION------> START	END
********ORIGINAL RECORD SUBMITTED BY STATE****************************			
RECORD IDENT CODE	X(03)	0001	0003
ELIGIBILITY MONTH/YEAR	9(06)	0004	0009
ELIGIBILITY STATUS	X(01)	0010	0010
HIC/RRB	X(15)	0011	0025
HIC-RRB IND	X(01)	0026	0026
SOCIAL SECURITY NUM	9(09)	0027	0035
SMA IDENTIFIER	X(20)	0036	0055
FIRST NAME	X(12)	0056	0067
LAST NAME	X(20)	0068	0087
MIDDLE NAME	X(15)	0088	0102
SUFFIX NAME	X(04)	0103	0106
SEX	X(01)	0107	0107
DATE OF BIRTH	9(08)	0108	0115
DUAL STATUS CODE	9(02)	0116	0117
FPL % IND	9(01)	0118	0118
DRUG COVERAGE IND	9(01)	0119	0119
INSTITUTIONAL STATUS IND	X(01)	0120	0120
PART D SUBSIDY APPLICATION APPROVAL CODE	X(01)	0121	0121
PART D SUBSIDY APPRVD/DISAPPRVD DATE	9(08)	0122	0129
PART D SUBSIDY START DATE	9(08)	0130	0137
PART D SUBSIDY END DATE	9(08)	0138	0145
PART D % OF FPL	9(03)	0146	0148
PART D SUBSIDY LEVEL	9(03)	0149	0151
INCOME USED FOR DETERMINATION	X(01)	0152	0152
RESOURCE LEVEL	X(01)	0153	0153
BASIS OF PART D SUBSIDY DENIAL	X(01)	0154	0154
RESULT OF AN APPEAL	X(01)	0155	0155
CHANGE TO PREVIOUS DETERMINATION	X(01)	0156	0156
DETERMINATION CANCLD	X(01)	0157	0157
FILLER	X(23)	0158	0180

Person-Level Detail Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
************ ERROR RETURN CODES (ERC) **************************************			
RECORD IDENT CODE ERC	X(02)	0181	0182

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ELIGIBILITY MONTH/YEAR ERC	X(02)	0183	0184
ELIGIBILITY STATUS ERC	X(02)	0185	0186
HIC/RRB ERC	X(02)	0187	0188
HIC-RRB IND ERC	X(02)	0189	0190
SOCIAL SECURITY NUM ERC	X(02)	0191	0192
SEX ERC	X(02)	0193	0194
DATE OF BIRTH ERC	X(02)	0195	0196
DUAL STATUS CODE ERC	X(02)	0197	0198
FPL % IND ERC	X(02)	0199	0200
DRUG COVERAGE IND ERC	X(02)	0201	0202
INSTITUTIONAL STATUS IND ERC	X(02)	0203	0204
PART D SUBSIDY APPLICATION APPROVAL CODE ERC	X(02)	0205	0206
PART D SUBSIDY APPRVD/DISAPPRVD DATE ERC	X(02)	0207	0208
PART D SUBSIDY START DATE ERC	X(02)	0209	0210
PART D SUBSIDY END DATE ERC	X(02)	0211	0212
PART D % OF FPL ERC	X(02)	0213	0214
PART D SUBSIDY LEVEL ERC	X(02)	0215	0216
INCOME USED FOR DETERMINATION ERC	X(02)	0217	0218
RESOURCE LEVEL ERC	X(02)	0219	0220
BASIS OF PART D SUBSIDY DENIAL ERC	X(02)	0221	0222
RESULT OF AN APPEAL ERC	X(02)	0223	0224
CHANGE TO PREVIOUS DETERMINATION ERC	X(02)	0225	0226
DETERMINATION CANCLD ERC	X(02)	0227	0228
********** **CMS MBD FILE** **********			
RECORD RETURN CODE	X(06)	0229	0234
MEDICARE PART A/B FINDER CODE	X(01)	0235	0235
MEDICARE PART D FINDER CODE	X(01)	0236	0236
*** BENEFICIARY IDENTIFICATION ***			
BENE CLM ACNT NUM	X(09)	0237	0245
BENE IDENT CD	X(02)	0246	0247
BENE BIRTH DT	9(08)	0248	0255
BENE DEATH DT	9(08)	0256	0263

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FIELD NAME	FORMAT	<------POSITION------> START	END
BENE SEX IDENT CD	X(01)	0264	0264
BENE GIVN NAME	X(30)	0265	0294
BENE MDL NAME	X(01)	0295	0295
BENE SURN NAME	X(40)	0296	0335
*** CROSS REFERENCE NUMBERS (10 TIMES) ***	0336		0445
XREF BENE CLM ACCT NUM	X(09)		

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XREF BENE IDENT CODE	X(02)		
*** SOCIAL SECURITY NUMBERS (5 TIMES) ***	0446	0490	
BENE SSN NUM	9(09)		
*** MAILING ADDRESS ***			
MLNG ADDR LINE1	X(40)	0491	0530
MLNG ADDR LINE2	X(40)	0531	0570
MLNG ADDR LINE3	X(40)	0571	0610
MLNG ADDR LINE4	X(40)	0611	0650
MLNG ADDR LINE5	X(40)	0651	0690
MLNG ADDR LINE6	X(40)	0691	0730
MLNG ADDR CITY NAME	X(40)	0731	0770
MLNG ADDR STATE CODE	X(02)	0771	0772
MLNG ADDR ZIP CD	X(09)	0773	0781
MLNG ADDR CHG DT	9(08)	0782	0789
*** RESIDENCE ADDRESS ***			
RSDNC ADDR LINE1	X(40)	0790	0829
RSDNC ADDR LINE2	X(40)	0830	0869
RSDNC ADDR LINE3	X(40)	0870	0909
RSDNC ADDR LINE4	X(40)	0910	0949
RSDNC ADDR LINE5	X(40)	0950	0989
RSDNC ADDR LINE6	X(40)	0990	1029
RSDNC ADDR CITY NAME	X(40)	1030	1069
RSDNC ADDR STATE CODE	X(02)	1070	1071
RSDNC ADDR ZIP CD	X(09)	1072	1080
RSDNC ADDR CHG DT	9(08)	1081	1088
*** REPRESENTATIVE PAYEE ***			
BENE REP PAYEE SW	X(01)	1089	1089
*** NON-ENTITLEMENT STATUS ***			
PRT A NENTLMT STUS CODE	X(01)	1090	1090
PRT B NENTLMT STUS CODE	X(01)	1091	1091
*** ENTITLEMENT REASON (5 TIMES) ***		1092	1151
BENE ENTLMT RSN CD			
CHG DT	9(08)		
BENE ENTLMT RSN CD	X(04)		

Person-Level Detail Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
*** PART A ENTITLEMENT (5 TIMES) ***		1152	1241
BENE PTA ENTLMT STRT DT	9(08)		
BENE PTA ENTLMT END DT	9(08)		
BENE PTA ENRLMT RSN CD	X(01)		
BENE PTA ENTLMT STUS CD	X(01)		
*** PART B ENTITLEMENT (5 TIMES) ***		1242	1331
BENE PTB ENTLMT STRT DT	9(08)		
BENE PTB ENTLMT END DT	9(08)		
BENE PTB ENRLMT RSN CD	X(01)		
BENE PTB ENTLMT STUS CD	X(01)		

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*** HOSPICE COVERAGE (5 TIMES) ***		1332	1411
BENE HSPC CVRG STRT DT	9(08)		
BENE HSPC CVRG END DT	9(08)		
*** DISABILITY INSURANCE (3 TIMES) ***		1412	1462
BENE DIB ENTLMT STRT DT	9(08)		
BENE DIB ENTLMT END DT	9(08)		
BENE DIB ENTLMT DT JSTFCTN CD	X(01)		
*** GROUP HEALTH ORGANIZATION (10 TIMES) ***		1463	1672
BENE GHO ENRLMT STRT DT	9(08)		
BENE GHO ENRLMT END DT	9(08)		
BENE GHO CNTRCT NUM	X(05)		
*** MBD PLAN BENEFITS PACKAGE ELECTION (10 TIMES) ***		1673	1962
MBD GHP ENRL EFCTV DT	9(08)		
MBD PBP STRT DT	9(08)		
MBD PBP END DT	9(08)		
MBD PBP NUM	X(03)		
MBD PBP CVRG TYPE CD	X(02)		
*** END STAGE RENAL DISEASE COVERAGE ***			
BENE ESRD CVRG STRT DT	9(08)	1963	1970
BENE ESRD CVRG END DT	9(08)	1971	1978
BENE ESRD TRMNTN RSN CD	X(01)	1979	1979
*** END STAGE RENAL DISEASE DIALYSIS ***			
BENE ESRD DLYS STRT DT	9(08)	1980	1987
BENE ESRD DLYS END DT	9(08)	1988	1995
*** END STAGE RENAL DISEASE TRANSPLANT ***			
BENE ESRD TRNSPLNT STRT DT	9(08)	1996	2003
BENE ESRD TRNSPLNT END DT	9(08)	2004	2011

Person-Level Detail Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
*** THIRD PARTY PART A HISTORY (5 TIMES) ***		2012	2111
BENE PTA TP STRT DT	9(08)		
BENE PTA TP PRM PYR CD	X(03)		
BENE PTA TP END DT	9(08)		
BENE PTA TP BUYIN ELGBLTY CD	X(01)		
*** THIRD PARTY PART B HISTORY (5 TIMES) ***		2112	2211
BENE PTB TP STRT DT	9(08)		
BENE PTB TP PRM PYR CD	X(03)		
BENE PTB TP TRMNTN DT	9(08)		
BENE PTB TP BUYIN ELGBLTY CD	X(01)		
*** PART D DATA ELEMENTS ***			
BENE FIRST ELIGIBLE PART D DATE	9(08)	2212	2219

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BENE AFF DECL IND (BENE PTD OPT OUT IND)	X(01)	2220	2220
****BENE COPAY HISTORY(10 TIMES)****		2221	2400
BENE COPAY TYPE	X(01)		
BENE COPAY LEVEL	X(01)		
BENE COPAY START DATE	9(08)		
BENE COPAY END DATE	9(08)		
****PART D PLAN BENEFIT PACKAGE(10 TIMES)		2401	2650
BENE CONTRACT NUM	X(05)		
BENE PTD PBP ENRLMNT STRT DT	9(08)		
BENE PTD PBP ENRLMNT END DT	9(08)		
BENE PTD PBP PLAN ID	X(03)		
BENE ENROLL TYPE IND	X(01)		
FILLER	X(250)	2651	2900
MATCH IND	X(01)	2901	2901
SPD CALCULATION IND	X(01)	2902	2902
*** REMAINDER OF RECORD ***			
FILLER	X(59)	2903	2961

File Summary Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
REC IDENT CODE	X(03)	0001	0003
STATE CODE	X(02)	0004	0005
FILE PROCESS TIMESTAMP	X(26)	0006	0031
FILE CREATE MONTH	9(02)	0032	0033
FILE CREATE YEAR	9(04)	0034	0037
RECORDS TOTAL	9(08)	0038	0045
RECORDS DUPLICATE	9(08)	0046	0053
RECORDS NONDUP	9(08)	0054	0061
RECORDS VALID	9(08)	0062	0069
RECORDS INVALID	9(08)	0070	0077
RECORDS MATCH	9(08)	0078	0085
RECORDS NOT MATCHED	9(08)	0086	0093
FILLER	X(01)	0094	0094
FILLER	X(20)	0095	0114
FILLER	X(26)	0115	0140
VALID DUAL RECORDS	9(08)	0141	0148
VALID DUAL MATCHES	9(08)	0149	0156
VALID DUAL NONMATCHES	9(08)	0157	0164
VALID LIS RECORDS	9(08)	0165	0172
VALID CURRENT DUALS	9(08)	0173	0180
VALID RETRO DUALS	9(08)	0181	0188
TOTAL ELIG MONTHS	9(02)	0189	0190
TOTAL VALID PRO RECORDS	9(08)	0191	0198
TOTAL INVALID PRO RECORDS	9(08)	0199	0206
TOTAL MATCHED PRO RECORDS	9(08)	0207	0214
FILLER	X(2747)	0215	2961

Month Summary Record Physical Layout
(One generated for each Eligibility month found in the file.)

FIELD NAME	FORMAT	<------POSITION------> START	END
REC IDENT CODE	X(03)	0001	0003
STATE CODE	X(02)	0004	0005
FILE PROCESS TIMESTAMP	X(26)	0006	0031
FILE CREATE MONTH	9(02)	0032	0033
FILE CREATE YEAR	9(04)	0034	0037
ELIGIBILITY MONTH	9(02)	0038	0039
ELIGIBILITY YEAR	9(04)	0040	0043
CALCULATION SWITCH	X(01)	0044	0044
TOTAL VALID RECORDS	9(08)	0045	0052
TOTAL VALID FULL DUAL RECORDS	9(08)	0053	0060
TOTAL VALID NON-FULL DUAL RECORDS	9(08)	0061	0068
NET TOTAL VALID FULL DUAL ENROLLMENTS	9(08)	0069	0076
NET TOTAL VALID FULL DUAL DISENROLLMENTS	9(08)	0077	0084
FILLER	X(2877)	0085	2961

Trailer Record Physical Layout

FIELD NAME	FORMAT	<------POSITION------> START	END
RECORD IDENT CODE	X(03)	0001	0003
FILE PROCESS TIMESTAMP	9(26)	0004	0029
FILE CREATE MONTH	9(02)	0030	0031
FILE CREATE YEAR	9(04)	0032	0035
FILE ACCEPT IND	X(01)	0036	0036
FILLER	X(07)	0037	0043
***********ORIG STATE TRAILER REC 180 characters ******************************			
RECORD IDENT CODE	X(03)	0044	0046
BENE RECORD COUNT	9(08)	0047	0054
STATE CODE	X(02)	0055	0056
CREATE MONTH	9(02)	0057	0058
CREATE YEAR	9(04)	0059	0062
FILLER	X(161)	0063	0223
***********REMAINDER OF RECORD**			
FILLER	X(2738)	0224	2961

Header Record Data Element Specifications

RECORD IDENT CODE	"SRF"
FILE PROCESS TIMESTAMP	Format: YYYY.MM.DD.hh.mm.ss.nnnn YYYY = Year; MM = Month; DD = Day; hh = hour; mm = minute; ss = second; nnnnnn = microsecond The exact time that the state file had been processed.
FILE ACCEPT IND	Y = The state file had been accepted; N = the state file had not been accepted.

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FILLER	Filler.
RECORDS TOTAL	The total number of detail records in the state file. RECORDS VALID + RECORDS INVALID = RECORDS TOTAL. RECORDS MATCHED + RECORDS NOT MATCHED = RECORDS TOTAL. This total does not include PRO records.
RECORDS DUPLICATE	The total number of duplicate detail records found in the state file. This count does not include PRO records.
RECORDS NONDUP	The total number of non-duplicate valid detail records found in the state file. This count does not include PRO records.
RECORDS VALID	The total number of valid detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes (ERC) Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth This count does not include PRO records.
RECORDS INVALID	The total number of invalid detail records found in the file See also Person-Level Record Data Element Specifications: Error Return Codes (ERC) This count does not include PRO records.
RECORDS MATCHED	The total number of detail records that could be matched successfully to an individual on the Medicare Beneficiary Database. This count does not include PRO records.
RECORDS NOT MATCHED	The total number of detail records that could not be matched successfully to an individual on the Medicare Beneficiary Database. This count includes Invalid detail records because no match is attempted on an invalid detail record. This count does not include PRO records.
FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) Create Month of the MMA State File
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created Create Year of the MMA State File
FILLER	

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**********	**ORIGINAL STATE HEADER RECORD 180 BYTES**
RECORD IDENT CODE	Always contains value of "MMA"
STATE CODE	**State Code - Valid Code** Alabama AL Alaska AK Arizona AZ Arkansas AR California CA Colorado CO Connecticut CT Delaware DE District of Columbia DC Florida FL Georgia GA Hawaii HI Idaho ID Illinois IL Indiana IN Iowa IA Kansas KS Kentucky KY Louisiana LA Maine ME Maryland MD Massachusetts MA Michigan MI Minnesota MN Mississippi MS Missouri MO Montana MT Nebraska NE Nevada NV New Hampshire NH New Jersey NJ New Mexico NM New York NY North Carolina NC North Dakota ND Ohio OH Oklahoma OK Oregon OR Pennsylvania PA Rhode Island RI South Carolina SC South Dakota SD Tennessee TN Texas TX Utah UT Vermont VT Virginia VA Washington WA West Virginia WV Wisconsin WI Wyoming WY
CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12)

CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created
FILLER	
**********	**REMAINDER OF RECORD**
FILLER	

Person-Level Detail Record Data Element Specifications

**********	**ORIGINAL RECORD SUBMITTED BY STATE**
RECORD IDENT CODE	Identifies record transaction type. Code as "DET" for an enrollment detail record, "PRO" for a prospective Dual Eligible records, and "LIS" is for a low-income subsidy determination. Each record type requires completion of different fields. Whether a field is required for each record type is indicated in the Record-Type = DET or LIS indication in the field specifications. PRO records require the same fields as DET records. For fields not applicable for the record type specified, code the field with the appropriate default or unknown value (e.g., "9" fill) **Essential field for detail record Validity (See RECORD IDENTIFIER ERC)**
ELIGIBILITY MONTH/YEAR	Applicable to RECORD TYPE – DET, PRO Format :MMCCYY Calendar Month/Year Code for applicable Medicaid eligibility (e.g.012006). Valid Month Values: 01 – 12 (e.g. January=01, December=12.) OR 999999 for a LIS record For retroactive records use effective month of the changes for each record. **Retroactive changes must be submitted to reflect prior-month changes in the following fields:** - ELIGIBILITY STATUS - HIC/RRB - HIC-RRB IND - SOCIAL SECURITY NUM - SEX - DATE OF BIRTH - DUAL STATUS CODE - FPL % IND - **INSTITUTIONAL STATUS IND** Retroactive records must include replacement values for ALL fields for that record, NOT just the field(s) that have changed. **Essential field for DET detail record Validity (See ELIGIBILITY MONTH/YEAR ERC)**
ELIGIBILITY STATUS	Applicable to RECORD TYPE – DET, PRO Indicator of beneficiary's Medicaid eligibility for that person-month – Valid values "Y" (yes) or "N" (no) or 9 for a LIS record 'N' should not be submitted for current month dual eligibles This field requires the value 'Y' for a PRO detail record, or the detail record will be rejected. **Essential field for DET detail record Validity (See ELIGIBILITY STATUS ERC)**

HIC/RRB	Applicable to RECORD TYPE – DET, LIS, PRO Either the Health Insurance Claim Number (HIC) or the Railroad Retirement Board Number (RRB), whichever the state has active and available for the beneficiary. (NOTE: Alphanumeric Field – LEFT JUSTIFIED) **Critical field for detail record Validity (See HIC ERC)**
HIC-RRB IND	Applicable to RECORD TYPE – DET, LIS, PRO Indicator for HIC or RRB – Valid Values: "R" for RRB and "H" for HIC; Indicates the type of value populating the HIC field above. This field is not used by CMS.
SOCIAL SECURITY NUMBER	Applicable to RECORD TYPE – DET, LIS, PRO Beneficiary's own Social Security Number **Critical for detail record Validity (See SOCIAL SECURITY NUMBER ERC)**
SMA IDENTIFIER	Applicable to RECORD TYPE – DET, LIS, PRO State Medicaid Agency Enrollee Identifier for the beneficiary – For use by state in associating records on Enrollment Return File.
FIRST NAME	Applicable to RECORD TYPE – DET, LIS, PRO Beneficiary First Name (First 12 letters)
LAST NAME	Applicable to RECORD TYPE – DET, LIS, PRO Beneficiary Last Name (First 20 letters)
MIDDLE NAME	Applicable to RECORD TYPE – DET, LIS, PRO Beneficiary Middle Name (First 15 letters)
SUFFIX NAME	Applicable to RECORD TYPE – DET, LIS, PRO Beneficiary Suffix Name (First 4 letters)e.g., JR, III
SEX	Applicable to RECORD TYPE – DET, LIS, PRO Beneficiary Gender – Sex code values F=Female, M=Male, 9=Unknown
DATE OF BIRTH	Applicable to RECORD TYPE – DET, LIS, PRO MMDDCCYY: Month, day, century and year of Beneficiary Birth, (e.g. 05051935). If unknown = '99999999' **Critical field for detail record Validity (See DATE OF BIRTH ERC)**
DUAL STATUS CODE	Applicable to RECORD TYPE – DET, PRO 01 = Eligible is entitled to Medicare- QMB only 02 = Eligible is entitled to Medicare- QMB AND Full Medicaid coverage

	03 = Eligible is entitled to Medicare- SLMB only 04 = Eligible is entitled to Medicare- SLMB AND Full Medicaid coverage 05 = Eligible is entitled to Medicare- QDWI 06 = Eligible is entitled to Medicare- Qualifying individuals 08 = Eligible is entitled to Medicare- Other Full Dual Eligibles (Non QMB, SLMB,QWDI or QI)with Full Medicaid coverage 09 = Eligible is entitled to Medicare – Other Dual Eligibles but without Medicaid coverage, includes Pharmacy Plus and 1115 drug-only demonstration. If unknown = 99. NOTE: For prospective enrollment (PRO) records, include a dual eligible code for full dual eligible status which best describes the dual status assuming that individual is Medicare eligible; i.e., codes 02-QMB plus, 04-SLMB plus, or 08-Other.
FPL% IND	Applicable to RECORD TYPE – DET, PRO Federal Poverty Level Indicator. Values: 1=at or below 100% FPL, 2=above 100% FPL. FPL is determined by the individual state. If unknown = 9. Include income based on the eligibility intake system, but do not derive this field from the Dual Status Code. If it is necessary to replace unknown FPL% IND values, CMS will derive the value using consistent rules.
DRUG COVERAGE IND	Applicable to RECORD TYPE – DET, PRO This field is not used by CMS. Effective January 2006, code this field as 9. For months prior to January 2006 the values submitted were: 0=no drug coverage by Medicaid; 1= Medicaid drug coverage. If unknown = 9.
INSTITUTIONAL STATUS IND	Applicable to RECORD TYPE – DET, PRO Indicator of NURSING FACILITY, INTERMEDIATE CARE FACILITY/MENTALLY RETARDED or INPATIENT PSYCHIATRIC HOSPITAL: Values “Y” or “N”. If unknown = “9”. Code this field as “Y” (yes) only when the individual is institutionalized (or projected to be for the current month) for the entire span of eligibility for the month.
PART D SUBSIDY APPLICATION APPROVAL CODE	Applicable to RECORD TYPE – LIS Identifies whether application was approved or not. Approved code values Y=yes, N=no , N/A=9 **Essential for LIS detail record Validity (See PART D SUBSIDY APPRVD ERC)**
PART D SUBSIDY APPRVD/DISAPPRVD DATE	Applicable to RECORD TYPE – LIS Approved date MMDDCCYY. N/A=‘99999999’ if unknown.

	Essential for LIS detail record Validity (See PART D SUBSIDY APPRVD DATE ERC)
PART D SUBSIDY START DATE	Applicable to RECORD TYPE – LIS Subsidy Start Date MMDDCCYY. N/A= '99999999'. May not be earlier than 01/01/2006. Must be first day of the month in which application received by state. **Essential for LIS detail record Validity (See PART D SUBSIDY START DATE ERC)**
PART D SUBSIDY END DATE	Applicable to RECORD TYPE – LIS Subsidy End Date MMDDCCYY; for determinations through 2006, end date is 12/31/2006. Thereafter, end date is determined by state, in manner and frequency state determines. N/A='99999999'.
PART D % OF FPL	Applicable to RECORD TYPE – LIS For those individuals who apply for the low income subsidy, identify the specific percent of Federal Poverty Level, as defined by Federal LIS income determination policy. Do not fill this out for those individuals who receive any Medicaid benefits, including payment of Medicare cost-sharing obligations. N/A='999'.
PART D SUBSIDY LEVEL	Applicable to RECORD TYPE – LIS Identifies portion of Part D premium subsidized, based on sliding scale linked to %FPL. If person is under 135% FPL, enter 100. If person is 136-140% FPL, enter 075. If person is 141-145% FPL, enter 050. If person is 146-149% FPL, enter 025. If person has 150% FPL, enter 000. N/A='999'.
INCOME USED FOR DETERMINATION	Applicable to RECORD TYPE – LIS Income Used Indicator 1=Individual, 2=Couple N/A='9'
RESOURCE LEVEL	Applicable to RECORD TYPE – LIS Resource Level 1=over limit, 2=under limit N/A='9'.
BASIS OF PART D SUBSIDY DENIAL	Applicable to RECORD TYPE – LIS Denial codes: 1 = NAB (Not enrolled in Medicare Part A or B); 2 = NUS (Does not reside in the USA); 3 = FTC (Failure to cooperate); 4 = RES (Resources too high); 5 = INC (Income too high); 9 = N/A
RESULT OF AN APPEAL	Applicable to RECORD TYPE – LIS Appeal Result Y=yes, N=no (Only populated if appeal is filed). N/A='9'.
CHANGE TO PREVIOUS	Applicable to RECORD TYPE – LIS

DETERMINATION	Change to Previous Determination Indicator Y=yes, N=no. Enter Y if this record changes a determination sent in a previous transmission. Default is N. N/A='9'.
DETERMINATION CANCLD	Applicable to RECORD TYPE – LIS Cancelled Indicator Y=yes, N=no. Default is N. Enter Y if this record cancels previous record sent. N/A='9'.
FILLER	
**********	**ERROR RETURN CODES (ERC)**
RECORD IDENT CODE ERC	**If this field is invalid, the detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value Set
ELIGIBILITY MONTH/YEAR ERC	**If this field is invalid, the DET detail record is invalid.** **If this field is invalid, the PRO detail record is invalid.** 00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 20: Invalid - Year value is before 2004 05: Invalid – PRO record Eligibility month/Year not Current Month/Year 99: Not Scanned - LIS Record
ELIGIBILITY STATUS ERC	**If this field is invalid, the DET detail record is invalid.** **If this field is invalid, the PRO detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value Set 06 – Invalid – PRO record Eligibility Status not = Y 99: Not Scanned - LIS Record
HIC/RRB ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 03: Invalid - Field is Empty **Critical Identification field**: Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth
HIC-RRB-IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set
SOCIAL SECURITY NUM ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 02: Invalid - Value is not Numeric 03: Invalid - Field is Empty **Critical Identification field**: Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth

	- HICN or RRB, Date of Birth - Social Security Number, Date of Birth
SEX ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set
DATE OF BIRTH ERC	00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 21: Warning - Year is before 1899 **Critical Identification field**: Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth
DUAL STATUS CODE ERC	**If this field is invalid, the PRO detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value Set 40: Warning - Value is 99 for Dual Eligible record 07: Invalid – PRO record with Dual Status not Full Dual 99: Not Scanned - LIS record
FPL % IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 99: Not Scanned - LIS record
DRUG COVERAGE IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 99: Not Scanned - LIS record
INSTITUTIONAL STATUS IND ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 99: Not Scanned - LIS record
PART D SUBSIDY APPLICATION APPROVAL CODE ERC	**If this field is invalid, the LIS detail record is invalid.** 00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
PART D SUBSIDY APPRVD/DISAPPRVD DATE ERC	**If this field is invalid, the LIS detail record is invalid.** 00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 31: Invalid - Value is later than Part D Subsidy End Date 98: Not Scanned – DET or PRO record
PART D SUBSIDY START DATE ERC	**If this field is invalid, the LIS detail record is invalid.**

	00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 10: Invalid - Value is Future 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 31: Invalid - Value is later than Part D Subsidy End Date 36: Invalid – Value is earlier than January 1, 2006 37: Warning - Day value is not first day of the month 98: Not Scanned – DET or PRO record
PART D SUBSIDY END DATE ERC	00: Value is Valid 02: Invalid - Value is not Numeric 04: Invalid - Date is Unknown 11: Invalid - Month value is not between 01 and 12 inclusive 12: Invalid - Day value is out of range 33: Invalid - Value is earlier than Part D Subsidy Approved/Disapproved Date 34: Invalid - Value is earlier than Part D Subsidy Start Date 35: Invalid - Value is earlier than Part D Subsidy Approved/Disapproved Date and Part D Subsidy Start Date 98: Not Scanned – DET or PRO record
PART D % OF FPL ERC	00: Value is Valid 02: Invalid - Value is not Numeric. 98: Not Scanned – DET or PRO record
PART D SUBSIDY LEVEL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
INCOME USED FOR DETERMINATION ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
RESOURCE LEVEL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
BASIS OF PART D SUBSIDY DENIAL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
RESULT OF AN APPEAL ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value set 98: Not Scanned – DET or PRO record
CHANGE TO PREVIOUS DETERMINATION ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 98: Not Scanned – DET or PRO record
DETERMINATION CANCLD ERC	00: Value is Valid 01: Invalid - Value is not in Valid Value Set 98: Not Scanned DET or PRO record
**********	**CMS MBD FILE**
RECORD RETURN CODE	This field is an assessment of the detail record. 000000: Record is Valid no errors. 000001: Record is Valid with errors.

	000002: Record is Invalid: Invalid Record Identification Code. 000003: Record is Invalid: Insufficient Valid Identifying Information [May potentially indicate a mismatch on the submitted date of birth.] 000004: Record is Invalid: DET Record - Invalid Key Fields 000005: Record is Invalid: LIS Record - Invalid Key Fields 000006: Record is Invalid: DET Record - Duplicate 000007: Record is Invalid: LIS Record - Duplicate 000008: Record is Invalid: Input Record is Incorrect Length 000009: Record is Invalid: PRO Record – Invalid Key Fields 000010: Record is Invalid: PRO Record – Invalid is PRO Duplicate 000011: Record is Invalid: PRO Record – Invalid is DET Duplicate
MEDICARE PART A/B FINDER CODE	For Dual Eligible (DET) records and Prospective Full Dual (PRO) records, this field indicates the presence of Medicare Part A and/or Medicare Part B entitlement during the Eligibility Month/Year. For Low-Income Subsidy (LIS) records, this field indicates the presence of Medicare Part A and/or Medicare Part B entitlement during the first month of the Subsidy period as given by the Part D Subsidy Apprvd/Disapprvd Date. Values: 0 = The person had Medicare Part A and/or Medicare Part B 1 = The person had neither Medicare Part A nor Medicare Part B. NOTE: For Eligibility Month/Eligibility Year values January 2006 and later, this field equates to Medicare Part D Eligibility. E.g., if the Eligibility Month/Year is 112005, this field would not indicate Medicare Part D Eligibility.
MEDICARE PART D FINDER CODE	For Dual Eligible (DET) records and Prospective Full Dual (PRO) records, this field indicates the presence of Medicare Part D enrollment during the Eligibility Month/Year. For Low-Income Subsidy (LIS) records, this field indicates the presence of Medicare Part D enrollment during the first month of the Subsidy period as given by the Part D Subsidy Apprvd/Disapprvd Date. Values: 0 = The person had Medicare Part D 1 = The person did not have Medicare Part D
**********	**BENEFICIARY IDENTIFICATION** This remainder of the record is populated if the person was found in the CMS Medicare information systems. A person will be found in the CMS Medicare information systems if they have Medicare. If the person is not found successfully in the CMS Medicare information systems, then the remainder of the record will be populated with SPACES (alphanumeric fields) and ZEROS (numeric fields).
BENE CLM ACNT NUM	The number identifying the primary Medicare Beneficiary under the SSA or RRB programs. This number along with the Beneficiary Identification Code uniquely identifies a Medicare Beneficiary.
BENE IDENT CD	A code that is used in conjunction with the Beneficiary Claim Account Number to uniquely identify a Medicare Beneficiary. The BIC Code establishes the beneficiary's relationship to a primary Social Security

	Administration (SSA) or Railroad Retirement Board (RRB) wage earner and is used to justify entitlement to Medicare benefits.
BENE BIRTH DT	The date of birth of the Medicare Beneficiary. MMDDCCYY: Month, day, century and year
BENE DEATH DT	The date of death of the Medicare Beneficiary. MMDDCCYY: Month, day, century and year
BENE SEX IDENT CD	Represents the sex of the Medicare Beneficiary. Examples include: Male and Female Valid values: 0 = Unknown 1 = Male 2 = Female
BENE GIVN NAME	The first name of the Medicare beneficiary.
BENE MDL NAME	The middle initial of the Medicare Beneficiary middle name.
BENE SURN NAME	The last name (surname) of the Medicare Beneficiary including any following titles.
**********	**CROSS REFERENCE MEDICARE NUMBERS (10 OCCURRENCES)** **First occurrence is the active/most recent cross-reference Medicare number.**
XREF BENE CLM ACCT NUM	An additional beneficiary claim account number associated with the Medicare Beneficiary. The beneficiary's entitlement has been cross-referenced from this number to the beneficiary's active claim account number. (Audited records are invalidated)
XREF BENE IDENT CODE	The beneficiary's identification code associated with the Medicare Beneficiary's cross-referred claim account number.
**********	**SOCIAL SECURITY NUMBERS (5 OCCURRENCES)** **First occurrence is the active/most recent Social Security Number.**
BENE SSN NUM	The beneficiary's identification number that was assigned by the Social Security Administration.
**********	**MAILING ADDRESS** This may be the address of a rep-payee where that represents the official mailing address.
MLNG ADDR LINE 1	The first line of the address.
MLNG ADDR LINE 2	The second line of the street address.
MLNG ADDR LINE 3	The third line of the street address.
MLNG ADDR LINE 4	The fourth line of the mailing address.
MLNG ADDR LINE 5	The fifth line of the mailing address.
MLNG ADDR LINE 6	The sixth line of the mailing address.
MLNG ADDR CITY NAME	The name of the city for the Medicare Beneficiary's residence, or temporary residence and/or mailing address.
MLNG ADDR STATE CODE	The beneficiaries' postal state code.

MLNG ADDR ZIP CODE	The zip code associated with the address
MLNG ADDR CHG DT	The date a new or corrected address becomes effective for a Medicare Beneficiary. MMDDCCYY: Month, day, century and year
**********	**RESIDENCE ADDRESS** The Residence address is NOT currently being used nor is it being populated
RSDNC ADDR LINE 1	The first line of the address.
RSDNC ADDR LINE 2	The second line of the street address.
RSDNC ADDR LINE 3	The third line of the street address.
RSDNC ADDR LINE 4	The fourth line of the mailing address.
RSDNC ADDR LINE 5	The fifth line of the mailing address.
RSDNC ADDR LINE 6	The sixth line of the mailing address.
RSDNC ADDR CITY NAME	The name of the city for the Medicare Beneficiary's residence, or temporary residence and/or mailing address.
RSDNC ADDR STATE CODE	The beneficiaries' postal state code.
RSDNC ADDR ZIP CODE	The zip code associated with the address
RSDNC ADDR CHG DT	The date a new or corrected address becomes effective for a Medicare Beneficiary. MMDDCCYY: Month, day, century and year
**********	**REPRESENTATIVE PAYEE**
BENE REP PAYEE SW	A switch that indicates whether the beneficiary has a Representative Payee for social security cash benefit purposes. Values: Space or N = Field is not applicable, no rep payee indicated Y = Beneficiary has designated a representative payee
**********	**MEDICARE NON-ENTITLEMENT STATUS**
PRT A NENTLMT STUS CODE	The reason for a beneficiary's current non-entitlement to Part A Medicare Benefits. Values: D = Coverage was denied F = Terminated due to invalid enrollment or enrollment voided H = Not eligible for free Part A, or did not enroll for premium Part A R = Refused benefits N Not a valid SSA HIC, but used by CMS' Third Party system to indicate a potential PTA entitlement date N = Not a valid SSA HIC, but used by CMS' Third Party system to indicate a potential PTA entitlement date This field may have the value SPACE if no non-entitlement reason applies to the beneficiary.
PRT B NENTLMT STUS CODE	The reason for a beneficiary's current non-entitlement to Part B Medicare Benefits. Values: D = Coverage was denied N = No (Foreign/Puerto Rican beneficiary not entitled to SMI) Also,

	dually/technically, beneficiary is not entitled to SMI. R = Refused benefits This field may have the value SPACE if no non-entitlement reason applies to the beneficiary.
**********	**MEDICARE ENTITLEMENT REASON (5 OCCURRENCES)** **This section is not presently populated.**
BENE ENTLMT RSN CD CHG DT	The date that the reason for entitlement was changed for a beneficiary. This is not the effective date of entitlement. MMDDCCYY: Month, day, century and year
BENE ENTLMT RSN CD	This code identifies the reason for the beneficiary's entitlement to Medicare Benefits. Values are: 0 = Beneficiary insured due to age (OASI); 1 = Beneficiary insured due to disability; 2 = Beneficiary insured due to End Stage; Renal Disease (ESRD); 3 = Beneficiary insured due to disability and current ESRD.
**********	**MEDICARE PART A ENTITLEMENT (5 OCCURRENCES)** **First occurrence is the active/most recent Medicare Part A entitlement.**
BENE PTA ENTLMT STRT DT	The date a beneficiary became entitled to Medicare Benefits. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no entitlement period is found.
BENE PTA ENTLMT END DT	The Medicare program entitlement termination date for a beneficiary. The last day that a beneficiary is entitled to benefits. After this day the benefits are terminated. MMDDCCYY: Month, day, century and year If this field and the Entitlement Start Date are both populated with zeros, then no entitlement period was found. If this field is populated with zeros and the entitlement start date is a valid date, then the entitlement period is not ended.
BENE PTA ENRLMT RSN CD	This code is used by SSA to reflect information about a specific Part A enrollment is based upon equitable relief (and Medicare's usual business rules for Part B start Date may not be appropriate) Values: A = Attainment of age 65 B = Equitable relief D = Disability G = General Enrollment Period I = Initial Enrollment Period J = MQGE Entitlement K = Renal disease is or was a reason for entitlement prior to age 65 or 25th month of disability L = Late filing M = Termination based on renal entitlement but entitlement based on disability continues N = Age 65 and uninsured P = Potentially insured beneficiary is enrolled for Medicare coverage only Q = Quarters of coverage requirements are involved R = Residency requirements are involved T = Disabled working individual U = Unknown Blank = Not applicable This field will be populate with SPACE if no entitlement period is found

BENE PTA ENTLMT STUS CD	Represent the Medicare Part A entitlement status for a beneficiary. Values are: E = Free Part A Entitlement G = Entitled due to good cause Y = Currently entitled, premium is payable Valid values when Part A Entitlement Effective date and Termination Date are present: C = No longer entitled due to disability cessation S = Terminated, no longer entitled under ESRD provision T = Terminated for non-payment of premiums W = Voluntary withdrawal from premium coverage X = Free Part A terminated or refused HI Valid Values when there is no Part A Entitlement date (and no Part A termination date): D = COVERAGE WAS DENIED F = TERMINATED DUE TO INVALID ENROLLMENT OR ENROLLMENT VOIDED H = NOT ELIGIBLE FOR FREE PART A, OR DID NOT ENROLL FOR PREMIUM PART A R = REFUSED BENEFITS N = NOT A VALID SSA HOC, BUT USED BY HCFA'S THIRD PARTY SYSTEM TO INDICATE A 'POTENTIAL' PTA ENTITLEMENT DATE This field will be populated with SPACE if no entitlement period is found.
**********	**MEDICARE PART B ENTITLEMENT (5 OCCURRENCES)** **First occurrence is the active/most recent Medicare Part B entitlement.**
BENE PTB ENTLMT STRT DT	The date a beneficiary became entitled to Medicare Benefits. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no entitlement period is found.
BENE PTB ENTLMT END DT	The Medicare program entitlement termination date for a beneficiary. The last day that a beneficiary is entitled to benefits. After this day the benefits are terminated. MMDDCCYY: Month, day, century and year If this field and the Entitlement Start Date are both populated with zeros, then no entitlement period was found. If this field is populated with zeros and the entitlement start date is a valid date, then the entitlement period is not ended.
BENE PTB ENRLMT RSN CD	This code is used by SSA to reflect information about a specific Part B enrollment is based upon equitable relief (and Medicare's usual business rules for Part B start Date may not be appropriate) Valid values: B = Equitable relief C = Good Cause D = Deemed date of birth F = Working Aged G = General enrollment period I = Initial enrollment period K = Renal disease is or was a reason for entitlement prior to age 65 or 25th month of disability M = Termination based on renal entitlement but entitlement based on

	disability continues R Residency requirements are involved S = State Buy-In U = Unknown This field will be populate with SPACE if no entitlement period is found
BENE PTB ENTLMT STUS CD	This code represents the Part B Medicare entitlement status for a beneficiary. Valid values when Part B Entitlement Effective date is present and Termination Date is blank: G Entitled due to good cause Y Currently entitled, premium is payable Valid values when Part B Entitlement Effective date and Termination Date are present: C No longer entitled due to disability cessation F Terminated due to invalid enrollment or enrollment voided S Terminated, no longer entitled under ESRD provision T Terminated for non-payment of premiums W Voluntary withdrawal from premium coverage Valid Values when there is no Part B entitlement date (and no Part B termination date): D = COVERAGE WAS DENIED N = NO (FOREIGN/PUERTO RICAN BENEFICIARY NOT ENTITLED TO SMI. ALSO DUALLY/TECHNICALLY BENEFICIARY IS NOT ENTITLED TO SMI) R = REFUSED BENEFITS This field will be populated with SPACE if no entitlement period is found.
**********	**HOSPICE COVERAGE (5 OCCURRENCES)** **First occurrence is the active/most recent Hospice coverage.**
BENE HSPC CVRG STRT DT	The elected start date of a beneficiary's period of Hospice Coverage. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no Medicare Hospice coverage period is found.
BENE HSPC CVRG END DT	The termination date of a beneficiary's period of Hospice Coverage. MMDDCCYY: Month, day, century and year If the Hospice Start Date is populate with zeros, then this date will be populated with zeros. This field will be populated with zeros if the hospice period is open (not ended).
**********	**DISABILITY INSURANCE (3 OCCURRENCES)** **First occurrence is the active/most recent Disability Insurance.**
BENE DIB ENTLMT STRT DT	The date that a beneficiary covered by the SSA disability program becomes entitled to Medicare benefits. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no disability coverage period is found.
BENE DIB ENTLMT END DT	The date that Medicare benefits due to disability end for a beneficiary who was covered by the SSA disability program. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the Disability Entitlement Start Date is zeros. This field will be zeros if the Disability Entitlement Period is open (not ended).
BENE DIB ENTLMT DT JSTFCTN	The justification for a beneficiary's Part A and/or Part B Medicare

CD	entitlement dates based upon his/her disability insurance benefits (DIB) status. 1 = BENEFICIARY IS ENTITLED TO MEDICARE COVERAGE DUE TO PRIOR PERIODS OF SSA DISABILITY ENTITLEMENT A = BENEFICIARY IS ENTITLED TO MEDICARE BASED UPON SSA DISABILITY AND THE 24 MONTH WAITING PERIOD HAS BEEN WAIVED BLANK = N/A This field will be populated with SPACE if no Disability Entitlement Period is found.
**********	**GROUP HEALTH ORGANIZATION (10 OCCURRENCES)** **The first occurrence is the active or most recent Medicare Group Health Organization coverage (i.e. plan enrollment). Presently, this section is populated with Medicare Part C and Medicare Part D plan enrollments.**
BENE GHO ENRLMT STRT DT	The date that the beneficiary enrolled in the Service Elections. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no service election (plan enrollment) has been found.
BENE GHO ENRLMT END DT	The date that the beneficiary disenrolled in the Service Elections. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the GHO Enrollment Start Date is populated with zeros. This field will be populated with zeros if the Service Election (plan enrollment) is open (not ended).
BENE GHO CNTRCT NUM	Unique identification for an agreement between CMS and a Managed Care Organization (MCO) enabling the MCO to provide Medicare + choice coverage to eligible beneficiaries. This field will be populated with spaces only if neither Medicare Part C nor Medicare Part D enrollment has been found. Generally the following applies, but there could be some exceptions especially with 9. A contract number beginning with the letter H indicates local MA (Medicare Advantage) plans, MA-PD (Medicare Advantage with Prescription Drug) plans, PACE organizations, cost plans, and some demonstrations. A contract number beginning with the letter R indicates regional MA and MA-PD plans. A contract number beginning with the number 9 indicates a Medicare Demonstration plan. A contract number beginning with the letter S indicates Stand-Alone PDP (Prescription Drug Plan). Starting with contract year 2007, a contract number starting with E indicates an employer sponsored prescription drug plan.
**********	**MBD PLAN BENEFIT PACKAGE ELECTION (10 OCCURRENCES)** **The first occurrence is the active or most recent Medicare Plan Benefit Package coverage. Presently, this section is populated with Medicare Part C and Medicare Part D plan benefit package selections.**
MBD GHP ENRLMT EFCTV DT	The date that the beneficiary enrolled in the Service Elections. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no service election (plan enrollment) has been found.
MBD PBP STRT DT	Date the PBP election started. MMDDCCYY: Month, day, century and year

	This field will be populated with zeros if no plan benefit package selection has been found.
MBD PBP END DT	Date the PBP election ended. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the PBP Start Date is populated with zeros. This field will be populated with zeros if the PBP election is open (not ended).
MBD PBP NUM	A unique identifier for the managed care benefit package. This field will be populated with spaces if no PBP election has been found for the beneficiary.
MBD PBP CVRG TYPE CD	Identifies the type of managed care enrollment or FFS period. 3 =CCP COORDINATED CARE PLAN 6 = PACE PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) 8 =DEMO DEMONSTRATION 5 = PFFS PRIVATE FEE FOR SERVICE 10 = Cost/HCPPCOST/HEALTH CARE PREPAYMENT PLAN 9 = FFS (FEE FOR SERVICE) 11 = PDP Election This field will be populated with spaces if no PBP election has been found for the beneficiary.
**********	**END STAGE RENAL DISEASE COVERAGE** **(1 OCCURRENCE)**
BENE ESRD CVRG STRT DT	The date on which the beneficiary is entitled to Medicare in some part because of a diagnosis of End Stage Renal Disease. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no ESRD coverage is found for the beneficiary.
BENE ESRD CVRG END DT	The date on which the beneficiary is no longer entitled to Medicare under ESRD Provisions. MMDDCCYY: Month, day, century and year This field will be populated with zeros if the ESRD Coverage Start Date is populated with zeros. This field will be populated with zeros if the ESRD Coverage period is open (not ended).
BENE ESRD TRMNTN RSN CD	The reason Medicare-Based ESRD coverage was terminated. DATA VALIDATION: A = Month of transplant plus 36 months; B = Last month of chronic dialysis; C = Part A termination; D = Death; E = ESRD ended This field will be populated with spaces if either no ESRD Coverage has been found for the beneficiary or the ESRD Coverage Period has not been ended (s open/active).
**********	**END STAGE RENAL DISEASE DIALYSIS** **(1 OCCURRENCE)**
BENE ESRD DLYS STRT DT	A date that indicates when the ESRD Dialysis started. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no ESRD Dialysis is found for the beneficiary.

BENE ESRD DLYS END DT	A date that indicates when ESRD Dialysis ended. MMDDCCYY: Month, day, century and year The field will be populated with zeros if the Dialysis Start Date is populated with zeros. This field will be populated with zeros if the beneficiary is presently receiving Dialysis care through Medicare.
**********	**END STAGE RENAL DISEASE TRANSPLANT** **(1 OCCURRENCE)**
BENE ESRD TRNSPLNT STRT DT	A date that indicates when a Kidney Transplant Operation Occurred. MMDDCCYY: Month, day, century and year This field will be populated with zeros if no ESRD Kidney Transplant is found for the beneficiary.
BENE ESRD TRNSPLNT END DT	A date that indicates when a Kidney Transplant failed. MMDDCCYY: Month, day, century and year The field will be populated with zeros if the Transplant Start Date is populated with zeros. This field will be populated with zeros if the beneficiary is presently benefiting from Kidney Transplant (i.e. the Transplant Start Date is populated with a date value).
**********	**THIRD PARTY PART A HISTORY** **(5 OCCURRENCES)** **First occurrence is the active/most recent Third Party Part A period.**
BENE PTA TP STRT DT	The start date of a private third party group's or state's liability for a beneficiary's Part A premium. MMDDCCYY: Month, day, century and year
BENE PTA TP PRM PYR CD	Part A – The identifier for a third party agency (either a private group's, state buy-in agency) responsible for paying a beneficiary's Medicare Part A premium. Part A: S01- S99 State billing T01-Z98 Private Third Party Billing Z99 Conditional State Group Payer Enrollment.
BENE PTA TP END DT	The termination date of a private third party group's or state's liability for a beneficiary's Part A premium. MMDDCCYY: Month, day, century and year
BENE PTA TP BUYIN ELGBLTY CD	A code that indicates the reason for Part A state buy-in eligibility. A = AGED RECIPIENT OF SSI PAYMENTS (CMS TO STATE) B = BLIND RECIPIENT OF SSI PAYMENTS (CMS TO STATE) C = ENTITLED TO PART A OF TITLE IV (AFDC) (STATE TO CMS) D = DISABLE RECIPIENT OF SSI PAYMENTS (CMS TO STATE) E = AGED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) F = BLIND RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) G = DISABLED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) H = AGED, BLIND, OR DISABLED RECIPIENT OF A ONE-TIME PAYMENT (OTP) (CMS TO STATE) M = ENTITLED TO MEDICAL ASSISTANCE ONLY (MAO), NON-CASH RECIPIENT (STATE TO CMS) Z = DEEMED CATEGORICALLY NEEDY (STATE TO CMS)

EXHIBIT I
FILE LAYOUTS

**********	**THIRD PARTY PART B HISTORY** **(5 OCCURRENCES)** **First occurrence is the active/most recent Third Party Part B period.**
BENE PTB TP STRT DT	The start date of a private third party group's or state's liability for a Part B premium. MMDDCCYY: Month, day, century and year
BENE PTB TP PRM PYR CD	Part B - The identifier for a third party agency (either a private group, state buy-in agency or the Office of Personnel Management (OPM) responsible for paying a beneficiary's Medicare Part B premium. Part B: Blank No Bill Determined 000 Beneficiary is having Part B premium deducted from Title II check 001 Uninsured beneficiary 005 Insured beneficiary 006 Program Service Center control, no bill 007 Special age 72 enrollee 008 PSC annual billing 010- 650 State billing 700 Office of Personnel Management (OPM) A01-R99 Group Payers for Part B premiums.
BENE PTB TP TRMNTN DT	The termination date of a private third party group's or state's liability for a beneficiary's Part B premium. MMDDCCYY: Month, day, century and year
BENE PTB TP BUYIN ELGBLTY CD	A code that indicates the reason for Part B state buy-in eligibility. A = AGED RECIPIENT OF SSI PAYMENTS (CMS TO STATE) B = BLIND RECIPIENT OF SSI PAYMENTS (CMS TO STATE) C = ENTITLED TO PART A OF TITLE IV (AFDC) (STATE TO CMS) D = DISABLE RECIPIENT OF SSI PAYMENTS (CMS TO STATE) E = AGED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) F = BLIND RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) G = DISABLED RECIPIENT OF SUPPLEMENTAL PAYMENT ADMINISTERED BY SSA (CMS TO STATE) H = AGED, BLIND, OR DISABLED RECIPIENT OF A ONE-TIME PAYMENT (OTP) (CMS TO STATE) M = ENTITLED TO MEDICAL ASSISTANCE ONLY (MAO), NON-CASH RECIPIENT (STATE TO CMS) P = Qualified Medicare Beneficiary (QMB) Z = DEEMED CATEGORICALLY NEEDY (STATE TO CMS)
**********	**PART D DATA ELEMENTS**
BENE FIRST ELIGIBLE PART D DATE	The first date on which a beneficiary had become eligible for Medicare Part D, whether or not enrolled on a Medicare Part D plan.
BENE AFF (AFFIRMATIVELY) DEC (DECLINE) INDICATOR also known as, Bene Part D Opt-Out Indicator	An indicator providing whether or not a beneficiary had chosen not to be auto-enrolled by CMS in a Medicare Part D plan. Values: Y = YES Space (default value) or N = NO
**********	**BENE COPAY HISTORY (10 TIMES)**
BENE COPAY TYPE	A code indicating whether the beneficiary was determined eligible for Low-Income Subsidy or Deemed eligible.

	Values: L = Low-Income Subsidy (LIS) D = Deemed
BENE COPAY LEVEL	An indicator providing the level of copay granted to the beneficiary. Values: If BENE LIS TYPE = L 1 = HIGH 4 = 15% If BENE LIS TYPE = D 1 = HIGH 2 = LOW 3 = 0 (ZERO)
BENE COPAY START DATE	The effective date of the copay period. Format: **MMDDCCYY**
BENE COPAY END DATE	The end date of the copay period. Format: **MMDDCCYY**
**********	**PART D PLAN BENEFIT PACKAGE (10 TIMES)** **The first occurrence is the active or most recent Medicare Part D Plan coverage. Presently, this section is populated with Medicare Part C offering drug coverage and Medicare Part D plan benefit package selections.** **For Medicare Part C plans that offer Part D (e.g. (Medicare Advantage MA-PD) the beginning date of enrollment in the Part C plan may be earlier than January 1, 2006 (the start of the Medicare Part D program).**
BENE CONTRACT NUM (NUMBER)	Unique identifications for an agreement between CMS and a managed care organization or PDP sponsor enabling the plan to provide Medicare Part D prescription drug coverage.
BENE PTD PBP ENRLMNT STRT DT	The effective date that the beneficiary was enrolled in the Service Elections (PBP). Format: **MMDDCCYY** **For Medicare Part C plans that offer Part D (e.g. (Medicare Advantage MA-PD) the beginning date of enrollment in the Part C plan may be earlier than January 1, 2006 (the start of the Medicare Part D program)**
BENE PTD PBP ENRLMNT END DT	The end date of the beneficiary's enrollment in the Service Elections (PBP). Format: **MMDDCCYY**
BENE PTD PBP PLAN ID	A unique identifier for the managed care benefit package. For Medicare Part D, this number is a unique identification for an agreement between CMS and a Medicare Part D provider, enabling the Medicare Part D provider to provide prescription drug coverage to eligible beneficiaries.
BENE ENROLL TYPE IND (INDICATOR)	An indicator providing the type of enrollment performed. Values: A = Auto-Enrolled B = Beneficiary Election C = Facilitated Enrollment D = System-Generated Enrollment (Rollover)
FILLER	
MATCH IND	This field indicates if a matched detail record has been matched under the Primary Match algorithm or the Secondary Match algorithm.

	** A matched detail record is indicated by the presence of an alphanumeric values in the fields: BENE CLM ACNT NUM, BENE IDENT CD Valid Values: SPACE (detail record Matched): Match accomplished by Primary Match Algorithm SPACE (detail record Not Matched): No Match Accomplished 'S': Match accomplished by Secondary Match Algorithm
SPD CALCULATION IND	This field indicates the disposition of the detail record with respect to the State Phase-Down Calculations (Refer also to the MSM records). Valid Values: 'N': Detail record Not Used in State Phase-Down calculations 'D': Detail record used as a 'Disenrollment' (Credit) in State Phase-Down calculations 'E': Detail record used as an 'Enrollment' (Charge) in State Phase-Down calculations 'C': Detail record represents information that was used in a previous month as an 'Enrollment' (Charge) in State Phase-Down calculations Note: the 'C' value is important in order to 'Disenroll' when an 'Enrollment' had occurred more than one month ago.
**********	**REMAINDER OF RECORD**
FILLER	

File Summary Record Data Element Specifications

REC IDENT CODE	"FSM"
STATE CODE	**State Code - Valid Code** Alabama AL Alaska AK Arizona AZ Arkansas AR California CA Colorado CO Connecticut CT Delaware DE District of Columbia DC Florida FL Georgia GA Hawaii HI Idaho ID Illinois IL Indiana IN Iowa IA Kansas KS Kentucky KY Louisiana LA

	Maine ME Maryland MD Massachusetts MA Michigan MI Minnesota MN Mississippi MS Missouri MO Montana MT Nebraska NE Nevada NV New Hampshire NH New Jersey NJ New Mexico NM New York NY North Carolina NC North Dakota ND Ohio OH Oklahoma OK Oregon OR Pennsylvania PA Rhode Island RI South Carolina SC South Dakota SD Tennessee TN Texas TX Utah UT Vermont VT Virginia VA Washington WA West Virginia WV Wisconsin WI Wyoming WY
FILE PROCESS TIMESTAMP	Format: YYYY.MM.DD.hh.mm.ss.nnnn YYYY = Year; MM = Month; DD = Day; hh = hour; mm = minute; ss = second; nnnnnn = microsecond The exact time that the state file had been processed.
FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) The month in which the MMA state file was created.
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created The year in which the MMA state file was created.
RECORDS TOTAL	The total number of detail records in the state file. RECORDS VALID + RECORDS INVALID = RECORDS TOTAL. RECORDS MATCHED + RECORDS NOT MATCHED = RECORDS TOTAL. This total does not include PRO detail records.
RECORDS DUPLICATE	The total number of duplicate detail records found in the state file. This count does not include PRO detail records.
RECORDS NONDUP	The total number of non-duplicate valid detail records found in the

	state file. This count does not include PRO detail records.
RECORDS VALID	The total number of valid detail records found in the file. Valid records are non-duplicate and provide valid essential information. Additionally, a detail record will be considered Invalid if it does not have one of the following combinations of identifying information: - HICN or RRB, Social Security Number, Date of Birth - HICN or RRB, Date of Birth - Social Security Number, Date of Birth This count does not include PRO detail records. See also Person-Level Record Data Element Specifications: Error Return Codes.
RECORDS INVALID	The total number of invalid detail records found in the file. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
RECORDS MATCHED	The total number of detail records that could be matched successfully to an individual on the Medicare Beneficiary Database. This count does not include PRO detail records.
RECORDS NOT MATCHED	The total number of detail records that could not be matched successfully to an individual on the Medicare Beneficiary Database. This count includes Invalid detail records because no match is attempted on an invalid detail record. This count does not include PRO detail records.
FILLER	Filler
FILLER	Filler
FILLER	Filler
VALID DUAL RECORDS	The total number of valid Dual Eligible detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
VALID DUAL MATCHES	The total number of valid Dual Eligible detail records that could be matched successfully to an individual on the Medicare Beneficiary Database. This count does not include PRO detail records.
VALID DUAL NONMATCHES	The total number of valid Dual Eligible detail records that could not be matched successfully to an individual on the Medicare Beneficiary Database. This count does not include detail records that were not tried in the match process i.e. invalid records.

	This count does not include PRO detail records.
VALID LIS RECORDS	The total number of valid Low-Income Subsidy detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
VALID CURRENT DUALS	The total number of valid Dual Eligible detail records with Eligibility Month/Year = File Create Month/Year. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
VALID RETRO DUALS	The total number of valid Dual Eligible detail records with Eligibility Month/Year < File Create Month/Year. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes. This count does not include PRO detail records.
TOTAL ELIG MONTHS	The total number of Eligibility months found in the file. This count does not include PRO detail records.
TOTAL VALID PRO RECORDS	The total number of valid Prospective Full Dual (PRO) detail records found in the file. Valid records are non-duplicate and provide valid essential information. See also Person-Level Record Data Element Specifications: Error Return Codes.
TOTAL INVALID PRO RECORDS	The total number of invalid Prospective Full Dual (PRO) detail records found in the file See also Person-Level Record Data Element Specifications: Error Return Codes (ERC)
TOTAL MATCHED PRO RECORDS	The total number of valid Prospective Full Dual (PRO) detail records that could be matched successfully to an individual on the Medicare Beneficiary Database.
FILLER	

Month Summary Record Data Element Specifications

**********	ONE OF THESE RECORDS WILL BE GENERATED FOR EACH ELIGIBILITY MONTH FOUND IN THE FILE.
REC IDENT CODE	"MSM"
STATE CODE	**State Code - Valid Code** Alabama AL Alaska AK Arizona AZ Arkansas AR California CA Colorado CO Connecticut CT Delaware DE District of Columbia DC

	Florida FL Georgia GA Hawaii HI Idaho ID Illinois IL Indiana IN Iowa IA Kansas KS Kentucky KY Louisiana LA Maine ME Maryland MD Massachusetts MA Michigan MI Minnesota MN Mississippi MS Missouri MO Montana MT Nebraska NE Nevada NV New Hampshire NH New Jersey NJ New Mexico NM New York NY North Carolina NC North Dakota ND Ohio OH Oklahoma OK Oregon OR Pennsylvania PA Rhode Island RI South Carolina SC South Dakota SD Tennessee TN Texas TX Utah UT Vermont VT Virginia VA Washington WA West Virginia WV Wisconsin WI Wyoming WY
FILE PROCESS TIMESTAMP	Format: The exact time that the state file had been processed.
FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) Create Month of the MMA State File
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created Create Year of the MMA State File
ELIGIBILITY MONTH	Calendar Month Code for applicable Medicaid eligibility (e.g.012006) found in the MMA state file. Valid Month Values: 01 – 12 (e.g. January=01, December=12.)
ELIGIBILITY YEAR	Calendar Year Code for applicable Medicaid eligibility (e.g.012006)

	found in the MMA state file. Valid Month Values: 01 – 12 (e.g. January=01, December=12.)
CALCULATION SWITCH	Y = This Eligibility Month/Year was used in the state phase-down calculation. N = This Eligibility Month/Year was not used in the state phase-down calculation. Please note: Months previous to 012006 are not used in State Phase-Down Calculation.
TOTAL VALID RECORDS	The total number of valid Dual Eligible detail records found in the MMA state file for this Eligibility Month/Year. TOTAL VALID FULL DUAL RECORDS + TOTAL VALID NON-FULL DUAL RECORDS = TOTAL VALID RECORDS This count does not include PRO detail records.
TOTAL VALID FULL DUAL RECORDS	The total number of valid full dual beneficiary records. This count does not include PRO detail records.
TOTAL VALID NON-FULL DUAL RECORDS	The total number of valid non-full dual beneficiary records. This count does not include PRO detail records.
NET TOTAL VALID FULL DUAL ENROLLMENTS	The net total number of valid Full Dual Eligible enrollments counted for this Eligibility Month/Year. This count does not include PRO detail records.
NET TOTAL VALID FULL DUAL DISENROLLMENTS	The net total number of valid Full Dual Eligible disenrollments counted for this Eligibility Month/Year. This count does not include PRO detail records.
FILLER	

Trailer Record Data Element Specifications

RECORD IDENT CODE	"TRL"
FILE PROCESS TIMESTAMP	Format: YYYY.MM.DD.hh.mm.ss.nnnn YYYY = Year; MM = Month; DD = Day; hh = hour; mm = minute; ss = second; nnnnnn = microsecond The exact time that the state file had been processed.
FILE CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar Month equals Month the file is created (e.g. January=01, December=12) The month in which the MMA state file was created.
FILE CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created The year in which the MMA state file was created.
FILE ACCEPT IND	Y = The state file had been accepted; N = the state file had not been accepted.

EXHIBIT I
FILE LAYOUTS

FILLER	
**********	**ORIGINAL STATE TRAILER RECORD (180 BYTES)**
RECORD IDENT CODE	Identifies Record as Trailer always = "TRL"
BENE RECORD COUNT	Total number of records on the file
STATE CODE	**State Code - Valid Code** Alabama AL Alaska AK Arizona AZ Arkansas AR California CA Colorado CO Connecticut CT Delaware DE District of Columbia DC Florida FL Georgia GA Hawaii HI Idaho ID Illinois IL Indiana IN Iowa IA Kansas KS Kentucky KY Louisiana LA Maine ME Maryland MD Massachusetts MA Michigan MI Minnesota MN Mississippi MS Missouri MO Montana MT Nebraska NE Nevada NV New Hampshire NH New Jersey NJ New Mexico NM New York NY North Carolina NC North Dakota ND Ohio OH Oklahoma OK Oregon OR Pennsylvania PA Rhode Island RI South Carolina SC South Dakota SD Tennessee TN Texas TX Utah UT Vermont VT Virginia VA Washington WA West Virginia WV Wisconsin WI Wyoming WY
CREATE MONTH	Month Code for Current Month – Valid Values (01 – 12)Calendar

EXHIBIT I
FILE LAYOUTS

	Month equals Month the file is created (e.g. January=01, December=12
CREATE YEAR	Year Code for Current Year – i.e. 2006 Current Year equals Calendar Year the file is created
FILLER	
**********	REMAINDER OF RECORD
FILLER	

PRIOR AUTHORIZATION FILE LAYOUT

Position	Name	Data Type	Length	Notes	Value if not populated
1	MMA Claim ID	CHAR	17		n/a
18	PRESCRIBER ID QLFR	CHAR	2	See current values below	
20	PRESCRIBER ID	CHAR	15		
35	Quantity Limitations Rule number	CHAR	9	Rule ID	zeroes
44	Quantity Approved	CHAR	15	format 9(12)V9(3)	zeroes
59	Begin Date	CHAR	8	YYYYMMDD	zeroes
67	End Date	CHAR	8	YYYYMMDD	zeroes
75	Days Supply Limitations Rule number	CHAR	9	Rule ID	zeroes
84	Days Approved	CHAR	3	format 999 (if in months we will multiply by 30)	zeroes
87	Begin Date	CHAR	8	YYYYMMDD	zeroes
95	End Date	CHAR	8	YYYYMMDD	zeroes
103	Age Limitations Rule number	CHAR	9	Rule ID	zeroes
112	Minimum Age	CHAR	3	format 999	zeroes
115	Maximum Age	CHAR	3	format 999	zeroes
118	Begin Date	CHAR	8	YYYYMMDD	zeroes
126	End Date	CHAR	8	YYYYMMDD	zeroes
134	Overflow IND	CHAR	1	More than 20 occurrences (Y or N)	N
135	PA Data will occur 20 times	CHAR	420	21 characters * 20 = 420 characters	see below
555	filler	CHAR	46	Spaces	spaces
	PA Data				

	Override Type	CHAR	1	To be defined if needed: e.g. Q = Qty Limits, D = Days Supply, A = Age Limits, G = Gender Limits, N = None	N
	EXTERNAL_REJECT_CD	CHAR	4	NCPDP Error Code	zeroes
	Begin Date	CHAR	8	YYYYMMDD	zeroes
	End Date	CHAR	8	YYYYMMDD	zeroes
PRESCRIBER ID QLFR	Description				
HC	HCIDEA HCID				
SI	SureScripts-RxHub Provider Identifier				
01	National Provider Identifier (NPI)				
02	Blue Cross				
03	Blue Shield				
04	Medicare				
05	Medicaid				
06	UPIN				
07	NCPDP Provider ID				
08	State License				
09	Champus				
10	Health Industry Number (HIN)				
11	Federal Tax ID				
12	Drug Enforcement Administration (DEA)				
13	State Issued				
14	Plan Specific				
99	Other				

VITAL STATISTICS FILE LAYOUT

```
typedef struct{
char recip_last       [15];
char recip_first      [15];
char recip_mid_init    [ 1];
char dt_of_birth_m     [ 2];
char dt_of_birth_d     [ 2];
char dt_of_birth_y     [ 4];
char sex_cd            [ 1];
char ssn               [ 9];
char dte_death_m       [ 2];
char dte_death_d       [ 2];
char dte_death_y       [ 4];
```

char cert_nbr [6];
char filler [38];
} INPUTREC;

VOIDS FROM VENDOR FILE LAYOUT

Column Name	Description	Type	Length
TCN / ICN	Number assigned to a claim processed in the system. This number is used for control purposes. If 13 or less non-blank characters it will be assumed that it contains an icn. If greater than 13 non-blank characters it will be assumed that it contains a tcn.	CHAR	17
CDE_EOB	Code identifying the action/reason associated to the void	CHAR	4
AMT_PAID	amount paid by TPL carrier	NUMBER	9
ID_PROVIDER	Provider ID value	CHAR	9
PAID_DATE	Date TPL carrier paid	NUMBER	6
ID_MEDICAID	Unique identifier for the recipient.	CHAR	12

CAPITATION ADJUSTMENT FILE LAYOUT

Field Name	Field Description	Type	Length	Comments
SAK CAPITATION	System assigned key to uniquely identify a capitation payment within the system	CHAR	17	Right Pad With Blanks
CDE_EOB	Code identifying the action/reason associated to the capitation	CHAR	4	Right Pad With Blanks
AMT_PAID	Amount paid by TPL carrier	CHAR	10	Left Pad with 0s as done for the Void File
DATE_CAPITATION	Month TPL Carrier Paid	CHAR	6	Right Pad With Blanks
ID_PROVIDER	Provider Id	CHAR	9	Right Pad With Blanks
ID_MEDICAID	Recipient Id	CHAR	12	Right Pad With Blanks

FINANICAL ADJUSTMENT FILE FROM VENDOR LAYOUT

Column Name	Description	Type	Length
TCN / ICN	Number assigned to a claim processed in the system. This number is used for control purposes. If 13 or less non-blank characters it will be assumed that it contains an icn. If greater than 13 non-blank characters it will be assumed that it contains a tcn.	CHAR	17
CDE_EOB	Code identifying the action/reason associated to the adjustment	CHAR	4
AMT_PAID	amount paid by TPL carrier	NUMBER	9
ID_PROVIDER	Provider ID value	CHAR	9
PAID_DATE	Date TPL carrier paid	NUMBER	6
ID_MEDICAID	Unique identifier for the recipient.	CHAR	12
filler	used by TPL vendor	CHAR	2
CDE_CARRIER	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	CHAR	7
NUM_TPL_POLICY	Policy number for this TPL policy.	CHAR	16

EXHIBIT I
FILE LAYOUTS

RESOURCE FILE FROM VENDOR

Column Name	Description	Type	Length
id_medicaid	Unique identifier for the recipient.	CHAR	12
num_ssn	This is the social security number of the policyholder.	CHAR	9
nam_last	This is the last name of the policyholder. It is used to send correspondence to the policyholder.	CHAR	15
nam_first	This is the first name of the policyholder. It is used to send correspondence to the policyholder.	CHAR	13
nam_mid_init	This is the middle initial of the policyholder. It is used to send correspondence to the policyholder.	CHAR	1
cde_relation	This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.	CHAR	1
cde_carrier	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	CHAR	7
nam_bus	This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.	CHAR	45
num_tpl_policy	Policy number for this TPL policy.	CHAR	16
dte_effective	The effective begin date of this coverage code.	NUM	8
dte_end	The effective ending date of this coverage code.	NUM	8
ind_group	Group or individual indicator. 'G', 'I', or blank for unknown	CHAR	1
cde_employer	Employer group number	CHAR	15
adr_mail_strt1	This is the street address of an employer.	CHAR	55
adr_mail_city	This is the city of an employer.	CHAR	30
adr_mail_state	This is the state of an employer.	CHAR	2
adr_mail_zip	This is the zip code of an employer.	CHAR	15
cde_coverage	This code identifies the type of coverage that a TPL policy provides.	CHAR	12
num_ssn	Unique identifier for the recipient.	CHAR	9
nam_last	The last name of a recipient.	CHAR	20
nam_first	The first name of a recipient.	CHAR	15
nam_mid_init	The middle initial of the recipient.	CHAR	1
dte_birth	The date of birth for the recipient.	NUM	8
cde_sex	Indicates the sex of the recipient.	CHAR	1
ind_hipp	Indicates whether or not the recipient participates in HIPP.	CHAR	1

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EXHIBIT I
FILE LAYOUTS

ACCOUNTS RECEIVABLE FORM

State of Florida
Agency For Healthcare Administration

Accounts Receivable Request

Requestor: **Request Date:**

Approved By:

Department:

MCM Letter #: **MCM Letter Date:**

Payee Type:	**Fund Code:**
Payee ID:	**Type: Manual / Automatic** (Circle one)
Setup Amount:	**Percentage: 100%**
Effective Date:	**Recoupment Amt: $**
	Reason:
Supplemental Information:	Dates of Service

Comments:

FUND CODE ASSIGNMENT TABLE:

If Payout Reason is D1-D8, then Fund Code = 020000000
If Payout Reason is S1, then Fund Code = 010519600
If Payout Reason is S3, then Fund Code = 010223300
If Payout Reason is X1-X-9, then Fund Code = 010158400
If Payout Reason is D9, then Fund Code = 010158200
If Payout Reason is S2, then Fund Code = 010254100

Accounts Receivable Form Key

Payee ID:	Medicaid Provider ID Number
Setup Amount:	Amount to be Recouped from Provider
Reason:	Use TPL EOB Codes Description
Recipient ID:	Medicaid Recipient Identification Number
Dates of Service:	Date of Service of Medicaid Claim
Comments:	Contract Component

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EXHIBIT I
FILE LAYOUTS

CASH RECEIPT FORM

State of Florida
Agency For Healthcare Administration

Cash Receipt/Accounts Receivable Disposition Request

Requestor: **Request Date:**

Approved By:

Department:

MCM Letter #: **MCM Letter Date:**

Payment Type:	**Receipt Date:**
Payment Amount:	**Reason/Unit:**
Payment No:	**Name:**
Payment Date:	**Second Name:**
Payee Type:	**A/R Number:**
Payee ID:	

Cash Receipt Comments:

Cash Receipt/Accounts Receivable Disposition Request Form Key

Payment Amount:	Amount of Check
Reason/Unit:	Use TPL EOB Codes Description
Payment No:	Check Number
Name:	Provider Name
Second Name:	Secondary Provider Name if Applicable
Payee ID:	Medicaid Provider ID Number
Cash Receipt Comments:	Contract Component

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EXHIBIT I
FILE LAYOUTS

EXPENDITURE FORM

State of Florida
Agency For Healthcare Administration

Expenditure Request

Requestor: **Request Date:**

Approved By:

Department:

MCM Letter #: **MCM Letter Date:**

Payee Type:	**Process Type:** **Regular** / **Immediate** (Circle one)
Payee ID:	**Payout Reason:**
Payout Amount:	**Fund Code:**
Supplemental Information:	Dates of Service

Comments:

FUND CODE ASSIGNMENT TABLE:

If Payout Reason is D1-D8, then Fund Code = 020000000
If Payout Reason is S1, then Fund Code = 010519600
If Payout Reason is S3, then Fund Code = 010223300
If Payout Reason is X1-X-9, then Fund Code = 010158400
If Payout Reason is D9, then Fund Code = 010158200
If Payout Reason is S2, then Fund Code = 010254100

Expenditure Request Form Key

Payee ID:	Medicaid Provider ID Number
Payout Amount:	Amount to be refunded to the Provider
Recipient ID:	Medicaid Recipient Identification Number
Dates of Service:	Date of Service of Medicaid Claim
Comments:	Contract Component

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EXHIBIT I
FILE LAYOUTS

CASH RECEIPT/DISPOSITION REQUEST FORM

State of Florida
Agency For Healthcare Administration

Cash Receipt/ Disposition Request

Requestor: **Request Date:**

Approved By: **MCM Letter #:**

Department: **MCM Letter Date:**

Cash Receipt Information

Payee Type:	**Payment Amount:**
Payee Name:	**Payment Date:**
Payment Type:	**Payment No:**
CCN:	**Cash Receipt Reason:**

Cash Disposition Information		**Related Txn Info**
Payee ID:	**Payee Name:**	
Amount:	**Adjustment Reason:**	**ICN:**
Amount:	**Adjustment Reason**	

Comments:

Cash Receipt/Disposition Request Form Key

Payee ID:	Medicaid Provider ID Number
Payment Amount:	Amount Received
Cash Receipt Reason:	TPL EOB Code for Recovery Project
Amount:	Payment Amount to be Dispositioned
Adjustment Reason:	TPL EOB Code for Recovery Project

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EXHIBIT I
FILE LAYOUTS

TPL EOB CODES

CODE	SHORT DESCRIPTION	LONG DESCRIPTION
9315	TPL REC MED A	TPL RECOVERY MEDICARE PART A
9316	TPL REC MED B	TPL RECOVERY MEDICARE PART B
9317	TPL REC HI	TPL RECOVERY HEALTH INSURANCE
9318	TPL REC CARRIER	TPL RECOVERY CARRIER BILLING
9319	TPL REC/TRI/CHM	TPL RECOVERY TRICARE/CHAMPVA
9320	TPL REC MPI	TPL RECOVERY MPI PROJECT
9321	TPL REC OTHER	TPL RECOVERY OTHER
9322	TPL V/S REC 08	TPL VENDOR/SUBCONTRACTOR RECOVERY 08
9323	TPL V/S REC 09	TPL VENDOR/SUBCONTRACTOR RECOVERY 09
9324	TPL V/S REC 10	TPL VENDOR/SUBCONTRACTOR RECOVERY 10
9325	TPL V/S REC 11	TPL VENDOR/SUBCONTRACTOR RECOVERY 11
9326	TPL REC CAS	TPL RECOVERY CASUALTY
9327	TPL REC ESTATE	TPL RECOVERY ESTATE
9328	TPL REC TRUST	TPL RECOVERY TRUST
9329	TPL V/S REC 15	TPL VENDOR/SUBCONTRACTOR RECOVERY 15
9330	TPL V/S REC 16	TPL VENDOR/SUBCONTRACTOR RECOVERY 16
9331	TPL V/S REC 17	TPL VENDOR/SUBCONTRACTOR RECOVERY 17
9332	TPL V/S REC 18	TPL VENDOR/SUBCONTRACTOR RECOVERY 18
9333	TPL V/S REC 19	TPL VENDOR/SUBCONTRACTOR RECOVERY 19
9334	TPL V/S REC 20	TPL VENDOR/SUBCONTRACTOR RECOVERY 20

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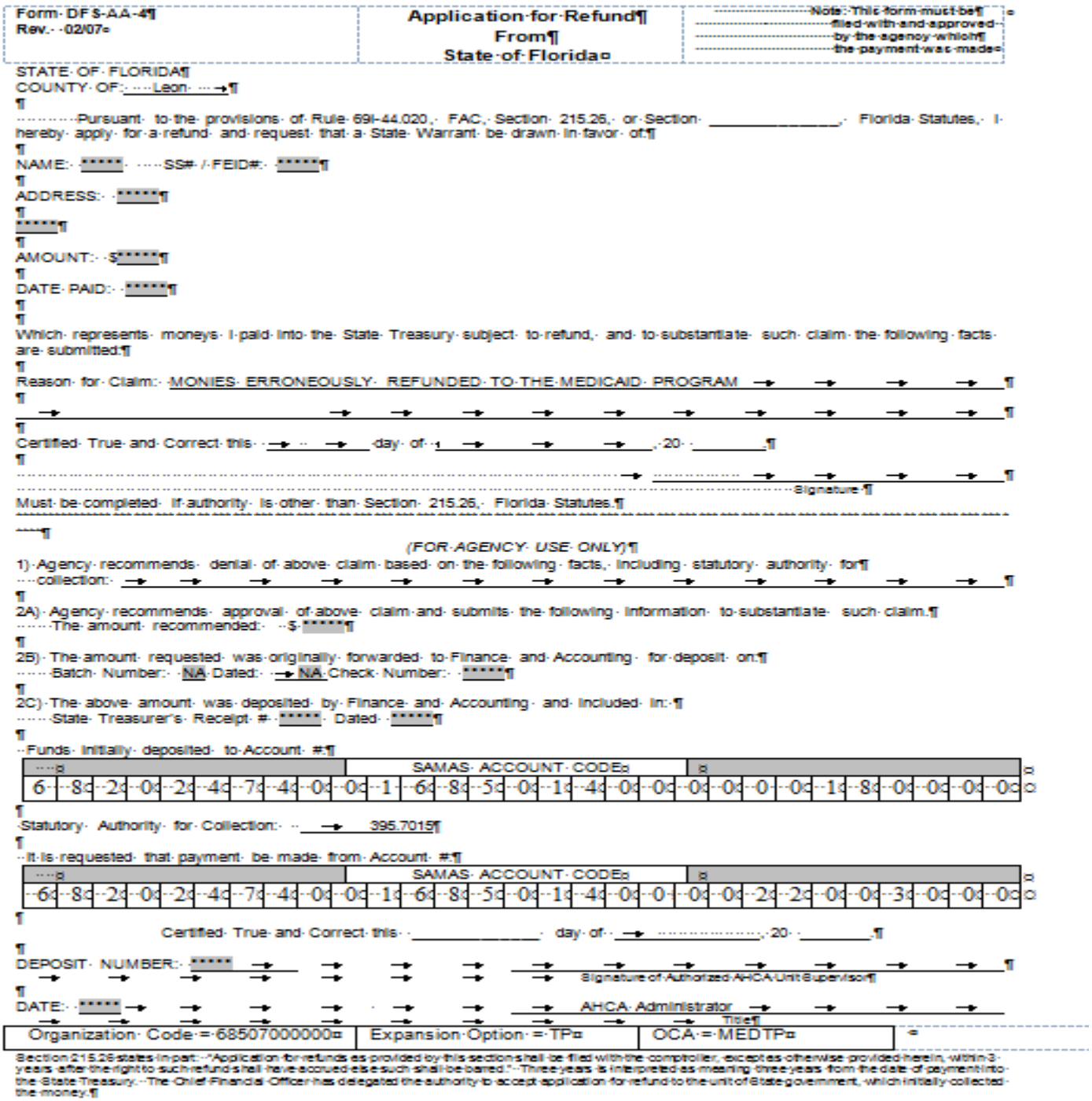
EXHIBIT I
FILE LAYOUTS

APPLICATION FOR REFUND FORM



Form DFS-AA-4
Rev. 02/07

Application for Refund From State of Florida

Note: This form must be filed with and approved by the agency which the payment was made

STATE OF FLORIDA
COUNTY OF: Leon

Pursuant to the provisions of Rule 69I-44.020, FAC., Section 215.26, or Section _____, Florida Statutes, I hereby apply for a refund and request that a State Warrant be drawn in favor of:

NAME: ***** SS# / FEID#: *****

ADDRESS: *****

*****

AMOUNT: $*****

DATE PAID: *****

Which represents moneys I paid into the State Treasury subject to refund, and to substantiate such claim the following facts are submitted:

Reason for Claim: MONIES ERRONEOUSLY REFUNDED TO THE MEDICAID PROGRAM

Certified True and Correct this _____ day of _____, 20__

Signature

Must be completed if authority is other than Section 215.26, Florida Statutes.

(FOR AGENCY USE ONLY)

1) Agency recommends denial of above claim based on the following facts, including statutory authority for collection:

2A) Agency recommends approval of above claim and submits the following information to substantiate such claim.
The amount recommended: $*****

2B) The amount requested was originally forwarded to Finance and Accounting for deposit on:
Batch Number: NA Dated: NA Check Number: *****

2C) The above amount was deposited by Finance and Accounting and included in:
State Treasurer's Receipt # ***** Dated *****

Funds initially deposited to Account #:

SAMAS ACCOUNT CODE																								
6	8	2	0	2	4	7	4	0	0	1	6	8	5	0	1	4	0	0	0	0	0	1	8	0	0	0	0

Statutory Authority for Collection: 395.7015

It is requested that payment be made from Account #:

SAMAS ACCOUNT CODE																								
6	8	2	0	2	4	7	4	0	0	1	6	8	5	0	1	4	0	0	0	0	2	2	0	0	3	0	0	0

Certified True and Correct this _____ day of _____, 20__

DEPOSIT NUMBER: *****

Signature of Authorized AHCA Unit Supervisor

DATE: *****

AHCA Administrator
Title

Organization Code = 68507000000	Expansion Option = TP	OCA = MEDTP

Section 215.26 states in part: "Application for refunds as provided by this section shall be filed with the comptroller, except as otherwise provided herein, within 3 years after the right to such refund shall have accrued else such shall be barred." Three years is interpreted as meaning three years from the date of payment into the State Treasury. The Chief Financial Officer has delegated the authority to accept application for refund to the unit of State government, which initially collected the money.

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EXHIBIT I
FILE LAYOUTS

NOTICE OF REFUND - CARRIER

DATE:

TO: AHCA TPL

FROM: VENDOR MANAGER

SUBJECT: **Notice of Refund - Carrier**

This is to certify that the Florida Agency for Health Care Administration needs to refund the following:

Refund Amount:

Recipient Information
Name:
Medicaid ID# :

Check Information
Check#:
Check Date:
Check Amount:

Claim Information
ICN#:
Provider#:
Date of Service:
Medicaid Paid Amount:

Payor Information
Payor:
Payor Claim# (if applicable):
Payor Tax ID# (Social Security# if individual):
Payor Address (where check will be sent):

Justification for Refund:
Refund Request from Carrier and Application for Refund Form is attached.

_____
Vendor Manager Name (Typed)

_____
Vendor Manager Signature Date

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EXHIBIT I
FILE LAYOUTS

NOTICE OF REFUND: CASUALTY, ESTATE, AND TRUST AND ANNUITY

DATE:

TO: AHCA TPL

FROM: VENDOR MANAGER

SUBJECT: **Notice of Refund**
Case from which the refund is to be made:
Case#:

This case is:

☐ Casualty ☐ Estate ☐ Trust ☐ Annuity

This is to certify that the Florida Agency for Health Care Administration needs to refund the following:

Refund Amount:

Recipient Information
Name:
Medicaid ID#:

Check Information
Check#:
Check Date:
Check Amount:

Payor Information
Payor:
Payor Claim# (if applicable):
Payor Tax ID# (Social Security# if individual):
Payor Address (where check will be sent):

Justification for Refund:

The refund check should be made payable to:
☐ the payor of the original check (see above) OR
☐ other than the payor of the original check (see below)
State the reason that it is not to be made payable to the payor.

Alternative payee (if applicable):
Name:
Tax ID# (Social Security# if individual):
Address (where check will be sent):

Application for Refund Form is attached. All payment and supporting documentation relating to this refund is located in the electronic case file. Image number(s) are:

_____
Vendor Manager Name (Typed)

_____
Vendor Manager Signature Date

EXHIBIT I
FILE LAYOUTS

NOTICE OF REFUND – PROVIDER

DATE:

TO: AHCA TPL

FROM: VENDOR MANAGER

SUBJECT: **Notice of Refund - Provider**
Project Name - e.g. Medicare Disallowance

This is to certify that the Florida Agency for Health Care Administration needs to refund the following:

Refund Amount:

Recipient Information
Name:
Medicaid ID#:

Check Information
Check#:
Check Date:
Check Amount:

Claim Information
ICN#:
Provider#:
Date of Service:
Date of Recoupment:
Amount of Recoupment:

Justification for Refund:
Supporting documentation and Expenditure Form is attached:

Copy of Medicaid remittance voucher on which recoupment occurred
Copy of provider claims listing with questionable claims highlighted
Copy of cancelled check from provider
FMMIS screen prints showing recoupment

_____
Vendor Manager Name (Typed)

_____
Vendor Manager Signature Date

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EXHIBIT II
IMPLEMENTATION DOCUMENTATION

Implementation Document	ITN Reference	Due Date
Final Implementation Plan	D.9	July 1, 2015
Final Risk Management Plan	D.9	July 1, 2015
Payment Return Method	D.6	August 1, 2015
PHI Report Format	D.7	August 1, 2015
Final Disaster Recovery Plan	D.9	August 1, 2015
Correspondence	D.10	August 1, 2015
Final Operational Policies and Procedures Manual	D.11	August 1, 2015
Final Training Manual	D.11	August 1, 2015
Training Report Format	D.11	August 1, 2015
Final Quality Assurance Policies and Procedures Manual	D.11	August 1, 2015
Quality Assurance Report Format	D.11	August 1, 2015
Final Organizational Chart	D.12	August 1, 2015
Privacy Compliance Plan	D.13	August 1, 2015
Telephone Report Format	D.13	August 1, 2015
Telephone Script	D.13	August 1, 2015
Website	D.13	August 1, 2015
Website Report Format	D.13	August 1, 2015
Final Outreach Plan	D.13	August 1, 2015
Outreach Report Format	D.13	August 1, 2015
Agency Access and Training on Claims Repository	D.14	August 1, 2015
Claims Repository Operational	D.14	August 1, 2015
Agency Access and Training on Case Tracking System	D.15	August 1, 2015
Case Tracking System Correspondence	D.15	August 1, 2015
Case Tracking System Operational	D.15	August 1, 2015
Agency Access and Training on TPL Web Portal	D.16	August 1, 2015
Web Portal Operational	D.16	August 1, 2015
Medicaid Provider Training Materials	D.16	August 1, 2015
Deliverables Report Format	D.17	August 1, 2015
Payment Hold Log Format	D.18	August 1, 2015
Daily Accounting Report Format	D.18	August 1, 2015
Weekly Accounting Report Format	D.18	August 1, 2015
Monthly Accounting Report Format	D.18	August 1, 2015
Invoice Format	D.20	August 1, 2015
Report Formats	D.22	August 1, 2015
Weekly Hearing Report Format	D.23	August 1, 2015
Monthly Hearing Report Format	D.23	August 1, 2015
Casualty Settlement Report Format	D.25	August 1, 2015
Computer Match Criteria	D.28	August 1, 2015
Data Matching Activities Report Format	D.28	August 1, 2015
Medicare Entitlement Report Format	D.28	August 1, 2015
Denial Reasons Report Format	D.28	August 1, 2015
Carriers – Denial Reasons Report Format	D.28	August 1, 2015
TPL Resource File Maintenance Activities Report Format	D.29	August 1, 2015
Leads Letter Follow-up Method	D.29	August 1, 2015

EXHIBIT II
IMPLEMENTATION DOCUMENTATION

Implementation Document	ITN Reference	Due Date
Leads Letters Report Format	D.29	August 1, 2015
Health Insurance Premium Payment (HIPP) Report Format	D.30	August 1, 2015
Other Recovery Projects Report Format	D.31	August 1, 2015
Social Networking Policies, Procedures and Monitoring Plan	D.33	60-Calendar Days Prior to Launch

EXHIBIT III
REPORTS

Report Name	ITN Reference	Daily	Weekly	Monthly	Quarterly	Annually	Upon Request
SAS – 70 Audit Results	D.7						X
Health Insurance Portability and Accountability Act (HIPAA) Staff Training	D.7						X
Protected Health Information (PHI) Report (PHI Released Inappropriately)	D.7			X			
Training	D.11			X			
Quality Assurance	D.11			X			
Telephone	D.13		X				
Website	D.13		X				
Outreach	D.13				X		
Case Tracking System	D.15						X
Deliverables	D.17			X			
Payment Hold Log	D.18	X					
Deposit Slips	D.18	X					
Daily Accounting	D.18	X					
Weekly Accounting	D.18		X				
Monthly Accounting	D.18			X			
Invoices	D.20			X			
Hearings	D.23		X	X			
Casualty Settlement	D.25			X			
County Probate Lists	D.26						X
Data Matching Activities	D.28			X			
Medicare Entitlement	D.28				X		
Denial Reasons	D.28			X			
Carriers – Denial Reasons	D.28			X			
TPL Resource File Maintenance Activities	D.29		X				
Leads Letters	D.29			X			
Health Insurance Premium Payment	D.30		X				

EXHIBIT III
REPORTS

Report Name	ITN Reference	Daily	Weekly	Monthly	Quarterly	Annually	Upon Request
Other Recovery Projects	D.31			X			
Social Networking Policies, Procedures and Monitoring Plan (Due November 1)	D.33					X	

Ad hoc reports required by the Agency shall be submitted by 5:00 p.m. EST or EDT as appropriate, within three (3) business days after the date of the request, unless otherwise specified by the Agency.

EXHIBIT IV
MOTION TO QUASH

IN THE CIRCUIT COURT
FOR «County» COUNTY, FLORIDA

«Plantiff_Line_1»
«Plantiff_Line_2»
«Plantiff_Line_3»

Case No.: «Case_No»

Plaintiff(s),

vs.

«Defendants»
«Defendants_Line2»
«Defendants_Line_3»

Defendant(s).
_____/

MOTION TO QUASH SUBPOENA

Non-Party Movant, AGENCY FOR HEALTH CARE ADMINISTRATION (Agency), by and through the undersigned attorney, objects to the Subpoena issued to the Records Custodian, and pursuant to Rule 1.410, Fla.R.Civ.P., moves that the Subpoena be invalidated or quashed and that an appropriate Order be entered in lieu thereof, and says:

(1) The only reports capable of being generated from the records on file would disclose:

a. Whether the individual was a Medicaid recipient during the time in question;

b. The dates of services for any medical services provided for the recipient and billed to Medicaid;

c. The names of the Medicaid providers who submitted claims to Medicaid;

d. The types of procedures provided to the recipient and billed to Medicaid.

(2) Neither the Agency nor its fiscal agent has copies of patient histories, diagnostic tests, narratives or other medical records.

EXHIBIT IV
MOTION TO QUASH

(3) Further, pursuant to 42 C.F.R. 431.300-307, Medicaid recipient information is confidential and may not be disclosed by the Agency unless we have a medical release or a court order. The request must relate to the direct administration of the Medicaid State Plan.

WHEREFORE, Non-Party Movant asks that this Motion to Quash be granted.

Respectfully submitted on _____, 20__

_____

Name, Esq.
Bar No. 9999999
Agency For Health Care Administration
Address Line 1
Address Line 2
Tallahassee, FL 323__
999/999-9999

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Motion has been furnished by U. S. Mail on _____, 20__, to

«Service_Atty_Name»
«Service_Address»
«Service_City_State_Zip»

_____
Name, Esq.

Case Number: «Case_Number»

EXHIBIT V
TPL STATE REVIEW PROCEDURES

Description of Suspended Claims

The TPL Matrix is the controlling mechanism of whether Medicaid requires an insurance attachment (EOB) explaining why an insurance company did not pay a claim. It is the responsibility of the reviewing authority to determine if the explanation of non-payment is valid.

Process Summary

- Claims are reviewed to ensure that the claims and the attachments are for the same recipient.

- Each recipient's TPL Resource File is accessed to determine what coverage and what companies are responsible for the claim. The attachments are reviewed to determine if the insurance denial reason is appropriate for the coverage shown on file.

- If the attachment indicates that changes need to be made to the Resource File (termination dates, policy numbers, policy holder names, types of coverage, etc.) the changes are made at this time.

- Multi–lined claims sometimes require that some lines are approved and some are denied and can be noted by identifying the claim lines. (Example: Forced Deny lines 1, 4, 5 and Forced Override 2, 3, 6)

Invalid Explanations (Deny the Claim)

- **The insurance company is requesting more information in order to process the claim. Medicaid providers are required to provide a third party all the necessary information they need to process a claim.**

    - Doctor's orders for this service not included in medical records.

    - Need information regarding spouse's other health insurance coverage.

    - Submit itemized billing statement.

    - Requested information not received.

    - Pending more information.

    - Waiting on "XYZ" form from insured.

    - Key words: pending, waiting, review, request, need, etc.

- **A provider not within the insurance company approved network of providers performed the medical services.**

    - Services obtained out of the primary care network are not covered.

- Care not coordinated by primary care physician.
- Out of network.
- Exception - PPO out of network benefits are paid at a lesser percentage, etc.

- **The provider did not obtain pre-authorization to perform the medical services.**
  - Service not pre-authorized, a valid authorization is required for this service.
  - Not pre-authorized or approved.
  - Pre-authorization not on file.

- **EOB is not valid.**
  - The services billed to the insurance company do not match the services performed.
  - The date of service (DOS) does not match the DOS on the EOB.
  - Exception - EOB states that this service is not covered and the date of the EOB is within the same calendar year as the DOS.
  - The insurance EOB does not match the insurance company on file with FMMIS. (Update FMMIS)

- **EOB explanation is unclear.**
  - Duplicate of service previously claimed.
  - These charges were previously considered.
  - Billed Medicaid 24 hours of service but billed the insurance company 8 hours of service.
  - EOB reason code definition is not provided.
  - Exception - Reviewing authority has reason code definition on file.
  - Verbal Denial. (Phone verification made by the Medicaid Provider)
  - Exception - A Verbal Denial is accepted for insurance termination, erroneous TPL, and invalid insurance type on record. (Update FMMIS)

- **Capitated Service**
    - Capitated service / Do not bill member.

Provider Error (Deny the claim)

- **UB92 claims - the Financial Class Code (FCC) is missing or invalid.**
    - Medicare TPL related claims require a FCC of 910.
    - Exception – Medicare Claims – Key 910 in the FCC field if the provider wrote "Medicare Crossover" in field one of the claim.
- **FCC of 100 for claim with a TPL payment.**
    - Examples of valid FCC codes (1st 2nd 3rd) of TPL paid claims. (210, 221, 310, 231, 910, etc.).
- **Code explanation:**
    - 1 – Medicaid
    - 2 - Health Insurance
    - 3 - Blue Cross and Blue Shield
    - 9 - Other
- **Medicare claims**
    - The TPL Form and/or the Explanation of Medicare Benefits (EOMB) are missing or invalid (does not match the claim).
    - EOMB does not match the claim.
    - CTEC TPL form not completed correctly (Claim keyed incorrectly based on CTEC TPL form).
- **Medicare Advantage Plan HMO**
    - Medicaid does reimburse for co-pays, coinsurance or deductibles.
    - Medicaid does not reimburse for services covered by the Medicare HMO.

- **The EOB indicates payment for the claim that is not accurately reflected on the claim.**

    - The provider did not enter the TPL payment amounts for each line of the claim (prorated when appropriate) with the exception of UB92 inpatient claims.

    - Lump sum payments from an insurance company not prorated line by line. (Deny all lines)

    - Payments paid line by line by an insurance company are totaled to one line. (Deny all lines)

    - The entered total TPL payment amount does not equal the sum of the line item TPL amounts.

    - Exception - Pay in Full Service contracts.

Valid explanations (Pay the Claim) with exceptions

- Non covered service. (Update FMMIS when appropriate)

    - Speech and Occupational Therapy are not covered.

    - Ensure that the procedure codes reflect Occupational therapy.

    - Please note: Per prior authorization, speech therapy under this member's group contract excludes speech therapy services except to restore speech loss or impairment resulting from trauma stroke or surgical procedure.

- **Excluded per contract.**

- **Contract does not cover accident services.**

    - Ensure that the accident indicator on the claim form was checked if appropriate.

- **Contract does not include coverage for hospital services.**

    - Ensure that the services in question are hospital services (services for use of the facility) and not physician, lab, etc. contracted through the hospital.

- **Pre-existing conditions not covered.**

    - Review prior Medicaid claims to help determine if this is a pre-existing condition.

EXHIBIT V
TPL STATE REVIEW PROCEDURES

- **Contract excludes payment for this procedure.**
    - Is the procedure one that cannot be excluded in the state of Florida?
    - HMO's and Lung Transplants (one example).
- **Immunizations are not covered.**
    - Ensure that the denial is not related to an exclusion because of Medicaid coverage. (unlawful)
- **Hearing aids not covered.**
    - Most plans that do not cover hearing aids will cover the diagnosis for a hearing aid.
- **Contract excludes office visits.**
    - Update FMMIS - if the plan on file is a major medical, CHAMPUS, or HMO.
- **Contract does not cover accident services.**
    - Verify that the service is accident related and update FMMIS if appropriate.
- **Non-covered supply.**
    - Was the correct supply ordered (a variation that is covered by the plan)?
- **Routine care (physical exams, injections) not covered.**
    - Deny and or update FMMIS if an HMO plan on file.
- **Rehabilitation services are not covered.**
    - Most plans will cover rehabilitative services that will result in improvement and or cure. (short term).
    - Subjective, a phone call to the Insurance Company may be necessary.
- **Pregnancies of dependent children are not covered by the plan.**
    - Is the patient, the policyholder?
    - Is the service pregnancy related?
    - Is the service for a condition related (caused) by the pregnancy but can be diagnosed separately? (must be covered by the plan).

EXHIBIT V
TPL STATE REVIEW PROCEDURES

- **Does not meet emergency criteria.**

    - Subjective, for example is the service for a flu that could become life threatening, if left untreated? Deny the claim if in your best judgment the claim is emergency related and the provider should have challenged the ruling.

- **These charges are not eligible for coverage under your contract.**

- **This contract provides no allowance for this type of dental service.**

    - Is the service trauma related? Most major insurance plans will cover some or most reconstruction dental services that are trauma related.

- **The charge exceeds the allowance limit for this service.**

    - Maximum benefit paid for these services.

    - Lifetime benefit - Update FMMIS is possible.

    - Year maximum reached - Make note in FMMIS.

- **Payment applied to the deductible or co-payment.**

- **Insurance has been terminated. (Update FMMIS)**

- **Services provided outside of the inclusive coverage dates of the policy.**

- **HMO not on file in FMMIS on the DOS.**

- **HMO does not have servicing providers in the State of Florida with the exception of HMO's that provide an out of network benefit. (Update FMMIS) Remove TPL from the Resource File.**

- **This contract does not include insurance coverage for this person. (Update FMMIS)**

- **Your Plan has a limited benefit amount for this expense. Payment is based on this limited benefit amount.**

EXHIBIT VI
HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM
COST EFFECTIVENESS CRITERIA

When determining cost effectiveness for the HIPP program, the following data elements shall be considered:

The amount of the Medicaid managed care premium that would have been paid for that recipient (Monthly Capitation Rate*).	A
Recipient's Monthly Employer Sponsored Insurance (ESI) Premium	B
The amount of copayments, coinsurance, deductibles and other cost sharing obligations as determined by the average fee-for-service expenditures for recipients with other comparable insurance coverage.	C
Administrative Cost	D

The calculation used to determine whether a recipient qualifies for HIPP assistance shall be A $\geq$ (B+C+D). The Medicaid managed care premium (A), must be greater than or equal to the amount of the recipient's share of the ESI premium (B), plus the amount for copayments, coinsurance, deductibles and other cost sharing obligations (C), plus the amount of any administrative cost (D)

*Medicaid Managed Care Organization Capitation Rates are located on the Agency's website.

ATTACHMENT E
EVALUATION CRITERIA

E.1 Review of Mandatory Criteria:

The Procurement Office will evaluate responses to this ITN against the mandatory criteria found in **Part I**, Mandatory Criteria. Responses failing to comply with all mandatory criteria will not be considered for further evaluation.

E.2 Past Performance Evaluation:

Past performance will be scored based on answers to the questions outlined in **Attachment F**, Past Performance – Client Reference Form, received from three (3) separate client references. A score will be assigned for each individual client reference. Each reference is worth a maximum of 60 points. The Agency will consider the three (3) clients who will complete an Evaluation Questionnaire for Past Performance, for evaluation scoring. The Agency reserves the right to contact sources other than those identified by the respondent to obtain additional information regarding past performance. Information obtained from contacted references and additional contacts may be used to determine whether the respondent is a responsible vendor, as defined in Section 287.012(25), Florida Statutes.

E.3 Financial Stability Evaluation:

An Agency Certified Public Accountant will evaluate each respondent's financial information. A score will be assigned for financial responsibility based on the following scale:

Points	
20	Financial stability is excellent.
15	Financial stability is above average.
10	Financial stability is average.
5	Financial stability is below average.
0	Financial stability is inadequate.

Respondents determined to have insufficient financial resources to fully perform the Contract requirements outlined in this ITN will be disqualified at the Agency's sole discretion.

E.4 Cost Proposal Evaluation:

The Agency will evaluate each cost proposal and award points based on the following:

The respondent with the lowest proposed fixed contingency fee (Table A of **Attachment, J**, Cost Proposal), will receive the maximum allowable points (10 points) for that fixed contingency fee. The remaining respondents will receive a percentage of the maximum points, rounded to the nearest whole number, based on the following formula:

Lowest Proposed Fixed Contingency Fee ÷ *Current Respondent's Proposed Fixed Contingency Fee*	*x*	*10*	=	*Total Points Awarded rounded to the nearest whole number*

The renewal costs in Table B of **Attachment J**, Cost Proposal, will not be evaluated.

Example:

In this example, there are three (3) respondents:

	Respondent A		Respondent B		Respondent C	
	Fixed Contingency Fee	Points Awarded	Fixed Contingency Fee	Points Awarded	Fixed Contingency Fee	Points Awarded
Proposed Fixed Contingency Fee	10%	5	5%	10	7%	7

E.5 Technical Response Evaluation:

Each response determined to be in compliance with all mandatory criteria will be independently evaluated based on the criteria and points scale indicated in **Part II**, Evaluation Criteria, below. Each response will be individually scored by at least three (3) evaluators, who collectively have experience and knowledge in the program areas and service requirements for which contractual services are sought by this ITN. The Agency reserves the right to have specific sections of the responses evaluated by less than three (3) individuals.

Detailed evaluation criteria components will be evaluated and awarded points based on the following point structure:

Points	
0	The component was not addressed.
1	The component contained significant deficiencies.
2	The component is below average.
3	The component is average.
4	The component is above average.
5	The component is excellent.

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E.6 Ranking of Responses:

A total score will be calculated for each response. The total point scores will be used to rank the responses by evaluator (response with the highest number of points = 1, second highest = 2, etc.). An average rank for each response will be calculated for all evaluators. The Agency may negotiate with one or more of the highest ranked respondents.

See scoring example below:

SCORING EXAMPLE:

In this example, there are 461 maximum available points and four (4) respondents.

Step 1

A total score will be calculated for each response.

Evaluator A		Evaluator B		Evaluator C		Evaluator D	
Respondent 1	451 pts.	Respondent 1	401 pts.	Respondent 1	316 pts.	Respondent 1	418 pts.
Respondent 2	425 pts.	Respondent 2	390 pts.	Respondent 2	443 pts.	Respondent 2	449 pts.
Respondent 3	397 pts.	Respondent 3	419 pts.	Respondent 3	389 pts.	Respondent 3	435 pts.
Respondent 4	410 pts.	Respondent 4	388 pts.	Respondent 4	459 pts.	Respondent 4	325 pts.

Step 2

The total point scores will be used to rank the responses by evaluator (response with the highest number of points = 1, second highest = 2, etc.).

Evaluator A		Evaluator B		Evaluator C		Evaluator D	
Respondent 1	1	Respondent 1	2	Respondent 1	4	Respondent 1	3
Respondent 2	2	Respondent 2	3	Respondent 2	2	Respondent 2	1
Respondent 3	4	Respondent 3	1	Respondent 3	3	Respondent 3	2
Respondent 4	3	Respondent 4	4	Respondent 4	1	Respondent 4	4

Step 3

An average rank will be calculated for each response for all the evaluators.

Respondent 1	1+2+4+3=10÷4=**2.5**
Respondent 2	2+3+2+1=8÷4=**2.0**
Respondent 3	4+1+3+2=10÷4=**2.5**
Respondent 4	3+4+1+4=12÷4=**3.0**

Step 4

The average rankings for each response will be used to determine which respondents will be invited to participate in negotiations.

Respondent Name: _____

PART I

MANDATORY CRITERIA

This evaluation sheet will be used by the Agency for Health Care Administration's Procurement Office to designate responses as "responsive" or "non-responsive". If the answer to any of the questions in the table below falls into the "No" column, the response will be designated as "non-responsive" and will not be considered for further evaluation.

	QUESTIONS	YES	NO
A.	Does the response include the Mandatory Documentation specified in **Attachment C**, Special Conditions, Section C.39.A, from each party, if applicable? **1. Transmittal (Cover) Letter:** Signed by an individual having authority to bind the respondent, as specified in **Attachment C**, Special Conditions, Section C.39.A.1. of this ITN ☐ **2. Original Proposal Guarantee:** In an amount of **$500,000.00** as specified in **Attachment C**, Special Conditions, Section C.15 of this ITN ☐		
B.	Does the response include Page 1 of Attachment F, as required in **Attachment C**, Special Conditions, Section C.39.B. and in **Attachment F**, Past Performance – Client Reference Form?		
C.	Does the response include financial information, as required in **Attachment C**, Special Conditions, Section C.39.C., from each party, if applicable?		
D.	Does the response include the completed **Attachment J**, Cost Proposal, as required in **Attachment C**, Special Conditions, Section C.39.D?		
E.	Does the response include a signed **Attachment G**, Required Certifications, as specified in **Attachment C**, Special Conditions, Section C.14 of this ITN, from each party, if applicable?		
F.	Does the response include a signed **Attachment K**, Required Statements, as required in **Attachment C**, Special Conditions, Section C.40, of this ITN, from each party, if applicable?		
G.	Does the response include a signed **Attachment L**, Vendor Certification Regarding Scrutinized Companies Lists, as required in **Attachment C**, Special Conditions, Section C.34, of this ITN, from each party, if applicable?		

Mandatory Criteria Verified by:

_____ _____
Name (printed) Title

_____ _____
Signature Date

Financial Criteria Verified by:

_____ _____
Name (printed) Title

_____ _____
Signature Date

Respondent Name: _____

PART II

EVALUATION CRITERIA

Independent evaluators will use this sheet to assign points to all responses evaluated and designated as "responsive". Evaluations will be based on the detailed evaluation criteria components indicated in **Attachment E**, Detailed Evaluation Criteria Components.

	Maximum Raw Score Possible		Weight Factor		Maximum Points Possible
A. Mandatory Documentation					
B. Past Performance					
1. Client #1	60	**X**	2	**=**	120
2. Client #2	60	**X**	2	**=**	120
3. Client #3	60	**X**	2	**=**	120
C. Financial Information	20	**X**	10	**=**	200
D. Cost Proposal					
1. Fixed Contingency Percentage Fee (casualty recovery, estate recovery, trust and annuity recovery and Medicare and other third party payor recovery)	10	**X**	5		50
2. Fixed Per Insurance Policy Fee	10	**X**	5		50
3. HIPP Per Enrollee Fee	10	**X**	5		50
E. Technical Response					
1. Table of Contents					
2. Executive Summary					
3. Organizational Structure and History	30	**X**	1	**=**	30
4. Respondent/Subcontractor Experience and Qualifications	25	**X**	1	**=**	25
5. Project Timeliness	10	**X**	1	**=**	10
6. Vendor Systems and Data Requirements	120	**X**	1	**=**	120
7. Vendor Subcontracting	15	**X**	2	**=**	30
8. Draft Plans and Manuals	40	**X**	2	**=**	80
9. Vendor Documents	30	**X**	1		30
10. Vendor Staffing	115	**X**	1		115
11. Vendor Customer Service	85	**X**	1		85
12. Vendor Claims Repository	55	**X**	2		110
13. Vendor Case Tracking System	60	**X**	2		120
14. Vendor Web Portal	75	**X**	2		150
15. Vendor Deliverables	5	**X**	1		5

Respondent Name: _____

16. Vendor Accounting	5	**X**	1		5
17. Vendor Invoicing	5	**X**	1		5
18. Vendor Reports	5	**X**	1		5
19. Vendor Legal Action Requirements	5	**X**	1		5
20. Recovery Systems and Management	35	**X**	4		140
Total Rating:					**1780**

Evaluation Criteria Verified by:

_____ _____

Name (printed) Title

_____ _____

Signature Date

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DETAILED EVALUATION CRITERIA COMPONENTS

(Each component will be evaluated based on the point structure delineated in Section E.5)

Technical Response

1. Table of Contents

The respondent shall include a Table of Contents in its response. The Table of Contents shall contain section headings and subheadings along with corresponding page numbers. ***(No points will be awarded for the Table of Contents.)***

2. Executive Summary

The respondent shall include an executive summary, no longer than ten (10) single sided pages in length, that demonstrates the respondent's overall understanding of the Scope of Services and describes the significant features of the respondent's technical response. ***(No points will be awarded for the Executive Summary.)***

3. Organizational Structure and History

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its organizational structure and history. ***(This section is worth a maximum of 30 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's description of its experience in operating TPL programs;

b. The adequacy of the respondent's description of its experience in designing and developing case tracking systems;

c. The adequacy of the respondent's description of its experience in conducting data mining activities;

d. The adequacy of the respondent's ability to provide the services described in this ITN based on its organizational structure, history, legal structure, ownership, affiliations and location(s);

e. The adequacy of the respondent's organizational chart, including the total number of employees; and

f. The adequacy of the respondent's corporate qualifications, indicating its abilities to provide the level of services described in this ITN.

4. Respondent/Subcontractor Experience and Qualifications

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its qualifications for, and experience in proving services similar in nature to those described in this ITN as well as its proposed subcontractor's experience and qualifications, if applicable. ***(This section is worth a maximum of 25 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's experience(s) and, if applicable, its proposed subcontractor's experience(s) with managing or providing services within structured timelines;

b. The adequacy of the respondent's experience(s) with projects developing case management systems and portals;

c. The adequacy of the respondent's experience(s) and, if applicable, its proposed subcontractor's experience(s) with Medicaid, including Florida Medicaid;

d. The adequacy of any professional qualifications that the respondent and, if applicable, its proposed subcontractor's has obtained that would relate to the services described in this ITN; and

e. The adequacy of the respondent's experience(s) and, if applicable, its proposed subcontractor's experience(s) with data mining activities.

5. Project Timeliness

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its ability and proposed approach to ensuring a smooth and timely Contract implementation. ***(This section is worth a maximum of 10 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of how the respondent intends to manage a Contract with multiple priorities; and

b. The adequacy of how the respondent intends to complete all activities in order to meet required deadlines and achieve the required implementation date as expeditiously as possible.

6. Vendor Systems and Data Requirements

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the systems and data requirements, as stated in Attachment D, Scope of Services, Section D.7, Vendor Systems and Data Requirements. ***(This section is worth a maximum of 120 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's description of how the respondent intends to cooperate, coordinate and adapt its systems to the requirements of the Florida Medicaid Management Information System (FMMIS);

b. The adequacy of the respondent's description of how its operating system intends to use the same software package as the Agency (currently Windows, Office and Internet Explorer) or the most current, up-to-date software and web browser versions available;

c. The adequacy of the respondent's description of how the respondent intends to maintain sufficient information technology resources (hardware, software, and personnel) to manage the Contract resulting from this ITN and generate all data including liens, claims, fulfillment of records requests, reports, etc. required for the Contract;

d. The adequacy of the respondent's demonstration that it owns, leases or has access to computer facilities in order to be able to accept electronic data, produce electronic billings, data match electronically, generate liens, claims and records requests and produce Medicaid voids, adjustments, accounts receivables, cash receipts, provider expenditures, refunds, reports, etc. through Agency designated electronic or paper media;

e. The adequacy of the respondent's description of how the respondent intends to obtain and supply all hardware, software, communication, and equipment necessary to perform the duties associated with the Contract resulting from this ITN, and be responsible for any associated programming, equipment, installation of software, maintenance and troubleshooting at no cost to the Agency or fiscal agent;

f. The adequacy of the respondent's description of how the respondent intends to have information management processes and information systems that enable it to meet Federal and State reporting requirements, all other Contract requirements resulting from this ITN and any other applicable Federal and State laws, rules and regulations including HIPAA requirements;

g. The adequacy of the respondent's description of how the respondent intends to possess capacity sufficient to handle the workload projected for the start of the Contract resulting from this ITN, and be scalable and flexible so it can be adapted as needed, within negotiated timeframes, in response to increases in caseload estimates;

h. The adequacy of the respondent's description of how the respondent intends to ensure systems contain controls at all appropriate points of processing in order to maintain information integrity;

i. The adequacy of the respondent's description of how the respondent intends to ensure systems controls are tested in periodic and spot audits, including SAS-70 audits;

j. The adequacy of the respondent's description of how the respondent intends to establish appropriate restrictions and safeguards against unauthorized access to all non-public data entrusted to vendor staff;

k. The adequacy of the respondent's description of how the respondent intends to restrict access to information on a "need to know" basis (e.g. users permitted inquiry privileges only shall not be permitted to modify information);

l. The adequacy of the respondent's description of how the respondent intends to limit attempts to access system functions to a set number with a system function that automatically prevents further access attempts and records these occurrences;

m. The adequacy of the respondent's description of how the respondent intends to put in place measures and technical security to prohibit unauthorized access to the regions of the data communications network inside a respondent's span of control;

n. The adequacy of the respondent's description of how the respondent intends to provide for the physical safeguarding of its data processing facilities and the systems and information housed therein, as well as accountability control to record access attempts, including attempts of unauthorized access;

o. The adequacy of the respondent's description of how the respondent intends to be responsible for submitting and managing vendor staff requests for access connectivity to the State's data communications network, and the relevant information systems attached to this network, in accordance with all applicable State policies, standards and guidelines;

p. The adequacy of the respondent's description of how the respondent intends to ensure staff are properly trained to utilize Agency and vendor systems and maintain confidentiality of system passwords;

q. The adequacy of the respondent's description of how the respondent intends to allow complete global interactive access to all its systems to specified Agency staff;

r. The adequacy of the respondent's description of how the respondent shall fully utilize the data provided by the Agency in order to conduct all Contract requirements resulting from this ITN;

s. The adequacy of the respondent's description of how the respondent shall establish a secure environment to provide sufficient storage space to house all documents including paper and electronic storage media at the respondent's facility until transfer to the Florida State Records Center;

t. The adequacy of the respondent's description of how the respondent shall ensure that the operation of all of its systems is performed in accordance with Federal and State regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations;

u. The adequacy of the respondent's description of how the respondent shall ensure all staff are trained regarding their regulatory obligations under HIPAA;

v. The adequacy of the respondent's description of how the respondent shall ensure any protected health information (PHI) released shall be in accordance with HIPAA requirements as interpreted by the Agency and Agency policy;

w. The adequacy of the respondent's description of how the respondent shall ensure a HIPAA compliant medical release or HIPAA Qualified Protective Order is received prior to releasing PHI for the casualty, estate and trust and annuity components of the Contract resulting from this ITN; and

x. The adequacy of the respondent's description of how the respondent shall ensure all electronic mail communications that contain PHI are encrypted in accordance with HIPAA requirements and Agency policy.

7. Vendor Subcontracting

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the vendor subcontracting requirements, as stated in Attachment D, Scope of Services, Section D.8, Vendor Subcontracting. ***(This section is worth a maximum of 15 raw points.)***

a. The adequacy of the respondent's description of how the respondent intends to maintain full responsibility for all work performed under the resulting Contract. ***(This component is worth a maximum of 5 raw points)***; and

b. Respondent's that do not subcontract for any of the core TPL services under the resulting Contract will receive 10 raw points for this component.

8. Draft Plans and Manuals

The respondent shall demonstrate its capability to provide the services described in this ITN by submitting the following draft plans/manuals as described in Attachment D, Scope of Services, Sections D.9, Vendor Implementation; D.11, Vendor Policies and Procedures; D.12, Vendor Staffing; and D.13, Vendor Customer Service. ***(This section is worth a maximum of 40 raw points with each component being worth a maximum of 5 points each.):***

a. The adequacy of the respondent's Implementation Plan;

b. The adequacy of the respondent's Risk Management Plan;

c. The adequacy of the respondent's Disaster Recovery Plan;

d. The adequacy of the respondent's Operational Policies and Procedures Manual;

e. The adequacy of the respondent's Training Manual;

f. The adequacy of the respondent's Quality Assurance Policies and Procedures Manual;

g. The adequacy of the respondent's Organizational Chart ; and

h. The adequacy of the respondent's Outreach Plan.

9. Vendor Documents

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the Vendor Documents requirements, as stated in Attachment D, Scope of Services, Section D.10, Vendor Documents. ***(This section is worth a maximum of 30 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's description of how the respondent shall ensure all correspondence developed and used in any format for the purposes of the Contract resulting from this ITN, shall be reviewed and approved by the Agency prior to use by the respondent;

b. The adequacy of the respondent's description of how the respondent shall ensure all correspondence, written or electronic developed and used by the respondent includes its toll-free telephone number, fax number, e-mail address and website address;

c. The adequacy of the respondent's description of how the respondent shall ensure all correspondence used by the respondent shall be written in a professional and efficient manner using plain language;

d. The adequacy of the respondent's description of how the respondent shall ensure all written and verbal communication are courteous and prompt, providing accurate and sufficient information;

e. The adequacy of the respondent's description of how the respondent shall generate and submit all billing files, recoupment files (electronic and paper), financial adjustment files, cost avoidance files, and refund/expenditure forms necessary to meet the requirements of the Contract resulting from this ITN, and at no cost to the Agency; and

f. The adequacy of the respondent's description of how the respondent shall ensure all correspondence, billing files, recoupment files, reports and other documents are correct and reflect a high level of professionalism.

10. Vendor Staffing

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the Vendor Staffing requirements, as stated in Attachment D, Scope of Services, Section D.12, Vendor Staffing. ***(This section is worth a maximum of 115 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's resumes submitted for the following required positions:

- o Contract Manager;
- o Casualty Manager;
- o Estate and Trust and Annuity Manager;
- o Medicare and Other Third Party Payor Manager;
- o Other Recovery Projects Manager;
- o Quality Assurance Manager;
- o Quality Assurance/Training Staff;
- o Information Technology Manager;
- o Accounting Manager;
- o Legal Staff; and
- o Legal Support Staff

b. The adequacy of the respondent's description of how the respondent intends to ensure the full time dedication of its proposed required staff;

c. The adequacy of the respondent's description of how the respondent shall ensure staff communicate all Contract issues resulting from this ITN, to the designated Contract Manager as the single point of contact;

d. The adequacy of the respondent's description of how the respondent shall be prepared at all times to recruit credentialed, appropriately licensed, and highly qualified staff;

e. The adequacy of the respondent's description of how the respondent shall ensure staff conduct all components of the Contract resulting from this ITN, in a timely, efficient, productive, consistent, courteous and professional manner as representatives of the State;

f. The adequacy of the respondent's description of how the respondent shall measure staff productivity and quality;

g. The adequacy of the respondent's description of how the respondent shall ensure all staff are familiar with and have a general knowledge of all components of the Contract resulting from this ITN;

h. The adequacy of the respondent's description of how the respondent will ensure it employs all required positions and that there are sufficient staff to complete all requirements initially and throughout the duration of the Contract resulting from this ITN;

i. The adequacy of the respondent's description of how the respondent will ensure it employs a sufficient number of staff fluent in both English and Spanish;

j. The adequacy of the respondent's description of how the respondent will ensure it contracts for interpreter services as required;

k. The adequacy of the respondent's description of how the respondent will replace any personnel whose continued presence would be detrimental to the success of the Contract resulting from this ITN;

l. The adequacy of the respondent's description of how the respondent will make its staff available to meet with Agency staff on a regular basis, as agreed upon by the Agency to review reports and all other obligations under the Contract resulting from this ITN; and

m. The adequacy of the respondent's description of how the respondent will ensure the required positions meet with Agency staff on at least a monthly basis to discuss the status of the Contract resulting from this ITN, vendor performance, reports, planning, etc.

11. Vendor Customer Service

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the Vendor Customer Service requirements, as stated in Attachment D, Scope of Services, Section D.13, Vendor Customer Service. ***(This section is worth a maximum of 85 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's description of how the respondent will utilize one (1) toll-free telephone system (number) for all Contract components resulting from this ITN;

b. The adequacy of the respondent's description of how the respondent will ensure the toll-free telephone number is accessible nationwide;

c. The adequacy of the respondent's description of how the respondent will ensure its toll-free number only is used when communicating its telephone contact information;

d. The adequacy of the respondent's description of how the respondent will assist all callers in a professional and courteous manner while following all guidelines regarding confidentiality of Medicaid information;

e. The adequacy of the respondent's description of how the respondent will ensure the telephone system is staffed at a minimum from the business hours of 8:00 a.m. to 5:00 p.m. EST or EDT, as appropriate, Monday through Friday, excluding State of Florida observed holidays;

f. The adequacy of the respondent's description of how the respondent will provide a before and after hours message advising the caller of the days and hours of operation;

g. The adequacy of the respondent's description of how the respondent will ensure callers do not encounter a busy signal during the required days and hours of operation;

h. The adequacy of the respondent's description of how the respondent will ensure through the use of an interactive voice response system, callers can choose to speak with a "live" person, rather than continue through additional prompts;

i. The adequacy of the respondent's description of how the respondent will ensure a "live" person shall be available during the required days and hours of operation;

j. The adequacy of the respondent's description of how the respondent will ensure the "live" person is familiar with and has a general knowledge of all components of the Contract resulting from this ITN;

k. The adequacy of the respondent's description of how the respondent will ensure all telephone calls are returned within eight (8) business hours;

l. The adequacy of the respondent's description of how the respondent will provide the Agency with continuous access to its telephone system from a remote location, for the purpose of monitoring calls in real time;

m. The adequacy of the respondent's description of how the respondent will ensure the average caller wait time shall not exceed ninety (90) seconds as measured on a weekly average;

n. The adequacy of the respondent's description of how the respondent will ensure the call abandonment/loss rate shall be less than five percent (5%) as measured on a weekly average;

o. The adequacy of the respondent's description of how the respondent will ensure the call blockage rate shall be less than one percent (1%) as measured on a weekly average;

p. The adequacy of the respondent's description of how the respondent will develop and maintain a website that provides educational information regarding all components of the Contract resulting from this ITN and ways of contacting the Vendor (address, telephone, fax, e-mail); and

q. The adequacy of the respondent's description of how the respondent will respond to messages sent to its e-mail account within eight (8) business hours of receipt.

12. Vendor Claims Repository

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the Vendor Claims Repository requirements, as stated in Attachment D, Scope of Services, Section D.14, Vendor Claims Repository. ***(This section is worth a maximum of 55 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's description of how the respondent will ensure that its recovery in one Contract component resulting from this ITN, does not overlap its recovery in another Contract component;

b. The adequacy of the respondent's description of how the respondent will develop, maintain and use a completely one hundred percent (100%) web based claims repository system;

c. The adequacy of the respondent's description of how the respondent will ensure all components of the claims repository system are completely one hundred percent (100%) web based;

d. The adequacy of the respondent's description of how the respondent will ensure the claims repository system maintains all claims identified by the respondent for recovery and the status of all claims for all Contract components resulting from this ITN;

e. The adequacy of the respondent's description of how the respondent will ensure the claims repository system maintains all claims transferred to the respondent from the prior Vendor;

f. The adequacy of the respondent's description of how the respondent will completely and totally utilize the data provided by the Agency as stated in Attachment D, Scope of Services, Section D.5, Data to be Provided to the Vendor by the Agency, as a component of its claims repository system;

g. The adequacy of the respondent's description of how the respondent will have controls in place to ensure appropriate security and integrity of the claims repository system in accordance with applicable Federal and State laws;

h. The adequacy of the respondent's description of how the respondent will ensure that the Agency has complete global interactive access to the claims repository system and training on the system at no cost to the Agency;

i. The adequacy of the respondent's description of how the respondent will ensure that the Agency has complete global interactive access to the claims repository system and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

j. The adequacy of the respondent's description of how the respondent will ensure that the claims repository system is operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015; and

k. The adequacy of the respondent's description of how the respondent will ensure the claims repository can be amended or updated as required by the Agency in accordance with the best interests of the State.

13. Vendor Case Tracking System

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the Vendor Case Tracking System requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System. ***(This section is worth a maximum of 60 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's description of how the respondent will develop, maintain and use a completely one hundred percent (100%) web based electronic case tracking system;

b. The adequacy of the respondent's description of how the respondent will ensure all components of the case tracking system are completely one hundred percent (100%) web based;

c. The adequacy of the respondent's description of how the respondent will ensure the case tracking system maintains all of the case files for casualty, estate and trust and annuity recoveries;

d. The adequacy of the respondent's description of how the respondent will completely and totally utilize the data provided by the Agency as stated in Attachment D, Scope of Services, Section D.5, Data to be Provided to the Vendor by the Agency, as a component of its case tracking system;

e. The adequacy of the respondent's description of how the respondent will have controls in place to ensure appropriate security and integrity of the case tracking system in accordance with applicable Federal and State laws;

f. The adequacy of the respondent's description of how the respondent will ensure that the Agency has complete global interactive access to the case tracking system and training on the system at no cost to the Agency;

g. The adequacy of the respondent's description of how the respondent will ensure that the Agency has complete global interactive access to the case tracking system and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

h. The adequacy of the respondent's description of how the respondent will ensure that the case tracking system is operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

i. The adequacy of the respondent's description of how the respondent will ensure the case tracking system can be amended or updated as required by the Agency in accordance with the best interests of the State;

j. The adequacy of the respondent's description of how the respondent will meet the Vendor Case Tracking System requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System, Subsection M.;

k. The adequacy of the respondent's description of how the respondent will meet the Vendor Case Tracking System requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System, Subsection O.; and

l. The adequacy of the respondent's description of how the respondent will meet the Vendor Case Tracking System requirements, as stated in Attachment D, Scope of Services, Section D.15, Vendor Case Tracking System, Subsection P.

14. Vendor Web Portal

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its capability to meet the Vendor Web Portal requirements, as stated in Attachment D, Scope of Services, Section D.16, Vendor Web Portal. ***(This section is worth a maximum of 75 raw points with each component being worth a maximum of 5 points each.)***

a. The adequacy of the respondent's description of how the respondent will develop, maintain and use a completely one hundred percent (100%) web based portal;

b. The adequacy of the respondent's description of how the respondent will ensure all components of the web portal are completely one hundred percent (100%) web based;

c. The adequacy of the respondent's description of how the respondent will ensure the web portal maintains information on Medicaid providers pertaining to claims identified, recovered and refunded for the Medicare and other third party payor and other recovery projects components of the Contract resulting from this ITN;

d. The adequacy of the respondent's description of how the respondent will ensure the web portal conforms to the requirements of this ITN;

e. The adequacy of the respondent's description of how the respondent will completely and totally utilize the data provided by the Agency as stated in Attachment D, Scope of Services, Section D.5, Data to be Provided to the Vendor by the Agency, as a component of its web portal;

f. The adequacy of the respondent's description of how the respondent will have controls in place to ensure appropriate security and integrity of the web portal in accordance with applicable Federal and State laws;

g. The adequacy of the respondent's description of how the respondent will ensure that the Agency has complete global interactive access to the web portal and training on the system at no cost to the Agency;

h. The adequacy of the respondent's description of how the respondent will ensure that the Agency has complete global interactive access to the web portal and training on the complete system no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

i. The adequacy of the respondent's description of how the respondent will ensure that the web portal is operational no later than 5:00 p.m. EST or EDT as appropriate on August 1, 2015;

j. The adequacy of the respondent's description of how the respondent will ensure the web portal can be amended or updated as required by the Agency in accordance with the best interests of the State;

k. The adequacy of the respondent's description of how the respondent will ensure the web portal is made available to Medicaid providers in order for them to review and submit information;

l. The adequacy of the respondent's description of how the respondent will provide training to Medicaid providers on the web portal at no cost to the Agency or Medicaid providers;

m. The adequacy of the respondent's description of how the respondent will make the web portal available to Medicaid providers by 8:00 a.m. EST or EDT as appropriate on November 1, 2015;

n. The adequacy of the respondent's description of how the respondent will meet the web portal requirements, as stated in Attachment D, Scope of Services, Section D.16, Vendor Web Portal, Subsection Q.; and

o. The adequacy of the respondent's description of how the respondent will meet the web portal requirements, as stated in Attachment D, Scope of Services, Section D.16, Vendor Web Portal, Subsection R.

15. Vendor Deliverables

The adequacy of the respondent's capability to provide the services described in this ITN by describing its capability to meet the Vendor Deliverables requirements, as stated in Attachment D, Scope of Services, Section D.17, Vendor Deliverables. ***(This section is worth a maximum of 5 raw points.)***

16. Vendor Accounting

The adequacy of the respondent's capability to provide the services described in this ITN by describing its capability to meet the Vendor Accounting requirements, as stated in Attachment D, Scope of Services, Section D.18, Vendor Accounting. ***(This section is worth a maximum of 5 raw points.)***

17. Vendor Invoicing

The adequacy of the respondent's capability to provide the services described in this ITN by describing its capability to meet the Vendor Invoicing requirements, as stated in Attachment D, Scope of Services, Section D.20, Invoicing. ***(This section is worth a maximum of 5 raw points.)***

18. Vendor Reports

The adequacy of the respondent's capability to provide the services described in this ITN by describing its capability to meet the Vendor Reports requirements, as stated in Attachment D, Scope of Services, Section D.22, Vendor Reports. ***(This section is worth a maximum of 5 raw points.)***

19. Vendor Legal Action Requirements

The adequacy of the respondent's capability to provide the services described in this ITN by describing its approach to develop and administer the Vendor Legal Action Requirements as specified in Attachment D, Scope of Services, Section D.23, Vendor Legal Action Requirements. ***(This section is worth a maximum of 5 raw points.)***

20. Recovery Systems and Management

The respondent shall demonstrate its capability to provide the services described in this ITN by describing its approach to develop and administer the following Contract components resulting from this ITN, as specified in Attachment D, Scope of Services, Sections D.25, Casualty Recovery; D.26, Estate Recovery; D.27, Trust and Annuity Recovery; D.28, Medicare and Other Third Party Payor Recovery; D.29 Cost Avoidance; D.30, Health Insurance Premium Payment (HIPP) Program; and D.31, Other Recovery Projects. ***(This section is worth a maximum of 35 raw points with each component being worth a maximum of 5 points each.)***:

a. The adequacy of the respondent's capability to conduct the Casualty Recovery component of the Contract resulting from this ITN;

b. The adequacy of the respondent's capability to conduct the Estate Recovery component of the Contract resulting from this ITN;

c. The adequacy of the respondent's capability to conduct the Trust and Annuity Recovery component of the Contract resulting from this ITN;

d. The adequacy of the respondent's capability to conduct the Medicare and Other Third Party Payor Recovery component of the Contract resulting from this ITN;

e. The adequacy of the respondent's capability to conduct the Cost Avoidance component of the Contract resulting from this ITN;

f. The adequacy of the respondent's capability to conduct the Health Insurance Premium Payment (HIPP) Program component of the Contract resulting from this ITN; and

g. The adequacy of the respondent's capability to conduct the Other Recovery Projects component of the Contract resulting from this ITN.

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ATTACHMENT F
PAST PERFORMANCE - CLIENT REFERENCE FORM

Vendor's Name:

In the spaces provided below, the respondent shall list all names under which it has operated during the past five (5) years.

_____

_____

_____

_____

_____

If the respondent elects to submit **Non-AHCA** client references, on the following pages, the respondent shall provide the information indicated for a maximum of three (3) separate and verifiable, **Non-AHCA** clients. The clients listed must be for work similar in nature to that specified in this solicitation. The same client may not be listed for more than one (1) reference and confidential clients shall not be included. In the event the respondent has had a name change since the time work was performed for a listed reference, the name under which the respondent operated at that time must be provided in the space provided for Vendor's Name.

If the respondent elects to submit **Non-AHCA** client references, the respondent must include with its response a completed, signed with original signature and dated Evaluation Questionnaire for Past Performance, provided by a maximum of three (3) **Non-AHCA** identified (in this Attachment) client references, in individual envelopes that contain a client signature across the sealed flap. The Agency will not accept any Evaluation Questionnaire for Past Performance which is not included with a prospective vendor's response.

Clients that are listed as subcontractors in the response will not be accepted as Past Performance references under this solicitation. Entities having an affiliation with the respondent (i.e. currently parent, subsidiary having common ownership, having common directors, officers or agents or sharing profits or liabilities) may not be accepted as Past Performance references under this solicitation.

AHCA will consider a maximum of three (3) clients who will complete an Evaluation Questionnaire for Past Performance, for evaluation scoring. Responses which do not contain client references will receive a score of zero (0) for the past performance evaluation component.

AHCA reserves the right to contact references other than those identified by the respondent to obtain additional information regarding past performance. Any information obtained as a result of such contact may be used to determine whether or not the respondent is a "responsible vendor", as defined in section 287.012(25), Florida Statutes.

QUESTIONS CONTAINED ON THE EVALUATION QUESTIONNAIRE FOR PAST PERFORMANCE THAT ARE NOT SCORED ACCORDING TO THE RATING SCALE PROVIDED, WILL RECEIVE A SCORE OF ZERO (0) FOR THE QUESTION.

Note: Agency for Health Care Administration (AHCA)

NON-AHCA
CLIENT REFERENCE #1

Vendor's Name:

Client's Name:

Address:

Contract Performance Period:

Location of Services:

Brief description of the services performed by the respondent for this client:

NON-AHCA
CLIENT REFERENCE #2

Vendor's Name:

Client's Name:

Address:

Contract Performance Period:

Location of Services:

Brief description of the services performed by the respondent for this client:

NON-AHCA
CLIENT REFERENCE #3

Vendor's Name:

Client's Name:

Address:

Contract Performance Period:

Location of Services:

Brief description of the services performed by the respondent for this client:

Evaluation Questionnaire for Past Performance

QUESTIONS THAT ARE NOT SCORED ACCORDING TO THE RATING SCALE PROVIDED, WILL RECEIVE A SCORE OF ZERO (0) FOR THE QUESTION.

Vendor's Name:

Non-AHCA Client's Name:

	Score
1. Briefly describe the services, and the dates of the services, the Vendor performed for your organization:	N/A
2. Define the relationship between the Vendor and the client reference as one of the following: (circle one) Prime Vendor; or Subcontractor	N/A
3. How would you rate the Contract implementation with this Vendor? (Excellent = 5, Good = 4, Acceptable = 3, Fair = 2, Poor = 1)	
4. Did the Vendor consistently meet all of its performance/milestones deadlines? (Yes = 5; No = 0)	
5. Did the Vendor submit reports and invoices that were timely and accurate? (Yes = 5; No = 0)	
6. Did you impose sanctions on the Vendor during the last 12 months? (Yes = 0; No = 5)	
7. How would you rate the Vendor's key staff and their ability to work with your organization? (Excellent = 5, Good = 4, Acceptable = 3, Fair = 2, Poor = 1)	
8. Did Vendor staff maintain open lines of communication with your organization? (Yes = 5; No = 0)	
9. Did the Vendor's Project/Contract Manager effectively manage the Contract? (Yes = 5; No = 0)	
10. Was the Vendor's staff responsive to technical direction from your organization? (Yes = 5; No = 0)	
11. How would you rate the Vendor's customer service to clients? (Excellent = 5, Good = 4, Acceptable = 3, Fair = 2, Poor = 1)	
12. Was the Vendor's staff knowledgeable of the Contract requirements and scope of work? (Yes = 5; No = 0)	
13. Was the Vendor proactive in developing/recommending improvements for increasing the efficiency of processes? (Yes = 5; No = 0)	
14. Would you contract with this Vendor again? (Yes = 5; No = 0)	
Total Score:	

Past Performance Verified by:

Name (printed) Title

Signature Date

ATTACHMENT G
REQUIRED CERTIFICATIONS

Acceptance of Contract Terms and Conditions

I hereby certify that should my company be awarded a Contract resulting from this solicitation, it will comply with all terms and conditions specified in this solicitation and contained in the Agency Standard Contract (Attachment H).

Signature of Authorized Official _____ Date _____

Statement of No-Involvement

I hereby certify my company had no prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of the solicitation or in developing the subject program.

Signature of Authorized Official _____ Date _____

Non-Collusion Certification

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, company, or parties submitting a response; that it is in all respects made in good faith; and as the signer of the response, I have authority to legally bind the vendor to the provision of this response.

Signature of Authorized Official _____ Date _____

Organizational Conflict of Interest Certification

I hereby certify that, to the best of my knowledge, my company (including its subcontractors, subsidiaries and partners):

Please check the applicable paragraph below:

☐ Has no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract resulting from this ITN.

☐ Has included information in its response to this solicitation detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan", as outlined in Attachment C, Section C.14.

Signature of Authorized Official _____ Date _____

Certification Regarding Terminated Contracts

I hereby certify that my company (including its subsidiaries and affiliates) has not unilaterally or willfully terminated any previous Contract prior to the end of the Contract with a State or the Federal government and has not had a Contract terminated by a State or the Federal government for cause, prior to the end of the Contract, within the past five (5) years, other than those listed on page 3 of this Attachment.

Signature of Authorized Official _____ Date _____

LIST OF TERMINATED CONTRACTS

List the terminated Contracts in chronological order and provide a brief description (half-page or less) of the reason(s) for the termination. Additional pages may be submitted; however, no more than five (5) additional pages should be submitted in total.

The Agency is not responsible for confirming the accuracy of the information provided.

The Agency reserves the right within its sole discretion, to determine the vendor to be an irresponsible bidder based on any or all of the listed Contracts and therefore may reject the vendor's response.

Vendor's Name:

Client's Name:

Term of Terminated Contract:

Description of Services:

Brief Summary of Reason(s) for Contract Termination:

Vendor's Name:

Client's Name:

Term of Terminated Contract:

Description of Services:

Brief Summary of Reason(s) for Contract Termination:

ATTACHMENT H
STANDARD CONTRACT

All prospective vendors should review the proposed contract language contained below. In responding to this AHCA solicitation, a prospective vendor has agreed to accept the terms and conditions of the contract contained in this attachment. The Agency reserves the right to make modifications to this contract if it is deemed to be in the best interest of the Agency or the State of Florida. Note: If this contract is funded with federal funds, additional terms and conditions may be included at the time of contract award based on the specific federal requirements.

Contract No.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
STANDARD CONTRACT

THIS CONTRACT is entered into between the State of Florida, **AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**", whose address is 2727 Mahan Drive, Tallahassee, Florida 32308, and hereinafter referred to as the "**Vendor**", whose address is , a (type of entity), to provide .

I. THE VENDOR HEREBY AGREES:

A. General Provisions

1. To provide services according to the terms and conditions set forth in this Contract, **Attachment I**, Scope of Services, and all other attachments named herein which are attached hereto and incorporated by reference (collectively referred to herein as the "Contract").

2. To perform as an independent vendor and not as an agent, representative or employee of the Agency.

3. To recognize that the State of Florida, by virtue of its sovereignty, is not required to pay any taxes on the services or goods purchased under the terms of this Contract.

B. Federal Laws and Regulations

1. This Contract contains federal funds, therefore, the Vendor shall comply with the provisions of 45 CFR, Part 74, and/or 45 CFR, Part 92, and other applicable regulations.

2. This Contract contains federal funding in excess of **$100,000.00**, therefore, the Vendor must, upon Contract execution, complete the Certification Regarding Lobbying form, **Attachment III.** If a Disclosure of Lobbying Activities form, Standard Form LLL, is required, it may be obtained from the Agency's Contract Manager. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Agency's Procurement Office.

3. Pursuant to 2 CFR, Part 376, the Vendor must, upon Contract execution, complete the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts, **Attachment IV**.

C. Audits and Records

1. To maintain books, records, and documents (including electronic storage media) pertinent to performance under this Contract in accordance with generally accepted accounting procedures and practices which sufficiently and properly reflect all revenues and expenditures of funds provided by the Agency under this Contract.

2. To assure that these records shall be subject at all reasonable times to inspection, review, or audit by state personnel and other personnel duly authorized by the Agency, as well as by federal personnel.

3. To maintain and file with the Agency such progress, fiscal and inventory reports as specified in **Attachment I**, Scope of Services, and other reports as the Agency may require within the period of this Contract. In addition, access to relevant computer data and applications which generated such reports should be made available upon request.

4. To comply with public record laws as outlined in Section 119.0701, Florida Statutes.

5. To ensure that all related party transactions are disclosed to the Agency Contract Manager.

6. To include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

D. Retention of Records

1. To retain all financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of six (6) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of six (6) years, the records shall be retained until resolution of the audit findings.

2. Persons duly authorized by the Agency and federal auditors, pursuant to 45 CFR, Part 74 and/or 45 CFR, Part 92, shall have full access to and the right to examine any of said records and documents.

3. The rights of access in this section must not be limited to the required retention period but shall last as long as the records are retained.

E. Monitoring

1. To provide reports as specified in **Attachment I**, Scope of Services. These reports will be used for monitoring progress or performance of the contractual services as specified in **Attachment I**, Scope of Services.

2. To permit persons duly authorized by the Agency to inspect any records, papers, documents, facilities, goods and services of the Vendor which are relevant to this Contract.

F. Indemnification

The Vendor shall save and hold harmless and indemnify the State of Florida and the Agency against any and all liability, claims, suits, judgments, damages or costs of whatsoever kind and nature resulting from the use, service, operation or performance of work under the terms of this Contract, resulting from any act, or failure to act, by the Vendor, its subcontractor, or any of the employees, agents or representatives of the Vendor or subcontractor.

G. Insurance

1. To the extent required by law, the Vendor shall be self-insured against, or will secure and maintain during the life of this Contract, Workers' Compensation Insurance for all its employees connected with the work of this project and, in case any work is subcontracted, the Vendor shall require the subcontractor similarly to provide Workers' Compensation Insurance for all of the latter's employees unless such employees engaged in work under this Contract are covered by the Vendor's self insurance program. Such self insurance or insurance coverage shall comply with the Florida Workers' Compensation law. In the event hazardous work is being performed by the Vendor under this Contract and any class of employees performing the hazardous work is not protected under Workers' Compensation statutes, the Vendor shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.

2. The Vendor shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal & advertising injury and products and completed operations. This insurance will provide coverage for all claims that may arise from the services and/or operations completed under this Contract, whether such services and/or operations are by the Vendor or anyone directly employed by it. Such insurance shall include the State of Florida as an Additional Named Insured for the entire length of the Contract and hold the State of Florida harmless from subrogation. The Vendor shall set the limits of liability necessary to provide reasonable financial protections to the Vendor and the State of Florida under this Contract.

3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Vendor's current insurance policy(ies) shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) calendar days written notice. The Vendor shall provide thirty (30) calendar days written notice of cancellation to the Agency's Contract Manager.

H. Assignments and Subcontracts

To neither assign the responsibility of this Contract to another party nor subcontract for any of the work contemplated under this Contract without prior written approval of the Agency. No such approval by the Agency of any assignment or subcontract shall be deemed in any event or in any manner to provide for the incurrence of any obligation of the Agency in addition to the total dollar amount agreed upon in this Contract. All such assignments or subcontracts shall be subject to the conditions of this Contract and to any conditions of approval that the Agency shall deem necessary.

I. Return of Funds

To return to the Agency any overpayments due to unearned funds or funds disallowed pursuant to the terms of this Contract that were disbursed to the Vendor by the Agency. The Vendor shall return any overpayment to the Agency within forty (40) calendar days after either discovery by the Vendor, its independent auditor, or notification by the Agency, of the overpayment.

J. Purchasing

1. **P.R.I.D.E.**

It is expressly understood and agreed that any articles which are the subject of, or required to carry out this Contract shall be purchased from the corporation identified under Chapter 946, Florida Statutes, if available, in the same manner and under the same procedures set forth in Section 946.515(2), and (4), Florida Statutes; and, for purposes of this Contract, the person, firm or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this Agency insofar as dealings with such corporation are concerned.

The “Corporation identified” is PRISON REHABILITATIVE INDUSTRIES AND DIVERSIFIED ENTERPRISES, INC. (P.R.I.D.E.) which may be contacted at:

P.R.I.D.E.
12425 28th Street North, Suite 300
St. Petersburg, FL 33716
E-Mail: info@pride-enterprises.org
(727) 556-3300
Toll Free: 1-800-643-8459
Fax: (727) 570-3366

2. **RESPECT of Florida**

It is expressly understood and agreed that any articles that are the subject of, or required to carry out, this Contract shall be purchased from a nonprofit agency for the blind or for the severely handicapped that is qualified pursuant to Chapter 413, Florida Statutes, in the same manner and under the same procedures set forth in Section 413.036(1) and (2), Florida Statutes; and, for purposes of this Contract, the person, firm, or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this Agency insofar as dealings with such qualified nonprofit agency are concerned.

The "nonprofit agency” identified is RESPECT of Florida which may be contacted at:

RESPECT of Florida
2475 Apalachee Parkway, Suite 205
Tallahassee, Florida 32301-4946
(850) 487-1471
Website: www.respectofflorida.org

3. **Procurement of Products or Materials with Recycled Content**

   It is expressly understood and agreed that any products which are required to carry out this Contract shall be procured in accordance with the provisions of Section 403.7065, Florida Statutes.

K. Civil Rights Requirements/Vendor Assurance

The Vendor assures that it will comply with:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.
2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.
3. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.
4. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.
5. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.
6. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.
7. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.

The Vendor agrees that compliance with this assurance constitutes a condition of continued receipt of or benefit from funds provided through this Contract, and that it is binding upon the Vendor, its successors, transferees, and assignees for the period during which services are provided. The Vendor further assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to participants or employees in connection with any of its programs and activities are not discriminating against those participants or employees in violation of the above statutes, regulations, guidelines, and standards.

L. Discrimination

An entity or affiliate who has been placed on the discriminatory vendor list may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list and intends to post the list on its website. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

M. Requirements of Section 287.058, Florida Statutes

1. To submit bills for fees or other compensation for services or expenses in detail sufficient for a proper pre-audit and post-audit thereof.

2. Where applicable, to submit bills for any travel expenses in accordance with Section 112.061, Florida Statutes. The Agency may establish rates lower than the maximum provided in Section 112.061, Florida Statutes.

3. To provide units of deliverables, including reports, findings, and drafts, in writing and/or in an electronic format agreeable to both Parties, as specified in **Attachment I**, Scope of Services**,** to be received and accepted by the Contract Manager prior to payment.

4. To comply with the criteria and final date, as specified herein, by which such criteria must be met for completion of this Contract.

   This Contract shall begin upon execution by both Parties or **,** (whichever is later) and end on , inclusive.

   In accordance with Section 287.057(13), Florida Statutes, this Contract may be renewed for a period that may not exceed three (3) years or the term of the original Contract, whichever period is longer. Renewal of the Contract shall be in writing and subject to the same terms and conditions set forth in the initial contract. A renewal Contract may not include any compensation for costs associated with the renewal. Renewals are contingent upon satisfactory performance evaluations by the Agency, are subject to the availability of funds, and optional to the Agency.

   Per the Agency's policy, employees will review existing contract renewals and re-procurements with the Vendor in an effort to reduce contract payments by at least five percent (5%), but not to affect the level and quality of services.

5. The Vendor agrees that the Agency may unilaterally cancel this Contract for refusal by the Vendor to allow public access to all documents, papers, letters, or other material made or received by the Vendor in conjunction with this Contract, unless the records are exempt from Section 24(a) of Art. I of the State Constitution and Section 119.07(1), Florida Statutes.

6. To comply with Patents, Royalties, Copyrights, Right to Data, and Works for Hire/Software requirements as follows:

   The Vendor, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Vendor. The Vendor has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Vendor or is based solely and exclusively upon the Agency's alteration of the article.

   The Agency will provide prompt written notification of a claim of copyright or patent infringement and shall afford the Vendor full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Vendor may, at its option and expense procure for

the Agency the right to continue the use of, replace or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Vendor and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).

If the Vendor brings to the performance of this Contract a pre-existing patent, patent-pending and/or copyright at the time of Contract execution, the Vendor shall retain all rights and entitlements to that pre-existing patent, patent-pending and/or copyright, unless this Contract provides otherwise.

If the Vendor uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Contract, the Vendor shall disclose, in writing, all intellectual properties relevant to the performance of this Contract which the Vendor knows, or should know, could give rise to a patent or copyright. The Vendor shall retain all rights and entitlements to any pre-existing intellectual property which is so disclosed. Failure to disclose will indicate that no such property exists. The Agency will then have the right to all patents and copyrights which arise as a result of performance under this Contract as provided in this section.

If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Vendor shall refer the discovery or invention to the Agency for a determination whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Vendor in such a manner as to preserve and protect the legal rights of the Agency.

Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the Agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the state. Pursuant to Section 286.021, Florida Statutes, no person, firm, corporation, including Parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

The Agency will have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Vendor under this Contract.

All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to

the terms and conditions of this Contract.

The computer programs, materials and other information furnished by the Agency to the Vendor hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Vendor. The services and products listed in this Contract shall become the property of the Agency upon the Vendor's performance and delivery thereof. The Vendor hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Vendor hereunder, together with the products delivered and services performed by the Vendor hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, Florida Statutes, and that the Vendor shall not disclose, publish or use same for any purpose other than the purposes provided in this Contract; however, upon the Vendor first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the Vendor prior to its receipt from the Agency; (2) became known to the Vendor from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Vendor shall be free to use and disclose same without restriction. Upon completion of the Vendor's performance or otherwise cancellation or termination of this Contract, the Vendor shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Vendor's possession.

The Vendor warrants that all materials produced hereunder will be of original development by the Vendor and will be specifically developed for the fulfillment of this Contract and will not knowingly infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the Vendor shall indemnify and hold the Agency harmless from and against any loss, cost, liability or expense arising out of any breach or claimed breach of this warranty.

The terms and conditions specified in this section shall also apply to any subcontract made under this Contract. The Vendor shall be responsible for informing the subcontractor of the provisions of this section and obtaining disclosures.

7. The financial consequences that the Agency must apply if the Vendor fails to perform in accordance with this Contract are outlined in **Attachment I**, Scope of Services.

N. Sponsorship

Pursuant to Section 286.25, Florida Statutes, any nongovernmental organization which sponsors a program financed partially by state funds or funds obtained from a state agency shall, in publicizing, advertising, or describing the sponsorship of the program, state:

"Sponsored by and the State of Florida**, AGENCY FOR HEALTH CARE ADMINISTRATION.**"

If the sponsorship reference is in written material, the words "State of Florida, AGENCY FOR HEALTH CARE ADMINISTRATION" shall appear in the same size letters or type as the name of the organization.

O. Final Invoice

The Vendor must submit the final invoice for payment to the Agency no more than calendar days after the Contract ends or is terminated. If the Vendor fails to do so, all right to payment is forfeited and the Agency will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this Contract may be withheld until all reports due from the Vendor and necessary adjustments thereto have been approved by the Agency.

P. Use Of Funds For Lobbying Prohibited

To comply with the provisions of Section 216.347, Florida Statutes, which prohibits the expenditure of Contract funds for the purpose of lobbying the Legislature, the judicial branch or a state agency.

Q. Public Entity Crime

A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, Florida Statutes, for category two, for a period of thirty-six (36) months from the date of being placed on the convicted vendor list.

R. Health Insurance Portability and Accountability Act

To comply with the Department of Health and Human Services Privacy Regulations in the Code of Federal Regulations, Title 45, Sections 160 and 164, regarding disclosure of protected health information as specified in **Attachment II**, Business Associate Agreement.

S. Confidentiality of Information

Not to use or disclose any confidential information, including social security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with state and federal laws, except upon written consent of the recipient, or his/her guardian.

T. Employment

To comply with Section 274A (e) of the Immigration and Nationality Act. The Agency will consider the employment by any contractor of unauthorized aliens a violation of this Act. If the Vendor knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. The Vendor shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Contract.

U. Work Authorization Program

The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The Vendor shall only employ individuals who may legally work in the United States (U.S.) – either U.S. citizens or

foreign citizens who are authorized to work in the U.S. The Vendor shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the Vendor during the term of this Contract and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Contract.

V. Scrutinized Companies Lists

The Vendor shall complete **Attachment V**, Vendor Certification Regarding Scrutinized Companies List, certifying that it is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the Vendor agrees the Agency may immediately terminate this Contract for cause if the Vendor is found to have submitted a false certification or if the Vendor is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the Contract.

II. THE AGENCY HEREBY AGREES:

A. Contract Amount

To pay for contracted services according to the conditions of **Attachment I**, Scope of Services, in an amount not to exceed **$** , subject to the availability of funds. The State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature.

B. Contract Payment

Section 215.422, Florida Statutes, provides that agencies have five (5) business days to inspect and approve goods and services, unless bid specifications, Contract or Purchase Order specifies otherwise. With the exception of payments to health care providers for hospital, medical, or other health care services, if payment is not available within forty (40) calendar days, measured from the latter of the date the invoice is received or the goods or services are received, inspected and approved, a separate interest penalty set by the Comptroller pursuant to Section 55.03, Florida Statutes, will be due and payable in addition to the invoice amount. To obtain the applicable interest rate, please contact the Agency's Fiscal Section at (850) 412-3901, or utilize the Department of Financial Services website at www.myfloridacfo.com/aadir/interest.htm. Payments to health care providers for hospital, medical or other health care services, shall be made not more than thirty-five (35) calendar days from the date eligibility for payment is determined, and the daily interest rate is .0003333%. Invoices returned to a vendor due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the Agency. A Vendor Ombudsman, whose duties include acting as an advocate for vendors who may be experiencing problems in obtaining timely payment(s) from a state agency, may be contacted at (850) 413-5516 or by calling the State Comptroller's Hotline, 1-800-848-3792.

III. THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE:

A. Termination

1. **Termination at Will**

   This Contract may be terminated by the Agency upon no less than thirty (30) calendar days written notice, without cause, unless a lesser time is mutually agreed upon by both Parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

2. **Termination Due To Lack of Funds**

   In the event funds to finance this Contract become unavailable, the Agency may terminate the Contract upon no less than twenty-four (24) hours' written notice to the Vendor. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Agency will be the final authority as to the availability of funds. The Vendor shall be compensated for all work performed up to the time notice of termination is received.

3. **Termination for Breach**

   Unless the Vendor's breach is waived by the Agency in writing, the Agency may, by written notice to the Vendor, terminate this Contract upon no less than twenty-four (24) hours' written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. If applicable, the Agency may employ the default provisions in Florida Administrative Code Rule 60A-1.006(3).

   Waiver of breach of any provisions of this Contract shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Contract. The provisions herein do not limit the Agency's right to remedies at law or to damages.

B. Contract Managers

1. The Agency's Contract Manager's contact information is as follows:

2. The Vendor's Contract Manager's contact information is as follows:

3. All matters shall be directed to the Contract Managers for appropriate action or disposition. A change in Contract Manager by either Party shall be reduced to writing through an amendment or minor modification to this Contract by the Agency.

C. Renegotiation or Modification

1. Modifications of provisions of this Contract shall only be valid when they have been reduced to writing and duly signed during the term of the Contract. The Parties agree to renegotiate this Contract if federal and/or state revisions of any applicable laws, or regulations make changes in this Contract necessary.

2. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Agency's operating budget.

D. Name, Mailing and Street Address of Payee

1. The name (Vendor name as shown on Page 1 of this Contract) and mailing address of the official payee to whom the payment shall be made:

2. The name of the contact person and street address where financial and administrative records are maintained:

E. All Terms and Conditions

This Contract and its attachments as referenced herein contain all the terms and conditions agreed upon by the Parties.

IN WITNESS THEREOF, the Parties hereto have caused this page Contract, which includes any referenced attachments, to be executed by their undersigned officials as duly authorized. This Contract is not valid until signed and dated by both Parties.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION

SIGNED BY: _____

NAME: _____

TITLE: _____

DATE: _____

SIGNED BY: _____

NAME: _____

TITLE: _____

DATE: _____

FEDERAL ID NUMBER (or SS Number for an individual):

VENDOR FISCAL YEAR ENDING DATE:

List of Attachments included as part of this Contract:

Specify Type	Letter/ Number	Description
Attachment	I	Scope of Services (Pages)
Attachment	II	Business Associate Agreement (4 Pages)
Attachment	III	Certification Regarding Lobbying (1 Page)
Attachment	IV	Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts (1 Page)
Attachment	V	Vendor Certification Regarding Scrutinized Companies List (1 Page)

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EXHIBIT I
BUSINESS ASSOCIATE AGREEMENT

The parties to this Attachment agree that the following provisions constitute a business associate agreement for purposes of complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Attachment is applicable if the Vendor is a business associate within the meaning of the Privacy and Security Regulations, 45 C.F.R. 160 and 164.

The Vendor certifies and agrees as to abide by the following:

1. Definitions. Unless specifically stated in this Attachment, the definition of the terms contained herein shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164.

    1a. Protected Health Information. For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164, limited to the information created, received, maintained or transmitted by the Vendor from, or on behalf of, the Agency.

    1b. Security Incident. For purposes of this Attachment, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system and includes any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity.

2. Applicability of HITECH and HIPAA Privacy Rule and Security Rule Provisions. As provided by federal law, Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA), also known as the Health Information Technology Economic and Clinical Health (HITECH) Act, requires a Business Associate (Vendor) that contracts with the Agency, a HIPAA covered entity, to comply with the provisions of the HIPAA Privacy and Security Rules (45 C.F.R. 160 and 164).

3. Use and Disclosure of Protected Health Information. The Vendor shall comply with the provisions of 45 CFR 164.504(e)(2)(ii). The Vendor shall not use or disclose protected health information other than as permitted by this Contract or by federal and state law. The sale of protected health information or any components thereof is prohibited except as provided in 45 CFR 164.502(a)(5). The Vendor will use appropriate safeguards to prevent the use or disclosure of protected health information for any purpose not in conformity with this Contract and federal and state law. The Vendor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information the Vendor creates, receives, maintains, or transmits on behalf of the Agency.

4. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The Vendor is permitted to use and disclose protected health information received from the Agency for the proper management and administration of the Vendor or to carry out the legal responsibilities of the Vendor, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the Vendor obtains reasonable assurances from the person to whom the protected health information is disclosed that: (1) the protected health information will be held confidentially, (2) the protected health information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the Vendor of any instance of which it is aware in which the confidentiality of the protected health information has been breached.

5. Disclosure to Third Parties. The Vendor will not divulge, disclose, or communicate protected health information to any third party for any purpose not in conformity with this Contract without prior written approval from the Agency. The Vendor shall ensure that any agent, including a subcontractor, to whom it provides protected health information received from, or created or received by the Vendor on behalf of, the Agency agrees to the same terms, conditions, and restrictions that apply to the Vendor with respect to protected health information. The Vendor's subcontracts shall fully comply with the requirements of 45 CFR 164.314(a)(2)(iii).

6. Access to Information. The Vendor shall make protected health information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the protected health information in accordance with 45 C.F.R. 164.524.

7. Amendment and Incorporation of Amendments. The Vendor shall make protected health information available for amendment and to incorporate any amendments to the protected health information in accordance with 45 C.F.R. 164.526.

8. Accounting for Disclosures. The Vendor shall make protected health information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528. The Vendor shall document all disclosures of protected health information as needed for the Agency to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. 164.528.

9. Access to Books and Records. The Vendor shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the Vendor on behalf of the Agency, available to the Secretary of the Department of Health and Human Services ("HHS") or the Secretary's designee for purposes of determining compliance with the HHS Privacy Regulations.

10. Reporting. The Vendor shall make a good faith effort to identify any use or disclosure of protected health information not provided for in this Contract.

    10a. To Agency. The Vendor will report to the Agency, within ten (10) business days of discovery, any use or disclosure of protected health information not provided for in this Contract of which the Vendor is aware. The Vendor will report to the Agency, within twenty-four (24) hours of discovery, any security incident of which the Vendor is aware. A violation of this paragraph shall be a material violation of this Contract. Such notice shall include the identification of each individual whose unsecured protected health

information has been, or is reasonably believed by the Vendor to have been, accessed, acquired, used, or disclosed during such breach.

10b. To Individuals. In the case of a breach of protected health information discovered by the Vendor, the Vendor shall first notify the Agency of the pertinent details of the breach and upon prior approval of the Agency shall notify each individual whose unsecured protected health information has been, or is reasonably believed by the Vendor to have been, accessed, acquired, used or disclosed as a result of such breach. Such notification shall be in writing by first-class mail to the individual (or the next of kin if the individual is deceased) at the last known address of the individual or next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. Where there is insufficient, or out-of-date contract information (including a phone number, email address, or any other form of appropriate communication) that precludes written (or, if specifically requested, electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting on the Web site of the covered entity involved or notice in major print of broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside. In any case deemed by the Vendor to require urgency because of possible imminent misuse of unsecured protected health information, the Vendor may also provide information to individuals by telephone or other means, as appropriate.

10c. To Media. In the case of a breach of protected health information discovered by the Vendor where the unsecured protected health information of more than 500 persons is reasonably believed to have been, accessed, acquired, used, or disclosed, after prior approval by the Agency, the Vendor shall provide notice to prominent media outlets serving the State or relevant portion of the State involved.

10d. To Secretary of Health and Human Services (HHS). The Vendor shall cooperate with the Agency to provide notice to the Secretary of HHS of unsecured protected health information that has been acquired or disclosed in a breach.

(i) Vendors Who Are Covered Entities. In the event of a breach by a contractor or subcontractor of the Vendor, and the Vendor is a HIPAA covered entity, the Vendor shall be considered the covered entity for purposes of notification to the Secretary of HHS pursuant to 45 CFR 164.408.The Vendor shall be responsible for filing the notification to the Secretary of HHS and will identify itself as the covered entity in the notice. If the breach was with respect to 500 or more individuals, the Vendor shall provide a copy of the notice to the Agency, along with the Vendor's breach risk assessment for review at least 15 business days prior to the date required by 45 C.F.R. 164.408 (b) for the Vendor to file the notice with the Secretary of HHS. If the breach was with respect to less than 500 individuals, the Vendor shall notify the Secretary of HHS within the notification timeframe imposed by 45 C.F.R. 164.408(c) and shall contemporaneously submit copies of said notifications to the Agency.

10e. Content of Notices. All notices required under this Attachment shall include the content set forth Section 13402(f), Title XIII of the American Recovery and Reinvestment Act of 2009 and 45 C.F.R. 164.404(c), except that references therein to a "covered entity" shall be read as references to the Vendor.

10f. Financial Responsibility. The Vendor shall be responsible for all costs related to the notices required under this Attachment.

11. Mitigation. Vendor shall mitigate, to the extent practicable, any harmful effect that is known to the Vendor of a use or disclosure of protected health information in violation of this Attachment.

12. Termination. Upon the Agency's discovery of a material breach of this Attachment, the Agency shall have the right to assess liquidated damages as specified elsewhere in the contract to which this Contract is an attachment, and/or to terminate this Contract.

12a. Effect of Termination. At the termination of this Contract, the Vendor shall return all protected health information that the Vendor still maintains in any form, including any copies or hybrid or merged databases made by the Vendor; or with prior written approval of the Agency, the protected health information may be destroyed by the Vendor after its use. If the protected health information is destroyed pursuant to the Agency's prior written approval, the Vendor must provide a written confirmation of such destruction to the Agency. If return or destruction of the protected health information is determined not feasible by the Agency, the Vendor agrees to protect the protected health information and treat it as strictly confidential.

The Vendor has caused this Attachment to be signed and delivered by its duly authorized representative, as of the date set forth below.

Vendor Name:

Signatur_____ Date _____

Name and Title of Authorized Signer

EXHIBIT II
CERTIFICATION REGARDING LOBBYING
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

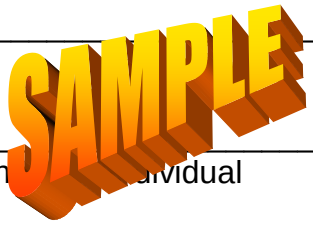
The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.



_____ _____

Signature Date

_____ _____

Name of Authorized Individual Applicable Contract Number

_____

Name and Address of Organization

EXHIBIT III
CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION
CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each Vendor whose contract/subcontract equals or exceeds $25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, Vendors who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of Vendors if they are debarred or suspended by the federal government.

2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.

3. The Vendor shall provide immediate written notice to the contract manager at any time the Vendor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.

5. The Vendor agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.

6. The Vendor further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal monies, to submit a signed copy of this certification.

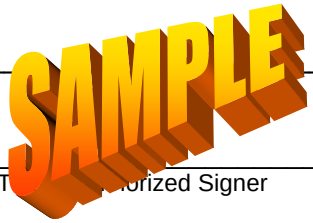
7. The Agency for Health Care Administration may rely upon a certification of a Vendor that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.

8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certifications must be kept at the contractor's business location.

CERTIFICATION

(1) The prospective Vendor certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective Vendor is unable to certify to any of the statements in this certification, such prospective Vendor shall attach an explanation to this certification.



_____ _____

Signature Date

_____

Name and T orized Signer

EXHIBIT IV
AGENCY APPROVED MODIFICATIONS
TO THE STANDARD CONTRACT

A. Section I., Item F., Indemnification, is modified as follows:

The Vendor agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.

1. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the "Duty to Indemnify and Defend"), extend to any completed, actual, pending or threatened action, suit, claim or proceeding, whether civil, criminal, administrative or investigative (including any action by or in the right of the Vendor), and whether formal or informal, in which the Agency is, was or becomes involved and which in any way arises from, relates to or concerns the Vendor's acts or omissions related to this Contract (inclusive of all attachments, etc.) (collectively "Proceeding").

    a. Duty to Indemnify. The Vendor agrees to hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages and costs of whatsoever name and description, including attorneys' fees, arising from or relating to any Proceeding.

    b. Duty to Defend. With respect to any Proceeding, the Vendor agrees to fully defend the Agency and shall timely reimburse all of the Agency's legal fees and costs; provided, however, that the amount of such payment for attorneys' fees and costs is reasonable pursuant to rule 4–1.5, Rules Regulating The Florida Bar. The Agency retains the exclusive right to select, retain and direct its defense through defense counsel funded by the Vendor pursuant to the Duty to Indemnify and Defend the Agency.

2. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Vendor pay the Agency's expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.

3. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) calendar days after written notice of such claim is delivered to the Vendor, the Agency may, but need not, at any time thereafter, bring suit against the Vendor to recover the unpaid amount of the claim (hereinafter "Enforcement Action"). In the event the Agency brings an Enforcement Action, the Vendor shall pay all of the Agency's attorneys' fees and expenses incurred in bringing and pursuing the Enforcement Action.

4. Contribution. In any Proceeding in which the Vendor is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys' fees, costs or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Vendor shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Vendor, including payment of damages, attorneys' fees and costs, without recourse against the Agency. No provision of this part or of any other section of this Contract (inclusive of all attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the state or the Agency's immunity to suit or limitations on liability; (ii) obligate the state or the Agency to indemnify the Vendor for the Vendor's own negligence or otherwise assume any liability for the Vendor's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

ATTACHMENT I
CERTIFICATION OF DRUG-FREE WORKPLACE

In the event of Identical or Tie Bids/Proposals: Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

_____ _____

Signature Date

_____

Printed Name of Signer/ Title of Signer/ Company Name

ATTACHMENT J
COST PROPOSAL

Instructions:

A. Where indicated in Table A below, the respondent shall propose a fixed contingency fee for each Recovery Project listed.

B. Where indicated in Table B below, the respondent shall propose a renewal fixed contingency fee for each Recovery Project listed.

TABLE A		
Recovery Project	**Current Rate**	**Proposed Fixed Contingency Fee**
1. Casualty Recovery, Estate Recovery, Trust and Annuity Recovery, and Medicare and Other Third Party Payor Recovery	5.81%	_____%
2. Fixed Per Insurance Policy Fee	$19.36	$_____
3. Health Insurance Premium Payment (HIPP) Program Per Enrollee Fee	$25.68 per member per month	$_____

TABLE B		
Recovery Project	**Current Rate**	**Proposed Renewal Fixed Contingency Fee**
1. Casualty Recovery, Estate Recovery, Trust and Annuity Recovery, and Medicare and Other Third Party Payor Recovery	5.81%	_____%
2. Fixed Per Insurance Policy Fee	$19.36	$_____
3. Health Insurance Premium Payment (HIPP) Program Per Enrollee Fee	$25.68 per member per month	$_____

_____ _____

Respondent Name **Name and Title of Respondent Representative**

_____ _____

Signature of Respondent Representative **Date**

ATTACHMENT K
REQUIRED STATEMENTS

1. CERTIFICATION STATEMENTS:

a. I hereby certify that my company shall make a documented good faith effort to ensure all services, provided directly or indirectly under the Contract resulting from this ITN, will be performed within the State of Florida.

Description of effort:

b. I hereby certify that my company shall ensure all services, provided directly or indirectly under the Contract resulting from this ITN, will be performed within the borders of the United States and its territories and protectorates.

2. STATEMENT OF SYSTEMS DEMONSTRATION:

I hereby certify that my company shall provide a demonstration of the following systems/portal at a negotiation meeting held with the Agency:

- Vendor Claims Repository;
- Vendor Claims Tracking System; and
- Vendor Web Portal

_____

Name and Title of Authorized Official

_____ _____

Signature of Authorized Official Date

FAILURE TO SUBMIT ATTACHMENT K, REQUIRED STATEMENTS, SIGNED BY AN AUTHORIZED OFFICIAL, WILL RESULT IN THE REJECTION OF A PROSPECTIVE VENDOR'S RESPONSE.

VENDORS ARE NOT AUTHORIZED TO MODIFY AND/OR MAKE CAVEAT STATEMENTS TO ATTACHMENT K, REQUIRED STATEMENTS. SUCH ACTIONS WILL RESULT IN REJECTION OF THE VENDOR'S RESPONSE.

ATTACHMENT L
VENDOR CERTIFICATION REGARDING SCRUTINIZED COMPANIES LISTS

Respondent Vendor Name: _____

Vendor FEIN: _____

Vendor's Authorized Representative Name and Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Email Address: _____

Section 287.135, Florida Statutes, prohibits agencies from contracting with companies, for goods or services over $1,000,000, that are on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. Both lists are created pursuant to section 215.473, Florida Statutes.

As the person authorized to sign on behalf of the Respondent, I hereby certify that the company identified above in the section entitled "Respondent Vendor Name" is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. I understand that pursuant to section 287.135, Florida Statutes, the submission of a false certification may subject company to civil penalties, attorney's fees, and/or costs.

Certified By: _____,

who is authorized to sign on behalf of the above referenced company.

Authorized Signature: _____

Print Name and Title: _____

State of Florida
AGENCY FOR HEALTH CARE ADMINISTRATION

SUBJECT: Information Technology Security Plan
POLICY/PROCEDURE NUMBER: #02-IT-01
DIVISION: Information Technology **BUREAU: IT Strategic Planning & Security**

1.0 PURPOSE

The purpose of the Agency for Health Care Administration (AHCA) Information Technology Security Plan (ITSP) is to ensure that the security of the information and communication processing resources of AHCA is sufficient to minimize the risk of loss, theft, improper use, or unauthorized destruction, disclosure or modification of those assets. The objectives of the ITSP are to:

- Establish AHCA policies regarding the security of Information Resources.
- Identify confidential information and take steps to protect such confidential information from loss, theft, improper use, or unauthorized destruction, disclosure or modification.
- Identify which information Resources are essential to the continued operation of critical governmental functions and take steps to ensure their controlled confidentiality, integrity and availability.
- Apply security controls which can be cost justified, considering the exposure to risk.
- Ensure the accuracy and integrity of data and automated processes.
- Educate employees and Information Resource Provider personnel concerning their responsibilities for maintaining the security of Information Resources.
- Adhere to requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2.0 SCOPE

The policy and standards set forth in this document will apply to all Information Resources within the Agency for Health Care Administration. They will apply equally to all AHCA employees.

AHCA's ITSP also applies to Information Resource Providers in those cases where AHCA has a statutory, contractual or fiduciary duty to protect the resources while in the custody of AHCA. In the event of a conflict, the more restrictive security measures apply. A Provider's failure to comply with these policies will be viewed as breach of contract.

3.0 AUTHORITY

A) Florida Administrative Code, Rule Chapter 60DD
B) Title 17 of the United States Code
C) Health Insurance Portability and Accountability Act of 1996 (HIPAA)
D) Chapter 815 Florida Statutes (2006) Computer-Related Crimes

4.0 POLICY

It is the policy of the Agency for Health Care Administration that:

1) An internal Information Technology Security Plan will be established in AHCA that will be responsive and adaptable to changing environments, vulnerabilities and technologies affecting State Information Resources. Appropriate personnel will be appointed with sufficient authority to oversee and administer the Plan.
2) Confidential Information will be protected from unauthorized access to include that which is transferred between entities.
3) Information Resources that are essential to critical State functions will be protected from unauthorized access. These Information Resources will be identified and appropriate measures will be taken to safeguard them, including provisions for protection and recovery.
4) Access requirements for Information Resources must be documented and strictly enforced.
5) The integrity of all confidential Information, its source, destination and processes applied to it must be assured. Data must change only in authorized, predictable, auditable and acceptable ways.
6) Security needs will be considered and addressed in all phases of development and acquisition of new information processing systems. Where conflict may exist in operational roles, steps will be taken to separate functions.
7) Information backup and Disaster Recovery Plans required to continue critical governmental services will be developed and maintained.
8) Agency employees and Providers will comply with all rules and regulations governing proper utilization of Agency Information Resources.
9) Security awareness will be continually emphasized and reinforced. Individuals will be accountable for their actions and dealt with on an individual basis per the policies and procedures outlined in the Agency Employee Handbook when breaches are discovered.
10) Procedures for recording and responding to security breaches will be maintained by the AHCA Computer Incident Response Team (CSIRT).

5.0 DEFINITIONS

Intellectual Property - A broad category of intangible materials that are legally recognized as proprietary to an organization. In the computer field, hardware circuits, software and text are copyrightable. Depending on the situation, the algorithms used within hardware circuits and software may also be patentable, and most brand names can be trademarked. However, IP covers more than just copyrights, trademarks and patents; for example, customer databases, mailing lists, trade secrets and other business information are also included.

Information Resources – Information Resources can be divided into two groups**:**

Information Physical Resources: such as servers, communications equipment, PCs, laptops, Blackberry pagers, Personal Digital Assistants (PDAs), etc.; and

Information Data Resources: such as information stored on these devices such as databases, data files, electronic documents, etc.; and Operating Systems, Utilities, Applications, etc.

Confidential Information – Information that is legally protected, or Protected/Patient Health Information (PHI) as defined by HIPAA, or any other information as deemed confidential by the Agency.

Confidential Software – Operating Systems, Utilities, Applications or similar software where by their very nature can be used to access confidential Information or could be copied and used in violation of copyright agreements.

Critical Information Resources— the resources determined by agency management to be essential to the agency's critical mission and functions, the loss of which would have an unacceptable impact.

Information Resource Provider – Examples are: outsourced vendors and political subdivisions of the State or agencies of the Federal government,

6.0 RESPONSIBILITIES

1) **Secretary, AHCA**- The Secretary, AHCA is responsible for designating AHCA's Information Security Manager, in writing. The Information Technology Security Plan (ITSP) is issued under the Secretary's signature.

2) **Information Security Manager (ISM)**- The ISM is responsible for overall development, implementation, administration, and coordination of the ITSP. The ISM will report via the AHCA Chief Information Officer (CIO), via the next level of AHCA management (Division Director), to the Secretary, AHCA. The ISM has the responsibility for:
   a) Assisting in determination of control requirements for all application systems;
   b) Determining the level of security classification appropriate for Information Resources;
   c) Ensuring procedures are in place to revoke access authorizations due to:
      i. personnel changes,
      ii. changes in job duties (access no longer required), and/or
      iii. a breach in security.
   d) Ensuring procedures are in place requiring all positions in AHCA to have signed the required Statement acknowledging their understanding of the ITSP;
   e) Acting as a contact point for distribution and management of security policies, procedures, and training;
   f) Conducting periodic risk analysis of threats to Confidential Information and Information Resources;
   g) Identifying safeguards and inform personnel of measures to eliminate, reduce or recover from threats;
   h) Developing and maintaining a disaster recovery or contingency plan;
   i) Ensuring AHCA personnel are provided opportunities for security awareness training;
   j) Monitoring development/changes in governing directives and informing management of actions necessary to maintain AHCA operations consistent with those directives;
   k) Appointing appropriate personnel, with approval of the Secretary, AHCA, to serve as members of the Information Security Work Group; and
   l) Maintaining adequate documentation on all of the above responsibilities.
   m) Developing AHCA information security standards, directives, procedures, and controls through regular reviews and when necessary, updates of the ITSP with the Chief Information Officer's approval.

3) **Information Security Work Group (ISWG)**- The ISM will appoint personnel to the Information Security Work Group. The ISM will have discretion to further augment this "advisory" work group, which will minimally include the Data Security Administrators and IT Data Processing Managers. The work group is responsible for:
   a) Ensuring that AHCA's Information Resources are identified, that all Information Resources are assigned ownership, and that the duties of Owners are prescribed;
   b) Reporting to management periodically on AHCA security posture and progress, including problem areas with recommended corrective action.
   c) Completing the Division's Procedures that document compliance with the Standards and Directives contained herein.

4) **Data Security Administrator (DSA)**- A full-time employee located in each Division office will be appointed by their respective Division Director as the Data Security Administrator for the Division. Data Security Administrators are responsible for:
   a) Managing the development, implementation and testing of security controls: directing efforts for including security safeguards in the development of their respective systems;
   b) Overseeing procedures for password control and for secure distribution of encryption keys (if applicable) to their respective system;
   c) Investigating breaches in security with the assistance of appropriate security, auditing and legal staff;
   d) Fulfilling the responsibilities assigned as members of the Information Security work group.

5) **Information Resource Owner (Owner)**- The Information Resources Owner is the designated Senior Management individual who is responsible for carrying out the program that uses the Information Resource(s). The Owner is responsible for:
   a) Judging the value of the information and classifying it;
   b) Ensuring that a Data Security Administrator is assigned to each major system and that the duties of the function are defined;
   c) Assigning an Information Resource Approver for each Information Resource;
   d) Specifying procedures and conveying them to the Approvers and Users of the information;
   e) Ensuring that valid User lists are current and auditable; and
   f) Ensuring compliance with the applicable controls.

6) **Information Resource Approver (Approver)**- The Information Resource Approver is the individual assigned responsibility for:
   a) Providing physical and procedural safeguards for the information;
   b) Implementing procedures specified by the Owners of the information;
   c) Administering access to the information;
   d) Assisting the Owners in evaluating the cost-effectiveness of the controls; and
   e) Making provisions for timely detection, reporting and analysis of unauthorized attempts to gain access to Information Resources.

7) **Information Resource User (User)**- The User (i.e. employees of the Agency) has the responsibility for:
   a) Using the information only for the purpose intended by the Owner;
   b) Complying with all controls established by the Owner and Approver;
   c) Protecting confidential Information against unauthorized disclosure; and
   d) Notifying Owners and Approvers of possible security breaches.

8) **User's Supervisor**- The User's supervisor has the responsibility for:
   a) Ensuring all personnel are thoroughly trained/informed of the requisite security requirements, their individual security responsibilities and the consequences of non-compliance with those requirements and responsibilities; and
   b) Supporting AHCA in the monitoring and enforcement of the ITSP. Security breaches or suspicion of such occurrences should be immediately reported to the Information Security Manager.

9) **Information Resource Provider (Provider)-** The Information Resource Provider has the responsibility for:
   a) Complying with provisions of the ITSP as it applies to the Provider's information and/or system;
   b) Informing AHCA ISM of any conflicts between the Providers' security requirements and AHCA's security requirements. Conflicts will be addressed in a timely manner. The more stringent security requirements will be preferred in most cases, and will always be preferred in cases where those requirements are dictated by legal rules and regulations which are superior to State or AHCA policy and standards;
   c) Ensuring all personnel employed by the Provider are thoroughly informed of AHCA's security requirements; and
   d) Supporting AHCA in the monitoring and enforcement of the ITSP within the Provider's area of responsibility. Security breaches or suspicion of such occurrences should be immediately reported to the Information Security Manager.

10) **Unsupported Information Resources -** The Senior Manager responsible for Information Resources that have been acquired without formal approval of the Division of Information Technology (IT) has the responsibility for:
   a) Complying with provisions of the ITSP as it applies to the Information Resource;
   b) Informing the ISM of any conflicts between the Information Resource's security requirements and AHCA's security requirements. Conflicts will be addressed in a timely manner. The more stringent security requirements will be preferred in most cases, and will always be preferred in cases where those requirements are dictated by legal rules and regulations which are superior to State or AHCA policy and standards; and
   c) Supporting the ISM in the monitoring and enforcement of the ITSP within the Division's area of responsibility. Security breaches or suspicion of such occurrences should be immediately reported to the ISM.

7.0 STANDARDS - *Unless otherwise explicitly stated, each Division Director is responsible for ensuring that written procedures are developed and kept current for his or her area of responsibility to comply with all stated Directives throughout the ITSP.*

AREA 1: General Applicability - Scope of Authority and Exceptions

STANDARD 1.1: **Information Technology Security Plan**
AHCA will document and maintain an up-to-date internal Information Technology Security Plan (ITSP). This plan will include internal policies and procedures for the protection of Information Resources, be an instrument implementing State information policies and standards, be applicable to all elements of AHCA and be signed by the Secretary, AHCA.

Directive 1.1.1
The ISM will be responsible for maintaining the ITSP and ensure compliance with HIPAA consistent with the recommendations of the General Counsel's Office.
Directive 1.1.2
Changes to security procedures must be recorded by the ISM. No change may become effective until the ISM has received the information.
Directive 1.1.3
The ISM will conduct regular Risk Analysis Assessments.
Directive 1.1.4
Division Directors having responsibility for Unsupported Information Resources have the responsibility to comply with the ITSP in full and document its compliance to the ISM.

STANDARD 1.2: **Information Security Manager**
The Secretary, AHCA will appoint in writing an ISM to administer AHCA's ITSP and will prescribe the duties and responsibilities of the function.

Directive 1.2.1
The AHCA CIO will recommend a qualified individual as the ISM to the Secretary, AHCA.

STANDARD 1.3: **Identification of Information Resource Owners, Approvers and Users**
Owners, Approvers and Users of Information Resources will be identified, documented and their responsibilities defined. All Information Resources shall be assigned an Owner. In cases where Information Resources are aggregated for purposes of ownership, the aggregation shall be at a level which assures individual accountability.

Directive 1.3.1
Owners and their responsibilities will be identified by the Division Director within the area of AHCA that is responsible for the collection or existence of the information.
Directive 1.3.2
Approvers will be designated by the Owners of the information and their responsibilities identified.
Directive 1.3.3
Users and their scope of use will be identified as appropriate by the Owners of information.
Directive 1.3.4
The ISM will maintain a current inventory of all Information Resources, their Owners and Approvers.

AREA 2: Software Ownership and Access to Software and Data

STANDARD 2.1: Access to Confidential Information

Confidential Information will be accessible only to personnel who are authorized by the Owner on the basis of strict "need to know" in the performance of their duties. Data containing any Confidential Information will be readily identifiable and treated as Confidential in its entirety.

Directive 2.1.1
Confidential data resources shall be labeled by its Owner and inventoried by the ISM.

Directive 2.1.2
Permission for access to Confidential Information will be granted only with the approval of the Owner of such information.

Directive 2.1.3
Owners of Confidential Information will develop a stricter standard of criteria for access to that information than for public access information.

Directive 2.1.4
The Owners of Confidential Information will ensure that access to systems containing such information is controlled. In addition, the Owners will ensure that access to such information via manual documentation, faxes, e-mails, voice mails, etc. is restricted to authorized users.

Directive 2.1.5
The ISM is responsible to ensure all retired Information Resources are disposed of properly to ensure the adequate destruction of Confidential Information.

STANDARD 2.2: Use of State Information Resources

All Information Resources will be used only to conduct State business in accordance with Agency Policy. Access will be limited to those individuals authorized to view, process or maintain particular Information Resources.

Directive 2.2.1
Information Resources may be utilized solely in the execution of State business.

Directive 2.2.2
Users of Information Resources shall be responsible for the security of those resources under their control.

Directive 2.2.3
The Owner will determine the criteria for authorized access to any Information Resources under control of AHCA. The Owner will maintain an updated list of Approvers and provide such list to the ISM upon request.

Directive 2.2.4
The Owner will ensure that access criteria to an Information Resource will be communicated to the Approver in a manner and form conducive to the objective of the request. The Approver will keep and maintain an updated list of Users.

Directive 2.2.5
Information Resources shall be made available to Users based on their need to use the resources to accomplish tasks assigned to their position, or contract, with AHCA.

Directive 2.2.6
Only software, which has been procured, developed, or licensed by AHCA, shall be installed or used on any AHCA computer. Exceptions to this Directive must be approved in writing by the CIO.

Directive 2.2.7
The ISM will maintain a complete, comprehensive, and updated list of all AHCA Information Data Resources, their Owners and authorized Approvers, Users, and Providers where appropriate.
Directive 2.2.8
Peer-to-peer file sharing services waste large amounts of state resources and open Agency information resources to malware. The primary use for these services is illegal sharing of licensed materials. Unless a peer-to-peer file sharing service is shown to have a legitimate government purpose, it will not be utilized on the AHCA network.

STANDARD 2.3: Handling Confidential Information
An auditable, continuous chain of custody will record the transfer and confidentiality of Confidential Information. When AHCA sends or receives Confidential Information to and/or from a Provider in connection with the transaction of official business, AHCA and the Provider will maintain the confidentiality of the information in accordance with the conditions imposed by the providing party and the terms of this Policy and relevant HIPAA requirements.

Directive 2.3.1
Each Division will develop procedures to document the transfer of Confidential Information**.**
Directive 2.3.2
AHCA will maintain the confidentiality level of Confidential Information transferred by another entity or as required by law.
Directive 2.3.3
Where applicable, AHCA will maintain a mechanism for obtaining consent for the use and disclosure of health information.

STANDARD 2.4: Ownership and Control of Software
All computer software developed by State employees or contract personnel on behalf of the State, or purchased for the use of the State, is State property and will be protected as such, unless the contract under which the software is developed specifically provides otherwise. Controls will ensure that no one can access software or system control information unless they have been authorized to do so.

Directive 2.4.1
Each Division will ensure that all software licenses and all AHCA purchased or internally developed software are inventoried.
Directive 2.4.2
Applications developed by Agency staff or under contract with the Agency may bear a copyright notification reserving rights to AHCA.
Directive 2.4.3
Each Division shall support and uphold the legitimate proprietary interests of Intellectual Property holders.
Directive 2.4.4
Installation of any software will be under the approval of the AHCA CIO.

Directive 2.4.5
All installed software and systems control information (e.g. network address tables, user-id and password files, etc.) will have restricted access where applicable.

AREA 3: Physical Security and Access to Data Processing Facilities

STANDARD 3.1: Computer Resource Center.
AHCA's Computer Resource Center (CRC) shall be housed in a secure area, protected by a defined security perimeter, with appropriate security barriers and entry controls.

Directive 3.1.1
The ISM will ensure that physical access to the CRC will be controlled.
Directive 3.1.2
The ISM will ensure that access by visitors to the CRC shall be recorded and supervised.
Directive 3.1.3
The ISM will regularly review and update access rights to the CRC.
Directive 3.1.4
The CIO will approve access rights to the CRC.

STANDARD 3.2: Other Information Processing Facilities.
Communication switches and network components outside the central computer room shall receive the level of physical protection necessary to prevent unauthorized access.

Directive 3.2.1
The ISM will document which Information Resource facilities are covered by this Standard and communicate that to AHCA management. The ISM will designate one or more persons responsible for the security of each facility.
Directive 3.2.2
The Division with administrative control (i.e. primary physical access) over wiring closets, communications and server rooms, will ensure that they are properly secured to protect the Information Resources and to not allow unauthorized access to Confidential Information.

STANDARD 3.3: Environmental Controls.
Proper controls over temperature, humidity, air movement, cleanliness, and power shall be maintained within vendor specifications to avoid computer downtime and malfunctions. The division with administrative control shall designate and train employees to monitor environmental control procedures, equipment and response procedures in case of emergencies or equipment problems.

Directive 3.3.1
Environmental control requirements will be considered during the design and planning phase in acquisition of new facilities and systems.

STANDARD 3.4: Power Supplies.
Equipment shall be reasonably protected from power failures and other electrical anomalies. A suitable electrical supply shall be provided which:

a) may include an uninterruptible power supply (UPS) for equipment supporting critical business operation to support orderly shut down or continuous running. Equipment shall be regularly checked to ensure it has adequate capacity and tested in accordance with the manufacturer's recommendations;
b) may include a back-up generator;
c) may include multiple feeds to avoid a single point of failure in the power supply; and/or
d) may include surge protection devices.

Directive 3.4.1
The ISM will document which Information Resource facilities or specified equipment within each facility are covered by this Standard.

STANDARD 3.5: Cabling Security.
Power and telecommunications cabling carrying information or supporting information services shall be protected from interception or damage.

Directive 3.5.1
The ISM will document what existing power and/or cabling is covered by this Standard and communicate that to AHCA management for appropriate protective action.

STANDARD 3.6: Security of Equipment
Regardless of ownership, the use of any equipment (inside or outside the Agency's premises) for information processing of state business requires approval of AHCA management. The security provided off-site equipment should be equivalent to that for on-site equipment used for the same purpose, taking into account the risks of accessing AHCA data while working outside the Agency's premises. Information processing equipment may include, but is not limited to, all forms of personal computers, personal digital assistants, mobile telephones, or similar devices, which are held for home working or are being transported away from the normal work location.

Directive 3.6.1
Each Division will ensure that any vendor providing outsourced services to that Division will adhere to the ITSP policies as a minimum standard.
Directive 3.6.2
Each Division will document the appropriate security procedures for all IT approved devices. AHCA management will ensure that their employees strictly adhere to the approved device list and related security procedures. In the case that AHCA management approves the purchase of any devices not approved by IT, is their responsibility to ensure that those devices provide the equivalent security of on-site equipment.

AREA 4: Logical and Data Access Controls

STANDARD 4.1: Personal Identification, Authentication and Access

Except for public users of Information Resources where such access is authorized or for situations where risk analysis demonstrates no need of individual accountability of users, each User of a multiple-user Information Resource will be assigned a unique personal identifier or User identification. User identification will be authenticated before access is granted.

Directive 4.1.1 (Unique identification)

The Owner will ensure that unique identification will be assigned to Users, Programs, or Processes (e.g. entry of Confidential Information into a computer program) of Information Resources.

Directive 4.1.2 (Authorization)

User, Program, or Process identification shall be granted in writing by the appropriate supervisory level for the purpose of Information Resource access.

Directive 4.1.3 (Authentication)

The actual access to information shall require User, Program, or Process identification authentication.

STANDARD 4.2: Access Cancellation/Removal

A User's access authorization will be removed when the User's employment is terminated or the User transfers to a position where access to the Information Resources is no longer required.

Directive 4.2.1

The User's supervisor will notify the Division of Information Technology by using the Network Access Form to ensure that Information Resource privileges will be immediately revoked when a User's relationship is terminated or when it is determined that a User no longer requires access.

STANDARD 4.3: Password Conformance

Systems which use passwords will conform to the standard developed by the ISM.

Directive 4.3.1

The Owner will ensure that all systems that access Confidential Information will require a password.

Directive 4.3.2

The Owner will ensure that Passwords will conform to the ITSP standard to be developed by the ISM.

Directive 4.3.3

Users are responsible for protecting unauthorized access to Confidential Information through the use of their PC by the proper application of network and system sign-on passwords, locking their PCs through the use of the network Lock Workstation function, the use of screen saver passwords.

STANDARD 4.4: Data Integrity

Controls will be established to ensure the accuracy and completeness of information. Information Resource Owners will ensure that information comes from the appropriate source for the intended use.

Directive 4.4.1

Appropriate programming logic checks assessing information accuracy and completeness will be determined by the Information Resource Owners.

Directive 4.4.2

Review processes will be established by the Owners in their respective Division's Information Technology Security Plan to safeguard the accuracy of the information.

Directive 4.4.3

Owners and Approvers will ensure that the information comes from the appropriate source and has not been altered or destroyed in an unauthorized manner.

Directive 4.4.4

Information Technology will ensure that Information Resources under its control will be protected from corruption and loss due to computer viruses. Division Directors will take responsibility for any Information Resources not under IT's control.

Directive 4.4.5

Information resource owners will ensure that appropriate safeguards will be employed to protect data while transmitted or stored electronically.

STANDARD 4.5: Separation of Functions

Owners will identify tasks which are susceptible to fraud or other unauthorized activities and develop procedures for these tasks that ensure adequate separation of functions and supervisory review to mitigate the risk of inappropriate activity.

Directive 4.5.1

The tasks which are susceptible to fraud or other unauthorized activities will be determined by the Owner and procedures that ensure adequate separation will be developed.

STANDARD 4.6: Testing Controls and Program Maintenance

The test functions will be kept either physically or logically separate from the production functions.

Directive 4.6.1

Processes to migrate application software and data from test environments to production environments will be established through a Change Control Process.

Directive 4.6.2

Processes to implement new operating systems software and new third-party software will be established through a Change Control Process.

Directive 4.6.3

Where appropriate (i.e. where the installation or migration could potentially impact production systems) processes to implement new hardware will be established through a Change Control Process.

AREA 5: Network Security

STANDARD 5.1: Resource Sensitivity

Network resources participating in the transmission of Confidential Information will have the necessary security features installed to ensure the protection of that information. Controls will be implemented commensurate with the appropriate risk.

Directive 5.1.1

Information Technology shall be responsible for the security of the network resources which they control and request periodic review of compliance with the ITSP of network resources under the control of outside entities (e.g. Department of Management Services, Providers, etc.).

Directive 5.1.2

The network will contain automated alarms, where appropriate, that will sense and report on abnormal conditions.

STANDARD 5.2: Encryption Requirement

While in transit, Confidential Information or information which in and of itself is sufficient to authorize disbursement of state funds will be encrypted if the complete network is not under positive state control, or if any portion of the network is accessible to personnel who have not been authorized access to the information.

Directive 5.2.1

Owners, with approval of the Secretary, AHCA can authorize acceptance of the risks of not encrypting the information based on evaluation of the costs of encryption against exposures to all relevant risks.

Directive 5.2.2

Owners shall conduct risk analysis to determine encryption requirements for information in transit.

Directive 5.2.3

IT will ensure that the most appropriate encryption standard will be utilized taking into consideration the network infrastructure, applications, and information to be encrypted.

Directive 5.2.4

Outgoing AHCA exchange e-mail will be scanned for possible confidential information, automatic encryption should take place on such e-mail.

STANDARD 5.3: Network Access

For services other than those authorized for the public, Users of AHCA network services will have their identity authenticated (e.g. by userid and password) to the systems being accessed.

Directive 5.3.1

Remote dial-up, wireless, and VPN access will be subject to established personal identification and password authentication controls.

Directive 5.3.2

Controls will be installed, where appropriate, to control and monitor access to the network by dial-up, wireless, and VPN devices.

AREA 6: Backup and Business Recovery

STANDARD 6.1: Backing up of Data

Data and software essential to the continued operation of critical AHCA functions will be backed up. The security controls over the backup resources will be at least as stringent as the protection required of the primary resources.

Directive 6.1.1

Adequate system and information backups will be performed on a regular basis and stored in one or more secured, off-site area(s). If AHCA elects to contract with a Provider to house the data backups, the Provider's security procedures will need to be at least as stringent as the relevant Directives contained within the ITSP.

Directive 6.1.2

Backup logs and restore testing will be performed to insure archival integrity.

Directive 6.1.3

The IT Database Administrator will ensure that appropriate database archiving facilities allow adequate backup of all production database information.

Directive 6.1.4

Each user is responsible for backing up the data that is essential to critical State functions which is not stored on a central AHCA server (including, but not limited to, data stored on the user's PC, thumb drive, diskettes, CD's, or any other digital storage medium). It is each user's responsibility to ensure the security of such backup data by protecting it commensurate with its business value to AHCA in fulfilling the agency's duties and responsibilities.

Directive 6.1.5

Other Information Resources not maintained by IT and containing Confidential Information will be backed up by the responsible division on a documented regular schedule and stored in a secure, off-site area.

Directive 6.1.6

Retention schedules shall be established for all backups maintained by the Agency.

STANDARD 6.2: Disaster Recovery and Business Continuity Planning

All Information Resource Owners', Approvers' and Users' functions identified as critical to the continuity of governmental operations will have written and cost effective contingency plans to provide for the prompt and effective continuation of critical State missions in the event of a disaster. These plans will be developed by the Division of Information Technology and the Bureau of Support Services.

Directive 6.2.1

An Information Technology Disaster Recovery Plan (ITDRP) will be developed and maintained by the Division of Information Technology for those Information resources under its positive control in coordination with each respective division.

Directive 6.2.2

Information resources not under the Division of Information Technology's direct control will be the responsibility of the respective division to ensure appropriate ITDRP and Continuity of Operations Plans (COOP) are developed, maintained and periodically tested.

Directive 6.2.3

A Continuity of Operations Plan (COOP) will be developed and maintained by the Bureau of Support Services.

Directive 6.2.4

Scheduled testing of the ITDRP and COOP will be controlled by the appropriate plan administrators.

AREA 7: Personnel Issues, Security Awareness and Training

STANDARD 7.1: General Employee Requirements

Every employee will be held responsible for Information Resource security to the degree that his or her job requires the use of Information Resources. Fulfillment of security responsibilities is mandatory. The AHCA is authorized to and will enforce compliance with security responsibilities through disciplinary actions, up to and including dismissal, civil penalties or criminal penalties.

Directive 7.1.1
Each employee is responsible for the Information Resource under his/her control.
Directive 7.1.2
Each employee has a duty to secure Information Resources.
Directive 7.1.3
AHCA will discipline, and/or refer to appropriate agencies for prosecution, employees who violate security policies, standards and directives.

STANDARD 7.2: Security Awareness

The AHCA will provide an ongoing awareness program in information security and in the protection of Information Resources for all personnel whose duties bring them into contact with Confidential Information. Security awareness for personnel will be ongoing. Security awareness will not be limited to formal training sessions, but will include ongoing briefings and continual reinforcement of the value of security consciousness.

Directive 7.2.1
Ongoing security awareness will be provided to all AHCA personnel by the respective Division's Data Security Administrator with assistance from the ISM.
Directive 7.2.2
Each Division of AHCA will be responsible for providing training or security awareness notification of appropriate procedures for handling Confidential Information specific to each unit. Records of training will be maintained by the Division.
Directive 7.2.3
The Information Resource Owner will ensure that non-AHCA personnel (i.e. Providers, etc.) also receive appropriate training.

AREA 8: Audits, Incident Reporting, and Response

STANDARD 8.1: Systems Acquisition
Appropriate information security and audit controls will be incorporated into new and existing systems that contain Confidential Information.

Directive 8.1.1
Owners of new Information Resources will determine if the resource is public or confidential and the ISM will implement appropriate measures.
Directive 8.1.2
All proposed purchases of hardware, network, software, and database components; and all developed software must be capable of conforming to all security-related standards.
Directive 8.1.3
Security components will be included in User training for newly developed or acquired Information Resources.

STANDARD 8.2: Audit of the Security Function
Audits and Assessments of the AHCA information security function will be performed on a periodic basis, when there are major system changes, or as directed by the Secretary, AHCA.

Directive 8.2.1
Periodic reviews and audits of system access to Confidential Information will be conducted by the ISM.
Directive 8.2.2
The Inspector General will perform required internal audits of AHCA information security function and systems.

STANDARD 8.3: Transaction History
The Division of Information Technology will maintain the ability to track access to Confidential Information
Directive 8.3.1
Access to Confidential Information shall be monitored.
Directive 8.3.2
Auditing capabilities will be implemented for the purpose of identifying attempted unauthorized access to the Information Resources.

STANDARD 8.4: Incident Reporting
Any actual or suspected security incidents and breaches or violations will be promptly investigated and reported to the appropriate authorities.

Directive 8.4.1
Any individual who becomes aware of a breach or suspected breach of security shall immediately report it to their supervisor and the ISM. Procedures for recording and responding to security breaches will be maintained by the AHCA Computer Incident Response Team (CSIRT).