ARKANSAS DEPARTMENT OF HUMAN SERVICES
PERFORMANCE BASED CONTRACTING

Pursuant to Ark. Code Ann. 19-11-1010 et. seq., the selected contractor shall comply with performance based standards. Following are the performance based standards that will be a part of the contract and with which the contractor must comply for acceptable performance to occur under the contract.

I. The contractor must comply with all statutes, regulations, codes, ordinances, and licensure or certification requirements applicable to the contractor or to the contractor's agents and employees and to the subject matter of the contract. Failure to comply shall be deemed unacceptable performance.

II. Except as otherwise required by law, the contractor agrees to hold the contracting Division/Office harmless and to indemnify the contracting Division/Office for any additional costs of alternatively accomplishing the goals of the contract, as well as any liability, including liability for costs or fees, which the contracting Division/Office may sustain as a result of the contractor's performance or lack of performance.

III. During the term of the contract, the division/office will complete sufficient performance evaluation(s) to determine if the contractor's performance is acceptable.

IV. The State **shall** have the right to modify, add, or delete Performance Standards throughout the term of the contract, should the State determine it is in its best interest to do so. Any changes or additions to performance standards will be made in good faith following acceptable industry standards, and may include the input of the vendor so as to establish standards that are reasonably achievable.

State law requires that all contracts for services include Performance Standards for measuring the of services provided. Attachment D: Performance Standards identifies expected deliverables, performance measures, or outcomes; and defines the acceptable standards a vendor **must** meet in order to avoid assessment of damages

The State may be open to negotiations of Performance Standards prior to contract award, prior to the commencement of services, or at times throughout the contract duration.

All changes made to the Performance Standards **shall** become an official part of the contract. Performance Standards **shall** continue throughout the term of the contract. Failure to meet the minimum Performance Standards as specified **shall** result in the assessment of damages.

In the event a Performance Standard is not met, the vendor will have the opportunity to defend o respond to the insufficiency. The State **shall** have the right to waive damages if it determines there were extenuating factors beyond the control of the vendor that hindered the performance of services. In these instances, the State **shall** have final determination of the performance acceptability.

The objective is to maximize cost avoidance and third party recoveries from all sources to ensure Medicaid is payor of last resort. The contractor will be required to perform the following functions to enhance and supplement the DMS with minimal impact on State staff and resources.

Service Criteria[1]	Acceptable Performance	Damages for Insufficient Performance[2]
(A) The contractor is responsible for the performance of automated data matches with commercial insurers, credit bureaus, Medicare, TRICARE/CHAMPUS/CHAMPVA, Arkansas Workers Compensation Commission and other alternative databases the contractor may propose to identify the third party resources of the Medicaid recipients. The third party resources to be identified are those previously unknown to Division of Medical Services (DMS). The process must assure timely transmission of the third party resources to DMS via its fiscal agent.	1. The contractor shall identify commercial or other databases with which it intends to match and the timeframe for completing such matches prior to performance. 2. Data match information used by the contractor shall include at a minimum full name (first name and last name), date of birth, sex, and social security number of recipient. The data information must be presented to DMS for approval prior to initiating any data matches. 3. The contractor must receive approval from DMS of the contractor's electronic and manual procedures for verifying the accuracy of its matches, individual's complete coverage prior to updating the DMS eligibility file. 4. The contractor shall present full results of data matches conducted to DMS for review prior to initiating any recoveries. 5. The contractor shall provide DMS with an automated means of updating the Medicaid Management Information System (MMIS) and Interchange file with the new complete Third Party Liability (TPL) information. The match criteria shall be full name (first name and last name), date of birth, sex and social security number. DMS will reserve the right to change match criteria if deemed necessary. 6. The contractor shall provide transmittals of Medicaid recipient TPL resources records acceptable to DMS within ninety (90) calendar days after contract issuance and every thirty (30) calendar days thereafter.	1. The contractor shall provide DMS the third party resource records within ninety (90) calendar days of the contract start date and every thirty (30) calendar days thereafter. Receipt of the records should be scheduled so that data may be incorporated into the DMS file no later than sixty (60) calendar days after the existence of a third party resource is known. Updates to erroneous third party resource information are transmitted by the contractor within thirty (30) calendar days of identification to the MMIS and Interchange contractor. 2. The contractor shall ensure that each phase of data matches is approved by DMS prior to implementation. 3. The contractor shall ensure the mutually agreed upon time frames for completion of the data matches are met. 4. The contractor

[1] These Service Criteria shall not be construed as the exclusive obligations of the contractor under the contract and are in addition to any and all other obligations under the contract.
[2] This compensation shall be in addition to any and all other damages or remedies available to the State at law or in equity.

	7. After the initial ninety (90) calendar day contract period, the contractor shall provide DMS with third party resources records within thirty (30) calendar days of contractor's identification of such records. 8. The contractor shall update previously verified TPL information to be transmitted to correct erroneous information within thirty (30) calendar days of identification to the MMIS and Interchange contractor. 9. The contractor's activities shall not overlap, interfere with or duplicate any past, present or ongoing TPL activities of DMS or its MMIS and Interchange contractor. 10. The contractor shall secure any necessary approvals, clearances, and information from Centers for Medicaid and Medicare (CMS) and other State agencies (i.e. Data Match Agreements, Waivers for timely filing, State Insurance Commission approval, etc.) prior to startup of initiative. 11. The contractor shall review MMIS and Interchange TPL file and update insurance no longer in effect (deletions) on a monthly basis.	shall ensure all necessary approvals, filing waivers, agreements, etc, were obtained. 5. The contractor shall comply with the above stated program deliverables and performance indicators. 6. A 5% monthly invoice deduction shall be allowed for each deficient month.
(B) The contractor is responsible for the identification, collection and transmittal to DMS of third party resources. The contractor shall assure transmission to DMS of accounts receivables files in a format acceptable to the DMS Medicaid fiscal agent.	1. The contractor shall provide DMS the initial collections and accounts receivable files within 150 calendar days of the contract start date and subsequent receipts of collections at least every thirty (30) calendar days thereafter. 2. The contractor shall deposit TPL recoveries to the DMS designated financial agent lockbox. 3. The contractor shall post TPL recoveries to accounts receivable files within 30 calendar days after recovery, for receipt by DMS, to allow for independent reconciliation of deposits to recoveries recorded. 4. The contractor shall close out all claims in which no response was received 180 calendar days following the initial billing, unless an extension was granted by DMS. 5. Contractor shall report unresolved variances to DMS on the monthly invoice on the 15th calendar day of the following month. 6. The contractor shall identify to DMS Medicaid providers that routinely review their credit balances and return	1. The initial collections and accounts receivable files are received within 150 calendar days following the date of contract issuance with receipt of collections at least every thirty (30) calendar days thereafter. 2. Recoveries are deposited into the Arkansas bank account (lockbox). 3. Deposits are posted and balanced to the accounts receivable files by the end of the month and shall be reported on the monthly invoice by the 15th calendar day of the following month. 4. Unresolved variances are reported to DMS by the end of the month and shall be reported on the monthly invoice by

	overpayments to DMS. “Routinely” is defined as at least quarterly. Based on the contractor’s findings and subject to DMS approval, Medicaid providers which routinely review their credit balances and make payment to the DMS can continue to process their own credit balances without subsequent contractor review.	the 15th calendar day of the following month. 5. All claims billed in which no response was received are closed within 180 calendar days following the initial billing unless an extension is granted.
(C) The contractor will be responsible for conducting on-going credit balance audits of Arkansas Medicaid providers to determine Medicaid credit balances and recover those credit balances for DMS, plan and perform on-going credit balance audits and recoveries, and identify those providers which routinely review their credit balances and return payments to DMS.	1. The contractor shall develop a methodology to identify Medicaid provider inpatient and outpatient overpayments. These will include payments made by Medicaid in excess of amounts billed by the provider, payments made in duplicate or otherwise incorrect billing, accounting error, switched charges between inpatient and outpatient units, as well as services reimbursed by another insurer. This methodology shall be acceptable to DMS and meet all federal and state regulations and requirements. 2. The contractor shall prepare and execute a written notification process to inform the providers that the credit balance audits are planned and give them an opportunity to voluntarily return any credit balances to Medicaid. 3. The contractor shall design and execute patient account review and payment audit programs in consultation with and subject to approval by DMS. 4. The contractor shall initiate a credit balance audit for each Medicaid provider that shall include the review of payment history data for at least one (1) year and shall be completed within the term of the contract. 5. The contractor shall request payment from the Medicaid provider when the contractor finds credit balances owed to DMS. 6. The contractor shall identify to DMS Medicaid providers that routinely review their credit balances and return overpayments to DMS. “Routinely” is defined as at least quarterly. Based on the contractor’s findings and subject to DMS approval, Medicaid providers which routinely review their credit balances and make payment to the DMS can continue to process their own credit balances without subsequent contractor review. Unless otherwise instructed by DMS, the contractor may assume that Medicaid	1. One hundred percent (100%) compliance with the performance indicator 2. A 5% penalty will be deducted from each monthly invoice for non-compliance.

	providers which routinely review their credit balances without subsequent contractor review.	
(D) The contractor shall comply with all general requirements of the contract as set forth by DMS.	1. Recover amounts equal to or exceeding the projections in the contractor's proposal for the term of the contract. 2. Provide a system for effective communication with a variety of entities including but not limited to employers, providers, recipients and insurance carriers, etc. 3. Provide a toll-free number (i.e. 800 or 888) to answer inquiries. The toll-free line must be operable and manned on State business days from 8:00 a.m. – 5:00 p.m. CST. TPL must be notified in writing by the next business day of all reasonable exceptions to regular business hours. 4. Provide staff and necessary equipment to offset the increased workload of the Agency (DMS) due to the contractor's activities during the term of the contract and for a period of 180 calendar days after the expiration of the contract. The staff and equipment will be provided as requested by DMS. 5. Secure any necessary approvals, clearances, and information from CMS and other state agencies (i.e. Data Match Agreements, Waivers for timely filings, State Insurance Commission approval, etc.). 6. Attend regularly scheduled status meetings with DMS. The schedule for status meetings will be determined in conjunction with DMS. 7. When credit balances owed to DMS are found, request payment from the provider and deposit recoveries into the Arkansas bank account (lock-box type account) designated by DMS. The contractor will provide facsimile transmission of deposit slips with actual deposit slips forwarded by mail to DMS. 8. Post recoveries to its accounts receivable files for receipt by DMS within 30 calendar days after recovery, to allow for independent reconciliation by DMS of	1. One hundred percent (100%) compliance with the performance indicator. 2. A 5% penalty will be deducted from each monthly invoice for non-compliance.

	deposits to recoveries recorded. 9. Propose and provide assurances of adequate cash control procedures in the contractor's processes of deposit of funds and disposition of recoveries to the accounts receivable files. These procedures must include separation of staff that perform deposit and disposition functions, security of receipts during working and non-working hours, and balancing deposits to the accounts receivable files within 30 calendar days of receipt of recoveries. Any unresolved variance must be reported to DMS by the end of the month and shall be reported on the monthly invoice by the 15th calendar day of the following month. 10. Submit monthly invoices to DMS based on finalized recoveries (those that the provider does not challenge or that have completed administrative appeals process) and that include the number of newly verified insurance policies added to MMIS and Interchange by the contractor (Adds). 11. Send recoveries and accounts receivable files to DMS within 150 calendar days following the effective date of the contract and subsequent receipts of recoveries at least every 30 calendar days thereafter. 12. Provide DMS with an automated means of updating the MMIS and Interchange file with complete information regarding credit balance recoveries from providers as well as requests to recover money from future payments. The recovery process must allow for the automated identification of the Internal Control Numbers (ICN) and automated MMIS and Interchange adjusting entries. 13. Maintain data processing equipment capable of accumulating the credit balance report data. The data must be sent to DMS in an automated format approved by DMS for its use in recovery activities analysis. Therefore, the contractor's equipment must be compatible with and able to interface with DMS's computer hardware and software as well as the MMIS and Interchange. 14. Pay any and all costs incurred in securing necessary files from the MMIS and Interchange fiscal agent contractor, performing analysis, and returning the results of audits and recovery activities to	

	DMS. 15. Use DMS files for the sole purposes of this contract. Any other use will be cause for cancellation of the contract and forfeiture of any payments due or made. 16. Maintain and organize working papers in a professional manner agreeable to DMS. 17. During the course of this contract, maintain all data, material and working papers in a location convenient to DMS. DMS requires that all data, material and working papers be retained and available for possible audit for a period of five (5) years after final payment is made to the contractor. DMS must approve the destruction of any data, material, or work papers that have been developed in performance of this contract. 18. Demonstrate compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and all regulations pertaining thereto. 19. Upon termination of the contract, the contractor shall have 120 calendar days to complete recoveries initiated before the termination date. The contractor may initiate no new collection claims during the 120 calendar day period. After 120 calendar days, the contractor shall not be paid for further collection of outstanding claims and the full amount of subsequent recoveries shall revert to DMS.	
(E) The contractor shall complete and submit all required reports in writing or on computer discs in a format specified by DMS and within required time frames. Also may submit this information via Secure Email.	1. Detailed report of actual recoveries, including date of check receipt, client name (first name and last name), client Medicaid ID number, carrier, and date of deposit. This information should balance to the deposits made to the bank account for each date. If any unidentified payments remain as of a given date, they shall be included on the report. The contractor shall submit this report to DMS by the end of the month and shall be reported on monthly invoice by the 15th calendar day of the following month. 2. Annual Report of Collections – This report must include the total amount billed and recovered, percentage of recovery and number of claims involved. The claims should not be duplicative. 3. Data Match Progress Reports – Narrative reports by the carrier specifying benchmarks, problems, and proposed solutions. The contractor shall submit this report as requested by TPL.	1. One hundred percent (100%) compliance with the performance indicator. 2. The contractor shall provide each report in the specified format, containing the requested information, within accuracy and according to the indicated timeframes. 3. A 5% penalty will be deducted from each monthly invoice for non-compliance.

	4. Periodic Accounts Receivable Summaries – Reports by the carrier, including detailed claims billed and re-billed, detailed claims and dollars paid, detailed claims and dollars outstanding, percentage of claims paid for initial and re-billing, with appropriate totals. The contractor shall submit this report as requested by TPL. 5. Reports of Carrier Payments to Other Entities – The contractor will provide detailed listings specifically identifying payee, recipient, paid claims affected, on a weekly basis. Additionally, DMS will require summary reporting which indicates by carrier, number and percentage of claims billed and dollar amounts requested and payments made. Outstanding claims should be reported in 30, 60, 90, 120 and over 120-day intervals. The contractor shall submit this report as requested by TPL. 6. Newly Identified Resources by Carrier – Verified data match results by the carrier indicating number of recipients with newly identified coverage by type of coverage, due by the contractor within thirty (30) calendar days of the match completion. 7. Comprehensive Recovery Report by Carrier – This will be a detailed report produced after all significant recoveries have been effected which will specify recoveries billed and paid, claims by procedure code, diagnosis and place of service. The contractor shall submit this report as requested by TPL. 8. Monthly Collection Report – This report must include the total amount billed and recovered and the number of unduplicated claims. 9. Monthly Status Report - This includes the number of newly identified and verified health insurance segments. **Provider Credit Balance Audit and Recovery:** 10. Within thirty (30) calendar days of completion of the initial audit of a provider, the contractor shall submit to DMS a report identifying the provider as one that routinely reviews credit balances and returns these monies to DMS. The contractor will list, by provider, monthly credit balances for the review period	

	which contains the following: (a) Recipients' names (First name and last name) (b) Recipients' Medicaid numbers (c) Provider account numbers (d) Dates of service (e) Amount of credit balances (f) Reasons for credit balances including the names of the insurance carriers and any other insurance information available to the contractor (g) Amount of credit balances returned. 11. Within thirty (30) calendar days of completion of the initial and subsequent annual audits of those providers not routinely completing credit balance audits, the contractor shall submit to DMS a report containing the following: (a) Recipients' names (First name and last name) (b) Recipients' Medicaid numbers (c) Provider account numbers (d) Date of service (e) Amount of credit balances (f) Reasons for credit balances including the names of the insurance carriers and any other insurance information available to the contractor (g) The report shall indicate why the accounts identified as paid in error were not identified and returned by the provider (h) Amount of credit balances recovered 12. The contractor will provide a report of recommendations for improvement within thirty (30) workdays following the end of each contract period for implementation of an expanded, more comprehensive and cost effective program. Recommendations will include the technological and resource requirements necessary to successfully implement new initiatives. 13. At least annually, or more often if required by DMS, the contractor shall report and make recommendations concerning the detection and correction of all improper, unallowable and unusual costs to DMS associated with Medicaid credit balances. 14. Monthly account receivable summaries shall be provided to DMS by the 15th workday of each month. The summary will include collection	

	summaries and totals for lock box that are unrelated to the contractor's activities. 15 .The contractor shall provide DMS with detailed claim level reporting on a monthly basis. The report is due by the 15th workday of each month and shall include the internal control number, date of service, amount billed, amount paid by Medicaid, Medicaid paid date, Medicaid provider number and provider name. 16. The contractor shall provide monthly reports of actual final recoveries by the 15th workday of each month. The report shall include both accounts receivable payments received and claim amounts recovered through provider recoupment. 17. A report of actual recoveries will be provided to DMS annually due within thirty (30) work days after the end of the contract period. The report shall include both accounts receivable payments from providers and total claims amount recovered through provider recoupment. 18. The contractor will provide DMS with a detailed report concerning the initial credit balance audit within thirty (30) work days following the initial audit.	
(F) The contractor will perform payment recovery where the state has identified potential TPL but has not initiated a recovery.	1. The contractor is responsible for the recovery of amounts owed by third parties for health care services paid by the Medicaid program for casualty insurance and tort claims. The State in its discretion will refer the tort case(s) to the contractor for recovery. 2. The contractor shall have staff available to respond to telephone and other requests relating to cases. 3. The contractor shall ensure that an audit trail is maintained within its case files. This audit trail shall include all materials used for each claim including, but not limited to, client profiles, payment records and any other correspondence. 4. The contractor shall respond in writing to every case by 60 calendar days of receipt of the case. 5. The contractor shall develop and provide a monthly electronic report which should include: a) Client's full name (first name and last name) b) Social Security number c) Date received information from TPL d) Date initial letter was sent to Client e) Related claims total and any other requested information.	1. One hundred percent (100%) compliance with the performance indicator. 2. A penalty of $500.00 per day when a claim is not initiated within 60 calendar days of receipt.

	6. The contractor must provide TPL with access to the contractor's portal system that maintains all of the data information regarding the casualty insurance and tort claims.	
(G) The contractor will be responsible for conducting recoupment and disallowances cycles to Arkansas Medicaid providers to determine if a Medicaid recovery involving electronic and paper media must be sent to the MMIS and Interchange for voids and adjustments for DMS. The contractor is responsible for planning and perform on-going recoupment and disallowances cycles, and identify those providers monthly for recovery and return adjustments and voids to DMS through the MMIS and Interchange.	1. The contractor shall develop and maintain a methodology to identify Medicaid provider recoupments and disallowances based on all paid claims that should have been paid as primary with other insurance (i.e. Medicare Parts A and B, Commercial insurance carriers). 2. The contractor shall prepare and execute a written notification process to inform the providers that they have a recoupment or disallowance that needs to be billed to other carriers including other insurance information (i.e. Medicare Parts A and B, Commercial insurance carriers). 3. The contractor shall provide DMS the initial recoupment and disallowances files electronic and paper media files within 150 calendar days of the contract start date for adjustments and voids and at least every 30 calendar days thereafter. 4. When recoupments and disallowances owed to DMS are found, the contractor must request the providers bill other insurance carrier (i.e. Medicare, Commercial carrier). The Contractor will send electronic and paper media files to MMIS and Interchange to adjust and void claims after 30 calendar days. 5. Provide a system for effective communication with a variety of entities including but not limited to employers, providers, recipients and insurance carriers, etc. 6. The contractor shall correspond (i.e. by provider portal, email, telephone conversations, facsimiles, etc.) to the Medicaid provider(s) to handle all refuted claims. The refuted claims are to be sent to DMS in a monthly report (by the 15th of the following month) unless the contractor handles the refuted claim before the 30 calendar day cycle has been closed. 7. The contractor shall never keep a cycle open for more than 30 calendar	1. One hundred percent (100%) compliance with the above performance indicators. 2. A 5% penalty will be deducted from each monthly invoice for non-compliance.

	days. 8. Provide a toll-free number (i.e. 800 or 888) to answer inquiries. The toll-free line must be operable and manned on business days from 8:00 a.m. – 5:00 p.m. CST. TPL must be notified in writing by the next business day of all reasonable exceptions to regular business hours.	

Failure to meet the minimum Performance Standards as specified **shall** result in the assessment of damages.

In the event a Performance Standard is not met, the vendor will have the opportunity to defend or respond to the insufficiency. The State **shall** have the right to waive damages if it determines there were extenuating factors beyond the control of the vendor that hindered the performance of services. In these instances, the State **shall** have final determination of the performance acceptability.

Should any compensation be owed to the agency due to the assessment of damages, vendor **shall** follow the direction of the agency regarding the required compensation process.

REMEDIES FOR UNACCEPTABLE PERFORMANCE

Acceptable performance of all provisions and performance indicators in this contract shall be determined in the sole discretion of the contracting division. In addition to other remedies identified herein, one or more of the following remedies may be imposed for unacceptable performance of a provision or performance indicator:

1. The contractor will be required to submit and implement an acceptable corrective action plan. Payment may be delayed pending satisfactory implementation of the plan.

2. Payment may be withheld or reduced.

3. The Contract may be terminated.

The remedies listed above are in addition to all others available at law or equity.