

DRAFT REQUEST FOR PROPOSAL
For the State of New Jersey
Transportation Broker Service

The State of New Jersey is presenting this draft Request for Proposal (RFP), Scope of Work, to solicit comments from the vendor community and any interested party. This draft document is released via posting to the web on July 10, 2014. Comments and feedback will be accepted through August 8, 2014. Input from the vendor community and the public at large must be sent to the State via e-mail to Holli.Arnold@dhs.state.nj.us

It is the intent of the State to accept comments that improve the structure of the RFP rather than questions concerning requirements that might be entertained in a normal question and answer period. As soon as practicable after the comment due date, the State intends to issue the actual RFP for this solicitation.

It is at the State's sole discretion whether any of the comments received will be incorporated in the final RFP. Vendors must not prepare a bid proposal. There are no dates or appendices included in this RFP because it is a draft document. Similarly, there are no forms or price schedule accompanying this draft document. When the final RFP is issued, it will contain data necessary for the bidder to make a proposal to the State.

PLEASE NOTE:

Responders agree that all documents are subject to public disclosure. A responder may designate specific information as not subject to disclosure pursuant to the exceptions to the Open Public Records Act (OPRA) found at N.J.S.A. 47:1A-1.1 or the common law Right to Know, when the responder has a good faith legal and/or factual basis for such assertion. The State reserves the right to make the determination as to what is proprietary or confidential, and will advise the responder accordingly. The location in the response of any such designation should be clearly stated in a cover letter. The State will not honor any attempt by a responder to designate its entire response as proprietary, confidential and/or to claim copyright protection for its entire response. In the event of any challenge to the responder's assertion of confidentiality with which the State does not concur, the responder shall be notified and shall be solely responsible for defending its designation.

Comments and feedback will only be accepted via e-mail to Holli.Arnold@dhs.state.nj.us

Telephone contact regarding this draft RFP or the forthcoming final document will not be accepted.

The response deadline is August 8, 2014 at 5:00 pm.



DRAFT Request for Proposal

For: Broker Transportation Service, Division
of Medical Assistance & Health Services

Event	Date	Time
Bidder's Electronic Question Due Date (Refer to RFP Section 1.3.1 for more information.)	TBD	5:00 PM
Mandatory/Optional Pre-Proposal Conference (Refer to RFP Section 1.3.6 for more information.)	Not Applicable	N/A
Mandatory/Optional Site Visit (Refer to RFP Section 1.3.5 for more information.)	Not Applicable	
Proposal Submission Date (Refer to RFP Section 1.3.2 for more information.)	TBD	2:00 PM

Dates are subject to change. All changes will be reflected in Addenda to the RFP posted on the Division of Purchase and Property website.

	Status	Category
Small Business Set-Aside	<input checked="" type="checkbox"/> Not Applicable	<input type="checkbox"/> I
	<input type="checkbox"/> Entire Contract	<input type="checkbox"/> II
	<input type="checkbox"/> Partial Contract	<input type="checkbox"/> III
	<input type="checkbox"/> Subcontracting Only	

RFP Issued By
State of New Jersey
Department of the Treasury
Division of Purchase and Property
Trenton, New Jersey 08625-0230

State of New Jersey
Department of Human Service
Division of Medical Assistance & Health Services

Date: July 9, 2014

1.0 PURPOSE

This Draft Request for Proposal (RFP) is issued by the Procurement Bureau, Division of Purchase and Property, Department of the Treasury on behalf of the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS). The purpose of this RFP is to solicit proposals for a primary single-source Contractor to serve as the non-emergency medical transportation broker to arrange for non-emergency medical transportation services for all eligible Medicaid Managed Care (MMC) and Fee for Service (FFS) beneficiaries. Services to be provided to all counties throughout the State for all eligible MMC and FFS beneficiaries include livery, Mobility Assistance Vehicle (MAV) transportation, Air Transportation Services, Basic Life Support (BLS), Advance Life Support (ALS), Ground Ambulance Services (GAS) and Routine Specialty Care Service (RSCS).

It will be the Contractor's responsibility to maintain a provider network; determining the appropriate mode of transport; dispatching an appropriate vehicle to transport beneficiaries; and developing a quality assurance program to ensure access to appropriate transportation based on medical necessity. The Contractor may engage current transportation providers, experienced in providing these services to the counties. The Contractor will be responsible for paying the network providers.

2.0 BACKGROUND

Transportation plays an important role in assuring eligible beneficiaries access to medical appointments. The location of providers and their practice sites may include, but is not limited to, practitioner offices, hospital outpatient departments, independent clinics, dialysis facilities, ambulatory surgery centers, and federally qualified health centers. This service is of particular importance to disabled beneficiaries needing critical services such as dialysis, rehabilitation, physical therapy, chemotherapy, or for children attending behavioral health programs. This transportation service is provided for certain institutionalized beneficiaries, including those residing in nursing facilities requiring transport to medical appointments.

From the period December 2012 through May 2013, net authorized trips were 2,667,361, averaging 444,560 per month. Verified paid trips were 2,196,817, averaging 366,136 per month. The capitated population averaged 1,080,030 per month with no discernible trend up or down. The number of unduplicated riders (a single rider provided with one or multiple trips) per month averaged 3.96% of the eligible population. Individual transportation providers subcontracted averaged about 172 per month. Total calls received averaged 203,742 per month with no discernible trend.

Livery service is a 'curb-to-curb' service for ambulatory beneficiaries and MAV service is a door through-door service for beneficiaries who use a wheelchair. Ambulatory MAV is a hybrid of the two in which the client is ambulatory but requires assistance/supervision door through door. A subcategory of MAV is bariatric wheelchair or stretcher and transports with multiple steps which require two person teams. These are difficult to cover trips and require the implementation of specific strategies to assure these clients are transported to their appointments appropriately. A second difficult to cover category consists of trips out of state, which are relatively common given the proximity of many population segments to Delaware, New York and Pennsylvania.

2.0 DEFINITIONS

2.1 GENERAL DEFINITIONS

The following definitions will be part of any contract awarded or order placed as result of this RFP.

Addendum – Written clarification or revision to this RFP issued by the Division of Purchase and Property.

All-Inclusive Hourly Rate – An hourly rate comprised of all direct and indirect costs including, but not limited to: overhead, fee or profit, clerical support, travel expenses, per diem, safety equipment, materials, supplies, managerial support and all documents, forms, and reproductions thereof. This rate also includes portal-to-portal expenses as well as per diem expenses such as food.

Amendment – An alteration or modification of the terms of a contract between the State and the Contractor(s). An amendment is not effective until it is signed by the Director or Deputy Director, Division of Purchase and Property.

Bidder – An individual or business entity submitting a proposal in response to this RFP.

Contract – This RFP, any addendum to this RFP, and the bidder's proposal submitted in response to this RFP, as accepted by the State.

Contractor – The bidder awarded a contract resulting from this RFP.

Director – Director, Division of Purchase and Property, Department of the Treasury. By statutory authority, the Director is the chief contracting officer for the State of New Jersey.

Division – The Division of Purchase and Property.

Evaluation Committee – A committee established or Division staff member assigned by the Director to review and evaluate proposals submitted in response to this RFP and to recommend a contract award to the Director.

Firm Fixed Price – A price that is all-inclusive of direct cost and indirect costs, including, but not limited to, direct labor costs, overhead, fee or profit, clerical support, equipment, materials, supplies, managerial (administrative) support, all documents, reports, forms, travel, reproduction and any other costs. No additional fees or costs shall be paid by the State unless there is a change in the scope of work.

Joint Venture – A business undertaking by two or more entities to share risk and responsibility for a specific project.

May – Denotes that which is permissible, not mandatory.

Project – The undertaking or services that are the subject of this RFP.

Request for Proposal (RFP) – This document which establishes the bidding and contract requirements and solicits proposals to meet the purchase needs of the using Agencies as identified herein.

Shall or Must – Denotes that which is a mandatory requirement. Failure to meet a mandatory requirement will result in the rejection of a proposal as materially non-responsive.

Should – Denotes that which is recommended, not mandatory.

Small business – Pursuant to N.J.A.C. 17:13-1.2, “small business” means a business that meets the requirements and definitions of “small business” and has applied for and been approved by the New Jersey Division of Revenue, Small Business Enterprise Unit as (i) independently owned and operated, (ii) incorporated or registered in and has its principal place of business in the State of New Jersey; (iii) has 100 or fewer full-time employees; and has gross revenues falling in one of the three following categories: (A) 0 to \$500,000 (Category I); (B) \$500,001 to \$5,000,000 (Category II); and (C) \$5,000,001 to \$12,000,000, or the applicable federal revenue standards established at 13 CFR 121.201, whichever is higher (Category III).

State – State of New Jersey.

State Contract Manager – The individual responsible for the approval of all deliverables, i.e., tasks, sub-tasks or other work elements in the Scope of Work, as set forth in Sections 8.1, 8.1.1 and 8.1.2.

Subtasks – Detailed activities that comprise the actual performance of a task.

Subcontractor – An entity having an arrangement with a State contractor, where by the State contractor uses the products and/or services of that entity to fulfill some of its obligations under its State contract, while retaining full responsibility for the performance of all of its [the contractor's] obligations under the contract, including payment to the subcontractor. The subcontractor has no legal relationship with the State, only with the contractor.

Task – A discrete unit of work to be performed.

Transaction - The payment or remuneration to the contractor for services rendered or products provided to the State pursuant to the terms of the contract, including but not limited to the following: purchase orders, invoices, hourly rates, firm fixed price, commission payments, progress payments and contingency payments.

Using Agency – A State department or agency, a quasi-State governmental entity, or a Cooperative Purchasing Program participant authorized to purchase products and/or services under a contract procured by the Division.

2.2 CONTRACT-SPECIFIC DEFINITIONS

ABD (Aged, Blind, Disabled) – Categories of eligibility limited to individuals 65 years of age or older; or individuals determined disabled and/or blind based on criteria established by the Social Security Administration.

Adjudication – The point in the processing of claims at which a final decision is reached to pay or deny a claim.

Advance Life Support (ALS) – Mobile Intensive Care Unit/Advance Life Support service.

Advance Reservations – A transportation request scheduled for a subsequent date and time.

Air Transportation Service – The provision of non-emergency medical transportation by air, to enable the beneficiary to access medically necessary services, in an aircraft certified by, and operated in accordance with, Federal Aviation Administration (FAA) requirements.

Basic Life Support (BLS) – Ambulance services provided in non-critical situations in which paramedic intervention is not immediately needed and time is not a critical factor in treatment.

Basic Service Area – Means the geographic area in which the contractor is obligated to provide covered services for its eligible enrollees under this contract.

Beneficiary – Any person eligible to receive fee-for-service (FFS) services and Medicaid Managed Care (MMC) services in the New Jersey Medicaid program, in accordance with N.J.S.A. 30:4D-1 et seq.

Call Center – Telephone facility with toll-free dedicated “800” telephone lines and corresponding numbers, which is staffed for the purpose of meeting customer service needs. Operation of the call center includes, but is not limited to: answering general questions of callers; handling requests for application packages, enrollment and other Medicaid service-related materials.

Capitated Service – Any covered service for which the contractor receives capitation payment.

Capitation Rate – The fixed monthly amount that the contractor is prepaid by DMAHS for each enrollee for which the contractor provides the services included in the Benefits Package described in this contract.

Claim – Request for payment by a network provider administered by the contractor.

Clean Claim – Network provider payment request submitted to the contractor in the proper claim format with sufficient information to be accepted for claims processing.

Clinic or Independent Clinic – An entity that provides medical services pursuant to N.J.A.C. 10:66. Clinics include, but are not limited to, drug treatment centers, federally qualified health centers, and mental health facilities.

Commencement of Operations – The date ninety (90) days after Contract Award upon which the Contractor will be required to provide the services required by this RFP.

Commercial Driver License (CDL) – A license issued to a person authorizing the person to operate a certain class of motor vehicle as defined at N.J.S.A. 39:3-10.11.

Commercial Motor Vehicle (CMV) – A commercial motor vehicle as the term is defined at N.J.S.A. 39:3-10.11.

Complaint – A protest by an enrollee as to the conduct of the contractor or any agent of the contractor, or an act or failure to act by the contractor or any agent of the contractor, or any other matter in which a beneficiary feels aggrieved by the contractor or any other agent of the contractor, that is communicated to the contractor and that

can be resolved by the contractor or any agent of the contractor within ten (10) business days.

Confidentiality of Records – Information concerning beneficiaries is kept private and subject to disclosure on a need to know basis. The standards governing maintenance of and access to enrollee records are defined under the Health Information Portability Accountability Act (HIPAA).

Credentialing – The contractor’s determination as to the qualifications and assigned privileges of a specific provider to render specific health care services.

County Welfare Agency (CWA)/County Board of Social Services (CBOSS) – The county-based agencies responsible for implementation of specified Medicaid and other eligibility screening and for implementation of non-emergency livery services.

Days – Calendar days, unless otherwise specified.

Division of Developmental Disabilities (DDD) – The division within the New Jersey Department of Human Services that provides evaluation, functional and guardianship services to eligible persons who are developmentally disabled. Services include residential services, family support, contracted day programs, work opportunities, social supervision, guardianship, and referral services.

Division of Disability Services (DDS) – The division within the New Jersey Department of Human Services that promotes the maximum independence and participation of people with disabilities in community life.

Deliverable – All individually mandated requirements, including, documents/reports/manuals to be submitted to DHS by the contractor, pursuant to this contract.

Department (DHS) – The Department of Human Services, in the executive branch of New Jersey State government, is the single state agency designated by the Centers for Medicare & Medicaid Services to administer the Medicaid program, in accordance with N.J.S.A. 30:4D-3 and 42 C.F.R. 412.30. The Department of Human Services includes the Division of Medical Assistance and Health Services (DMAHS) and the terms are used interchangeably for this contract. The Department also includes: the Division of Family Development (DFD), the Division of Mental Health Services (DMHS), the Division of Disability Services (DDS), the Commission for the Blind and Visually Impaired (CBVI), the Division of the Deaf and Hard of Hearing (DDHH) and the Division of Developmental Disabilities (DDD).

Division of Aging Services (DoAS) – The division within the executive branch of New Jersey State government that is responsible for administering specified Title XIX Medicaid services to the aged and disabled on behalf of the Department of Human Services.

Department of Children and Families (DCF) – The department in the executive branch of New Jersey State government that is responsible for programs for children and families, including the programs of the Division Child Protection and Permanency (DCPP) and the Children’s System of Care Division (CSCD). Many of the children served by DCPP and CSCD are Medicaid beneficiaries.

Division of Medical Assistance and Health Services (DMAHS) – The division within the Department of Human Services that is responsible for the administration and oversight of the Title XIX Medicaid program on behalf of DHS.

Door-to-Door - Service to include assistance to the point of entry for the beneficiary, (i.e., medical office, outpatient clinic, etc.).

Driver's License – A license issued by the Motor Vehicle Commission (MVC) authorizing a person to operate a particular type of motor vehicle.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services – Covered outpatient services furnished by an approved transportation provider that are necessary to stabilize an emergency medical condition. Emergency transportation services are not provided through the contractor under this contract.

Emergent Service -Treatment of a condition that is potentially harmful to a patient's health and for which his/her physician determined it is medically necessary for the patient to receive medical treatment within twenty-four (24) hours to prevent deterioration. Emergent care is not covered under this contract.

Encounter Claim – The basic unit of service used in accumulating utilization data and/or a face-to-face contact between a patient and a health care provider resulting in a service to the patient.

Encounter Data – The record of the number and types of services rendered to patients during a specific time period.

Endorsement – As defined at N.J.S.A. 39:3-10.11, an authorization to provide a commercial driver license that authorizes the permit holder of the license to operate certain types of commercial motor vehicles.

Escort – One that accompanies a beneficiary. An escort may be employed by the transportation provider, and/or may be a parent, caregiver or caseworker of the beneficiary.

Fair Hearing – The appeal process available to all Medicaid eligibles pursuant to N.J.S.A. 30:4D7 and administered pursuant to N.J.A.C. 10:49-10.

Fee-for-Service (FFS) – A method for provider reimbursement based on payment for specific services rendered to a specific enrollee.

Fixed Rate – Claims that are paid based on HIPAA-approved procedure codes and all-inclusive amounts as established by the contractor.

Fraud – A deliberate deceptive practice so as to secure unfair or unlawful gain.

Ground Ambulance Service (GAS) – The provision of emergency or non-emergency medical transportation in a vehicle that is licensed, equipped, and staffed in accordance with New Jersey State Division of Aging and Community Services rules, as specified at N.J.A.C. 8:40.

Health Insurance Portability and Accountability Act (HIPAA) – The Federal statute governing transmission of medical information between providers of medical services and payers, Public Law 104-191, 42 U.S.C. 1320d through 42 U.S.C. 1320d-8. Associated Federal regulations are codified at 45 CFR Parts 160, 162, and 164.

Institutionalized – Residing in a nursing facility, psychiatric hospital, or intermediate care facility/mental retardation (ICF/MR); this does not include admission to an acute care or rehabilitation hospital setting.

In-service - An ongoing coordinated education program for DMAHS staff and/or contractor or subcontractor staff concerning policies and procedures, to be conducted with new employees of the contractor or subcontractor within thirty (30) days of employment.

Livery Service – Non-emergency transportation reserved for sick, infirm, or otherwise disabled persons who are under the care and supervision of a physician and whose medical condition requires transportation for medical care. Livery transportation services shall be curb-to-curb. Providers shall not be required to enter residences and/or facilities to pick up beneficiaries. Providers are responsible only for assisting beneficiaries into and out of the vehicle.

Livery Vehicle – A van or sedan licensed, registered, insured, maintained and operated as required in this RFP and by the laws and regulations of the State of New Jersey or of the state in which the vehicle operates or is licensed. Livery standards are included in N.J.A.C., Title 10 (Department of Human Services), Chapter 50, Section 1.12.

Managed Care – A comprehensive approach to the provision of health care, which combines clinical, preventive, restorative, and emergency services, in addition to administrative procedures within an integrated and coordinated system, to provide timely access to primary care and other medically necessary health care services in a cost effective manner.

Medicaid – The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., which is administered in New Jersey by DMAHS within DHS pursuant to N.J.S.A. 30:4D-1 et seq.

Medicaid Eligible – An individual eligible to receive services under the New Jersey Medicaid program. **Medicaid Beneficiary or Beneficiary** – An individual eligible for Medicaid who has applied for and been granted Medicaid benefits by DMAHS, generally through a County Welfare Agency (CWA) or Social Security District Office.

Medical Assistance Customer Center (MACC) – The DMAHS local office delegated to assist beneficiaries and providers in the delivery and receipt of Medicaid services.

Medical Director – May be a physician, registered nurse or a nurse practitioner, licensed in the State of New Jersey and designated by the contractor to exercise general supervision over the prior authorization process.

Medically Necessary Services (MNS) – Services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this RFP.

Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and/or medical/pediatric community acceptance.

In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter whether or not they are ordinarily covered services for all other Medicaid enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

Medical Necessity Form (MNF) – The form used by the contractor to request information from the provider regarding a transportation prior authorization request.

Medicare – The program authorized by Title XVIII of the Social Security Act to provide payment for health services to federally defined populations, generally, the aged and/or disabled.

Mobility Assistance Vehicle (MAV) – MAV service is a non-emergency health care transportation vehicle that is licensed, equipped, and staffed in accordance with New Jersey State Department of Health rules to provide non-emergency health care transportation, MAV service, as specified in N.J.A.C. 8:40 and 8:41, by certified trained personnel, for sick, infirm or otherwise disabled individuals who are under the care and supervision of a physician and whose medical condition is not of sufficient magnitude or gravity to require transportation by ambulance, but whose medical condition requires transportation from place to place for medical care. MAV transportation services shall be door-through-door. Providers are required to enter residences and/or facilities to pick up beneficiaries. Providers shall be responsible for lifting wheelchair and/or gurney beneficiaries up and down a maximum of four stairs.

Medicaid Fee Allowance – Rates established by DMAHS for covered transportation services.

Molina – The State’s current fiscal agent, for Medicaid/Medicare payments.

Motor Vehicle Commission (MVC) – The New Jersey Motor Vehicle Commission, which is responsible for licensing vehicles and drivers in the State of New Jersey.

Non-Emergency Medical Transportation (NEMT) – Those services specified in the Title XIX

State Plan and this RFP that are needed to assist beneficiaries who are not experiencing a medical emergency in accessing medically necessary services.

New Jersey Administrative Code (N.J.A.C.) – The compilation of the regulations of the State of New Jersey, as amended and supplemented by rule adoptions published in the New Jersey

Register. The N.J.A.C. and the New Jersey Register may be accessed on a no-cost basis at

www.lexisnexis.com/njoal.

New Jersey Statutes Annotated (N.J.S.A.) – Means the compilation of the statutes of the State of New Jersey, as amended and supplemented. The text of the N.J.S.A. may be accessed for free at <http://www.njleg.state.nj.us/>.

Non-Clean Claim - A network provider claim that requires additional information prior to submission for adjudication.

Non-Covered Medicaid Services – All services that are not covered by the New Jersey Medicaid State Plan.

Participating Provider – A provider that has entered into a provider contract with the contractor to provide services.

Prior Authorization – Approval of medical services or transportation services based on medical necessity and issued by the State or an approved authorizing agent, such as the contractor, based on the criteria described in Section 3.6.

Project Manager – The contractor’s employee responsible for contract oversight and management.

Provider – Any person, public or private institution, agency or business concern approved by the DMAHS, lawfully providing medical care, services, goods, and supplies holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

Provider Contract – Any written contract between the contractor and a provider that requires the transportation provider to perform specific parts of the contractor’s obligations for the provision of the health care transportation services under this contract.

Provider Network – Network of providers established by the contractor to service eligible beneficiaries in accordance with the scope of the RFP.

Reports – The compilation of relevant data required by DMAHS in accordance with this contract for the purpose of monitoring utilization of non-emergency transportation services and contractor performance.

Reservation – Requests received by the contractor for transportation based on medical need.

Routine Speciality Care Trip (RSCT)- The interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Service Area – The geographic area or region comprised of All New Jersey counties, as specified in this RFP, from which beneficiaries will be transported, plus all areas to which such beneficiaries will be transported outside the State as determined to be medically necessary.

Service Location/Service Site – Any location at which an enrollee obtains any health care service.

Short-Term – A period of 30 calendar days or fewer.

Subcontractor Payments – Any amounts the contractor pays a subcontractor for services they furnish directly.

Subscription Service – Repetitive requests for transportation by the same beneficiary to the same destination.

Temporary Assistance for Needy Families (TANF) – Federal welfare reform program which replaced the Aid to Families with Dependent Children, or AFDC, that is a program administered through DFD in coordination with the CWA/CBOSS agencies.

Telecommunication Device for the Deaf (TDD) – An electronic telecommunications device used to communicate with individuals who have difficulty communicating due to hearing or speech difficulties, by means of telephone service.

Text Telephone (TT) – Used for sending and receiving messages that are typed and transmitted as text. It consists of a keyboard and display which are connected to the telephone network. It is used by individuals with communication difficulties.

Tracking – A process for keeping a record of the usage of transportation services.

Transportation – The use of an approved vehicle to move Medicaid beneficiaries from place to place for the purpose of obtaining a Medicaid covered service.

Transportation Reimbursement Allowance – Claims paid on a FFS basis, as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS).

Urgent Care – Treatment of a condition that is potentially harmful to a patient's health and for which his/her physician determined it is medically necessary for the patient to receive medical treatment within 24 hours to prevent deterioration.

Urgent Service – A transportation need which must be met within 24 hours of the request made of the Contractor. (See Exhibit B for more details on urgent service and reporting).

Utilization Review Process (URP) – Used by the contractor to communicate with practitioners for the purpose of requesting information to justify medical necessity in the prior authorization process.

Utilization – The rate patterns of service usage or types of service occurring within a specified time period.

Valid Driver's License – Driver's license legally acquired, current, up-to-date, and not expired, revoked or suspended by the State issuing the driver's license. NJMVC regulation shall apply regarding residence status changes.

Waiting Time – That period of actual time, beginning thirty (30) minutes following scheduled appointment time for the A-leg and scheduled pick-up time for the B-leg, for non-emergency ground ambulance and MAV service.

Work First New Jersey (WFNJ)/General Assistance (GA) – The single public assistance program established pursuant to P.L. 1997, c.13, c.14, c.37 and c.38, which provides assistance to single adults, couples without dependent children and families with dependent children.

3.0 SCOPE OF WORK

3.1 GENERAL DESCRIPTION OF SERVICES

3.1.1 The Contractor shall have in place ninety (90) days after award of the contract all contractual services to be provided, which shall include, but may not be limited to, creation of a provider network that incorporates contract negotiation, credentialing and enrollment of providers, claims adjudication, prior authorization, management information systems, financial management, and reporting.

The Contractor shall conduct any and all necessary beneficiary evaluations for the purpose of determining appropriate medical necessity for the requested transportation service within three (3) business days of the request. The Contractor shall meet a compliance rate of 99%. **NOTE: The Contractor may be assessed liquidated damages per Exhibit A to this RFP.**

3.1.2 The Contractor shall arrange for statewide livery services for all Medicaid MMC and FFS beneficiaries. Public transportation shall be arranged in lieu of livery when determined appropriate by the prescriber in the MNF.

The Contractor shall also arrange for the following non-emergency transportation services throughout the State for eligible Medicaid clients: MAV transportation, BLS, ALS, GAS, Specialty Care, Mileage Reimbursement and Air Transportation. Lower mode partial care day clinic treatment transportation is excluded (ambulatory and ambulatory/MAV), as this service is provided by the partial care facilities directly. However, partial care clinics will be included in the determination for eligibility for public transportation passes.

NOTE: 911 Emergency transportations services are not provided through the Contractor under this contract.

The Contractor shall arrange for the provision of non-emergency medical transportation by air, to enable the Medicaid beneficiary any needed access to medically necessary services, in an aircraft certified by, and operated in accordance with Federal Aviation Administration (FAA) requirements. Air transportation will be provided through the Contractor when the beneficiary requires air transportation outside the State of New Jersey to travel to and/or from an appointment with a health care service provider to receive medically necessary services. During the provision of air transportation services, escorts are provided to accompany beneficiaries who are blind, deaf, mentally ill, mentally retarded or under 21 years of age. Escorts may be employed by the transportation provider, and/or may be a parent, caregiver or caseworker of the beneficiary. Prior authorization by the Contractor is required for non-emergency air transportation.

NOTE: The Contractor shall be reimbursed for air travel based on the actual cost of the airline ticket without Contractor markup (i.e., The State will not pay any increase over the actual invoice cost).

The cost of meals and lodging must be covered for a beneficiary and one (1) escort, when required in conjunction with in-State and out-of-State travel to receive medical care. When the escort is a family member, the family member shall not be eligible for any fee, but the family member's transportation and any costs directly associated with the transportation (meals and lodging) are covered. Meals and lodging costs shall be covered when the costs are directly associated with transportation to the location where

the medical service is rendered or transportation from the location where the medical service is rendered. The cost of meals and lodging en route to and from in-State and out-of-State medical care must have prior authorization from the State Contract Manager. NOTE: The Contractor will be reimbursed for the cost of meals and lodging, based on the GSA per diem rates for the State of New Jersey, without Contractor markup, located on the following web site:

GSA - Domestic Per Diem Rates, www.gsa.gov/HP/01Trvl_perdiem
(Domestic per diem rates and links to foreign per diem rates).

3.1.3 The Contractor shall provide a Call Center to all eligible beneficiaries with twenty-four (24) hours per day/seven (7) days per week service viability. The Contractor's personnel shall be available for calls during regular business hours, Monday through Friday, from 8AM to 4PM. The contractor shall also provide phone answering service or have personnel on-call outside regular business hours and all calls must be addressed within the first two (2) hours of the next business day.

3.1.4 The Contractor shall manage the overall day-to-day operations necessary for the provision of transportation services, reports and the maintenance of appropriate records and systems of accountability to report to the State Contract Manager.

3.1.5 Trips must be scheduled and dispatched in a manner that ensures the average waiting time for pickup or delivery does not exceed thirty (30) minutes, and at least 90% of all pick-ups occur within thirty (30) minutes of the scheduled pick-up time, measured on a monthly basis. Network providers shall report instances of excessive wait times to the Contractor, who shall report this information to the State Contract Manager. The Contractor shall ensure that beneficiaries arrive at pre-arranged times for appointments and are picked up at pre-arranged times, unless beneficiaries have requested, and qualify medically for, "will call" return pick-ups. In the case of "will call" pick-ups, the Contractor must arrive at the pick-up location within ninety (90) minutes of the beneficiary's notification to the Contractor that the beneficiary is ready for the return trip pickup.

The Contractor must develop procedures to prevent excessive multi-loading of vehicles and excessively long trips. A transportation provider shall be allowed to transport up to four (4) adult or nine (9) child beneficiaries at a time. Ninety percent (90%) of shared ride (multi-load) trips must take no more than thirty (30) minutes more than the time required to accomplish the same trip, at the same time of day, under the same weather and traffic conditions, on a non-shared basis.

No more than 1% of scheduled trips shall be missed on a monthly basis.

3.1.6 The Contractor shall develop an operations procedures manual detailing the protocols to be used in scheduling and delivery of transportation services. This manual must be submitted to the State Contract Manager for review and approval at least twenty-five (25) business days prior to Commencement of Operations. The Contractor shall incorporate modifications required by DMAHS and present a revised operations procedures manual to the State within ten (10) business days of written notification of needed corrections and/or modifications. The Contractor shall not be allowed to begin operations without an approved operations procedures manual.

3.1.7 The operations procedures manual must be given to all Contractor staff and must be incorporated into all training programs for new employees. The operations procedures manual shall be reviewed and updated annually and whenever changes in

operations are made. Updates to the manual must be approved by the State Contract Manager before distribution.

3.1.8 The Contractor shall determine and authorize the most appropriate and overall economic mode of transportation is charged to the Medicaid System for each eligible beneficiary requesting transportation services. A person must be non-ambulatory or require assistance to be eligible for MAV transport. If an MNF assessment reveals the beneficiary does not require MAV, then livery and/or public transit are acceptable alternatives. The Contractor may utilize other alternatives with the approval of the State Contract Manager.

3.1.9 The Contractor shall use a scheduling methodology to schedule beneficiary trips and ensure that trip assignment activities are performed efficiently. The scheduling method shall include online scheduling of non-emergency medical transportation by members as well as facilities. Additionally, the scheduling method shall be capable of accommodating advance reservations, subscription service, and requests for Urgent Services, hospital discharges and shall be approved by the State Contract Manager.

3.1.10 The Contractor shall include in its operations procedures manual protocols to improve the compliance of target populations with scheduled transports. The Contractor shall develop procedures to deal with last minute requests from beneficiaries; hospital discharges; scheduling changes; no shows, by clients or providers; and, late running vehicles.

3.1.11 All transport services, except for urgent services and hospital discharges, should be scheduled by Noon two (2) working days prior to the appointment. **NOTE: Emergency (9-1-1) services are not covered under the contract resulting from this RFP.**

3.1.12 The Contractor shall be reimbursed by capitation payments, which encompass payments for all services provided. Capitation payments from the State will be provided by the tenth (10th) day of each month.

3.1.13 Same-day scheduling must be available for urgent situations as may be determined by the Medical Director and hospital discharges. The State Contract Manager, or a designee, will work with the Contractor, if appropriate, to resolve a dispute between the broker and the beneficiary related to transportation services.

3.1.14 The primary site for New Jersey operations must be in New Jersey within thirty (30) miles of the current location at Quakerbridge Plaza in Hamilton, New Jersey.

3.1.15 The Contractor's staff must be available for meetings and conferences at Quakerbridge Plaza, Hamilton Township, New Jersey, at the discretion of the State Contract Manager. If the DMAHS offices move, the Contractor shall attend meetings and conferences at the new location.

3.1.16 The Contractor shall be available to DMAHS staff via telephone on an as-needed basis.

3.2 STAFFING

3.2.1 The Contractor shall have in place ten (10) days prior to the commencement of operations, i.e., ten (10) days prior to the conclusion of the Mobilization Period, the organization, management and administrative systems necessary to fulfill all contractual requirements, in addition to a list of staff members. Before the commencement of

operations, the Contractor shall demonstrate to the State Contract Manager's satisfaction that it has the necessary staffing, by function and qualifications, to fulfill its contractual obligations, which include at a minimum:

- Project manager/liaison who shall be the main point of contact with the State Contract Manager: he/she will be responsible for coordinating all administrative activities for this contract;
- Medical director who shall be a physician, registered nurse or a nurse practitioner licensed in the State of New Jersey;
- Financial officer(s) or accounting and budgeting officer;
- Quality Management Coordinator (QMC);
- Sufficient staff with the qualifications and skills required to provide prior authorization for transportation requests of Customer services staff;
- Provider services staff;
- Facilities services staff;
- Claims processing staff with the qualifications and skills to accommodate processing of transportation claims; and
- Adequate administrative and support staff, including staff to support State fair hearings and serve as compliance contact with the State Contract Manager (see fair hearing).

*Note: Both medical director and financial officer may be located out-of-state and neither is required to be full-time.

3.2.2 The Contractor shall ensure that all staff has appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold, and shall verify and document that it has met this requirement.

3.2.3 The Contractor shall inform the State Contract Manager, in writing and in accordance with RFP Section 5.6, within seven (7) days of key administrative staffing changes including, but not limited to, project manager, medical director, financial officer, QMC, and supervisory staff. Additionally, the Contractor must designate a Project Manager and provide the name, title, address and telephone number of the Project Manager as well as a detailed resume that includes references.

3.2.4 In all cases, vacated positions must be filled and approved by the State Contract Manager and replacement staff must be performing the duties of the vacated position within thirty (30) calendar days, with a reasonable period for transition between new and old staff.

3.2.5 Failure of the Contractor to provide contractually required services due to inadequate staffing, as outlined in this RFP, or to receive prior written approval from the State Contract Manager for staffing changes, or to provide satisfactory replacement personnel, may be cause for contract termination.

3.3 PROVIDER NETWORK RESPONSIBILITIES

3.3.1 The Contractor shall have established ten (10) days prior to commencement of operations, a provider network with sufficient capacity to provide the transportation services covered under the scope of this contract. **NOTE: The contractor is prohibited from being an owner, in full or in part of any organization participating as a transportation provider in the Medicaid program or having equity interest in or being involved in the management of a provider organization or entity.** This prohibition extends to family members of the owners of the Contractor, managers of the

Contractor and any administrative or management services subcontractors of the Contractor on this project as well as former New Jersey-based employees of the Contractor.

3.3.2 The Contractor shall ensure that at least twenty (20) hours of classroom and behind-the-wheel training for all drivers is provided before providing transportation services. Driver training shall minimally include defensive driving techniques, wheelchair securing, wheelchair lift operation, cultural and disability sensitivity training, passenger assistance techniques, first aid, and general customer service. Additionally, new hires shall have forty-five (45) days in which to obtain the requisite twenty (20) hours of training.

Additionally, it is the Contractor's responsibility to ensure that all transport drivers have a valid driver's license and that all vehicle transports are properly insured with a minimum of \$1,000,000 general liability insurance.

3.3.3 The Contractor shall use public transportation passes and its provider network to provide livery, A-MAV, MAV, ground ambulance transportation services for both FFS and MMC beneficiaries throughout the entire State.

3.3.4 Network providers shall not receive or respond to direct requests from beneficiaries for transportation. The beneficiary must contact the Contractor directly. The Contractor shall follow the requirements set by DMAHS regarding provider enrollment, as described in N.J.A.C. 10:50-1.1 et seq.

3.3.5 Network providers must wait at least ten (10) minutes after the scheduled pick-up time before "no-showing" the beneficiary at the pick-up location. The network provider shall document all "no shows."

3.3.6 The Contractor shall provide an escort to accompany any beneficiary during transport who is blind, deaf, mentally ill, developmentally delayed, or under twenty-one (21) years of age. The escort must be at least twenty-one (21) years of age or older. A maximum of four (4) beneficiaries per escort is allowed.

3.3.6.1 A parental waiver may be obtained for beneficiaries older than seventeen (17) years of age through their twenty-first (21) birthday. The Contractor is responsible for making escorts available when required. The cost for this service shall be included in the Contractor's capitation rates.

NOTE: Medicaid regulations limit transportation services to beneficiaries "whose medical condition requires transportation for medical care only." Trips to the pharmacy (excluding DME), or to appointments other than medical care are not covered by the contract resulting from this RFP.

3.3.7 The Contractor is prohibited from contracting with providers who have been terminated elsewhere for fraud or abuse (see N.J.A.C. 10:49). This information may be available at the following website: <http://oig.hhs.gov>. Failure to comply with this requirement may be cause for contract termination.

3.3.8 The Contractor shall be responsible for and require network providers to maintain a daily log, which shall include but not be limited to the following information:

- Date;
- Driver's name;

- Driver's signature (or authenticated log-in ID);
- Transportation provider name and number;
- Actual start time (from base station);
- Each authorized beneficiary with actual pick up time;
- Actual pick-up location;
- No-show indicator;
- Each actual drop off time for authorized beneficiary;
- Actual drop-off location;
- Authenticating beneficiary signature or ID card swipe;
- Actual return time (to base station);
- Authorized stamp and signature of transportation provider; and
- Other pertinent information regarding completion of the trip (cardiac arrest, vehicle break down or accident, etc.).

3.3.9 All network provider agreements must comply with the following requirements for drivers of transportation vehicles:

- All drivers, at all times during their employment, must be at least eighteen (18) years of age and have a current, valid driver's license from the State of New Jersey to operate the transportation vehicle to which they are assigned. (A valid driver's license from another state is acceptable, i.e., New York, Pennsylvania and Delaware.);
- Drivers shall have no more than four (4) chargeable accidents and/or moving violations within the last three (3) years. Drivers shall not have had their driver's license, commercial or other, suspended or revoked within the previous five (5) years;
- Drivers shall not have any prior convictions for substance abuse, sexual abuse or crimes of violence. Refer to Section 3.15 of this RFP for Security Clearance;
- All drivers shall be courteous, patient, and helpful to all passengers and be neat and clean in appearance at all times;
- No driver or escort shall use alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time. The transportation provider shall not use drivers who are known abusers of alcohol or known consumers of narcotics or drugs/medications that would endanger the safety of beneficiaries;
- All drivers and escorts shall wear or have visible, easily readable proper organization identification;
- At no time shall drivers or escorts smoke while in the vehicle, while involved in beneficiary assistance, or in the presence of any beneficiary;
- Drivers shall not utilize any type of personal entertainment device or cellular telephone at any time the vehicle is in motion;
- Drivers shall assist passengers in the process of being seated and confirm that all car seats, booster seats, seat belts are fastened properly and wheelchairs and wheelchair passengers are properly secured. State law requires that children up to age eight (8) or eighty (80) pounds ride in a safety or booster seat in the rear seat of the vehicle;
- Drivers shall provide necessary assistance, support, and oral directions to passengers. Such assistance shall include assistance with beneficiaries of limited mobility, and movement and storage of mobility aids and wheelchairs; and
- It will be the beneficiary's responsibility to have their own booster or car seat, but the contractor shall advise the beneficiary that these items may be obtained through Medicaid.

3.3.10 The Contractor shall ensure that all transportation providers maintain all vehicles adequately to meet the requirements set by the Division of Aging Services (DoAS) and MVC. Vehicles and all components shall comply with or exceed State, Federal, and manufacturer's safety and mechanical operating and maintenance standards for the vehicles. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations. In addition, all vehicles shall meet the following requirements:

- Provide two-way communications between the contractor and network providers, and between network providers and drivers;
- Be equipped with properly functioning heating and air conditioning;
- Have functioning, clean, and accessible seat belts for each passenger seat position. Each vehicle shall utilize child safety seats when transporting children under age eight (8);
- Be equipped with a properly functioning speedometer and odometer;
- Have a clean interior and exterior. The exterior must be free of broken mirrors or windows, excessive grime, major dents, or paint damage that detracts from the overall appearance of the vehicle;
- Have passenger compartments that are clean, free from torn upholstery, free from floor or ceiling covering damage, and do not have broken seats and/or protruding sharp edges. The passenger compartment shall also be free of dirt, oil, grease and litter;
- Have the transportation provider's name, fleet number and telephone number prominently displayed within the interior of each vehicle. This information and the complaint procedures shall be available in written form in each vehicle for distribution to beneficiaries on request;
- Have a smoking prohibition notice that must be visible in all vehicles at all times. All vehicles shall have posted in all vehicle interiors, easily visible to the passengers: "NO SMOKING" "ALL PASSENGERS MUST USE SEAT BELTS";
- Include a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms;
- Contain a fully equipped first aid kit and biohazard spill kit;
- Be available for immediate inspection upon the State Contract Manager's or Contractor's request; and
- Possess functioning interlock system for MAV vehicles, preventing a vehicle from being driven while lift is deployed.

3.3.11 Any vehicle or driver found out of compliance with these requirements and/or State or Federal regulations shall be removed from service immediately until the provider verifies correction of deficiencies to the Contractor. Any deficiencies and actions taken shall be documented and become a part of the vehicle's and the driver's permanent records as appropriate, and shall be reported to the State Contract Manager.

3.3.12 The Contractor shall develop and implement an annual inspection process in addition to the applicable State vehicle inspection requirements to verify that vehicles used by contracted network providers meet the above requirements, those found in N.J.A.C. 10:50-1.1 et seq., and that safety and passenger comfort features are in good working order (e.g., brakes, tires, tread, signals, horn, seat belts, air conditioning/heating, etc.).

Prior to contract award and the service agreement between the Contractor and each network provider, the Contractor shall complete an initial inspection of all the network provider vehicles. Records of all inspections shall be maintained on file for a minimum of five (5) years and readily accessible to DMAHS staff upon request.

Additionally, random inspections of one-twelfth (1/12) of the fleet shall occur each month.

3.3.13 The Contractor shall negotiate rates for related transportation services with network providers. The Contractor may negotiate rates through competitive bidding or utilize other strategies to ensure that the most appropriate and least costly transportation services are provided.

3.3.14 All network providers of non-emergency BLS and ALS must be Medicare-approved providers.

3.3.15 The Contractor shall provide timely payment to each network transportation provider based on the authorized services rendered. Full payment of all authorized trips shall be made to the transportation provider within thirty (30) calendar days of receipt of a clean claim. If information is missing or incomplete, the claim must be resolved within sixty (60) days (i.e., the Contractor may deny if necessary, but may not leave open referrals beyond sixty (60) days). The Contractor's payment procedures shall ensure that transportation provider claims for reimbursement match verification of authorized trips. The Contractor shall validate that all transportation services paid for under the contract are properly authorized and actually rendered. The Contractor shall also have adequate safeguards in place against fraudulent activity by transportation providers and beneficiaries. The Contractor shall be responsible for obtaining refunds from network providers for all fraudulent charges paid.

3.3.16 The Contractor shall not release for distribution newsletters, alerts, letters or related materials to network providers unless approved by DMAHS. Provider communication concerning Medicaid beneficiaries requires DMAHS approval.

NOTE: If the Contractor fails to provide the required service, the State may obtain the required service elsewhere, in which case the costs incurred by the State will be charged to the Contractor.

3.4 CREDENTIALING/RE-CREDENTIALING RESPONSIBILITIES

3.4.1 Fifteen (15) days prior to commencement of operations, the Contractor shall implement a credentialing/recredentialing process to ensure that those requiring licensure/certification under the scope and terms of this RFP are qualified to perform covered services. This process shall include, at a minimum:

- Written policies and procedures – The Contractor shall have written policies and procedures for the credentialing process that include the Contractor's initial credentialing of providers, as well as its subsequent recredentialing, recertifying and/or reappointment of providers;
- Oversight by Medical Director – The Medical Director must review and approve the credentialing policies and procedures;
- Credentialing committee – The Contractor shall designate a credentialing peer review body to make recommendations regarding credentialing decisions; and,
- Process – The initial credentialing process must obtain, review and verify at minimum, all of the following information:
 - valid Division of Aging and Community Services (DACS) vehicle license for MAV;
 - valid New Jersey MVC or neighboring state driver license;

- valid vehicle registration;
- valid Certificate of Insurance;
- valid insurance identification cards;
- Criminal History Background Check;
- fingerprinting, (National fingerprint data-base); and
- approved Medicare Provider, if applicable.

3.4.2 The Contractor shall recredential network providers annually, meeting the same initial credentialing requirements.

3.4.3 The credentialing/recredentialing process shall include review of data from: beneficiary complaints;

- Results of quality reviews;
- Utilization management; and
- Customer satisfaction surveys.

3.4.4 The Contractor retains the right to approve new providers, and to terminate or suspend individual providers. The Contractor shall have policies and procedures for the suspension, reduction or termination of network privileges. The Contractor shall report immediately to the State Contract Manager any suspension, reduction or termination of a network provider's privileges.

3.4.5 The Contractor shall provide a mechanism for, and evidence of, the implementation of the reporting of serious quality deficiencies resulting in suspension or termination of a provider, to the appropriate authorities. MAV and BLS deficiencies should be reported to DoAS and livery deficiencies should be reported to the State Contract Manager.

3.4.6 While the Contractor may terminate a network provider for "no cause", the network provider shall be afforded an appeals process, which shall be described in the Operations Manual and will be subject to State approval. This process shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a State licensing board or other governmental agency.

3.4.7 The Contractor shall not terminate or refuse to renew a contract for participation in the Contractor's network, solely because the provider has (1) advocated on behalf of a beneficiary; (2) filed a complaint against the Contractor; (3) appealed a decision of the Contractor; or (4) requested review.

3.4.8 The Contractor shall ensure compliance with Federal requirements prohibiting employment of or contracts with individuals excluded from participation under the terms and requirements set forth by either, Medicare, Medicaid or both.

3.5 CONTRACTOR OPERATIONAL RESPONSIBILITIES

3.5.1 For each beneficiary requesting transportation services, the Contractor shall make a determination of the beneficiary's eligibility for Medicaid transportation services. Fifteen (15) days after Mobilization Period ends the Contractor shall be able to query the eligibility data utilizing an on-line access site, to be provided by the State as set forth in Section 3.18.1. This information shall be used to confirm beneficiary eligibility and assist with service authorization and trip scheduling.

3.5.2 The Contractor may verify the transportation necessity by confirming the appointment with the medical provider.

3.5.3 The Contractor shall contact the beneficiary to confirm the transportation arrangements with the beneficiary twenty-four (24) hours ahead of the scheduled medical appointment to reduce the possibility of a no-show.

3.5.4 The contractor must not pick up a member from a partial care home after twelve o'clock Noon. Any member with a medical appointment before twelve o'clock Noon will be returned to the partial care home if requested.

3.6 PRIOR AUTHORIZATION RESPONSIBILITIES

3.6.1 The Contractor shall call the beneficiary and acknowledge the beneficiary's request for transportation within two (2) business days. The Contractor shall provide sufficient staff to ensure that the request is acknowledged in this time frame. The Contractor shall meet a monthly compliance rate of 98%.

3.6.2 The Contractor shall be responsible for obtaining the MNF, as part of its prior authorization process for transportation services covered. Beneficiary eligibility must be checked prior to every service.

3.6.3 Prior authorization protocols developed by the Contractor must incorporate current DMAHS policies, as found in N.J.A.C. 10:50-1.1 et seq.

3.6.4 All medical criteria and protocols used as part of the prior authorization process must be approved by the State Contract Manager prior to implementation.

3.6.5 The Contractor shall authorize or deny transportation services for eligible Medicaid beneficiaries based on:

- The transportation must be for a Medicaid covered service;
- The beneficiary must have no other transportation available; and
- The least costly appropriate mode of transportation must be provided as determined by the Contractor.

The Contractor may need to contact the beneficiary's physician to assess the beneficiary's medical need for transportation services.

3.6.6 Medicaid funds may not be used to pay for transportation services that are otherwise available free-of-charge to the general public. Medicaid is always the payer of last resort. Beneficiaries, who are able, should use the public transit system; Medicaid does pay for bus passes. In the event of a hardship i.e., appointment not within reasonable distance from public transportation, Contractor-provided transportation would qualify due to the beneficiary's inability to walk the distance from the public transit system to the appointment.

3.6.7 The Contractor shall arrange within five (5) business days of the request for all beneficiary evaluations requisite to determining appropriate medical necessity for the requested transportation services, as stipulated in RFP Section 3.6.2.

3.6.8 The Contractor shall be required to establish and maintain a database of all initial and follow-up inquiries with prescribers relevant to the URP. The database must include, but not be limited to, beneficiary name, Medicaid number, date of initial request, date of

follow-up request, contact at prescriber's office, disposition of the request, and delivery date of the scheduled transportation.

3.6.9 If the Contractor is unable to determine medical necessity for requested transportation, the Contractor shall request that the prescriber complete and return a MNF. The Contractor and the State Contract Manager shall both be responsible for developing the MNF. (See Exhibit B for a Sample MNF.)

3.6.10 If the prescriber does not respond to the MNF within seven (7) business days of receiving the MNF, the Contractor must again contact the prescriber. If no response is received after fourteen (14) business days from the second contact, the Contractor must notify both the prescriber and the beneficiary in writing that the transportation request is being denied due to the prescriber's failure to respond to the Contractor's request for a completed MNF.

3.6.11 Within one (1) business day of a decision concerning the MNF, the Contractor shall generate a notification letter. In the case of approval, the notification letter shall be sent to the provider and prescriber. In the case of denial, the notification letter shall be sent to the prescriber and beneficiary. These letters are to include, but not be limited to, beneficiary name, mailing address, Medicaid number, reviewer, service description, service dates, prior authorization number (if indicated), and notification of the availability of a Fair Hearing, which is conducted by an Administrative Law Judge.

3.6.12 The Contractor shall document any reduction in level of service by a MNF through investigations or through formal reports from the transportation provider/driver. Service cannot be reduced solely because of failure to provide an MNF.

3.6.13 The Contractor shall prescreen one-way trips over twenty (20) miles from a client's residence to obtain medical necessity with the following provisos:

As an alternative to changing a healthcare provider, a member may arrange for their own transportation to the distant healthcare provider.

The Contractor shall continue to transport any client beyond the twenty (20) miles when a willing participating provider cannot be found within this distance. In addition, when special circumstances require a client to see a provider possessing a particular level of expertise, transportation shall be provided. This can be accomplished by having the referring physician or insurance care manager complete a one-time medical necessity form indicating the reason in detail for this exemption. If insufficient information is provided, refer to the MACC.

3.6.14 The Contractor shall schedule nursing home and hospital trips using the facilities' preferred providers. Such scheduling shall operate as follows:

- The transportation provider is a contracted provider with the Contractor;
- All reservations received will be assigned to the selected contracted transportation provider. Facilities must choose a preferred transportation company that is within the Contractor's provider network; and
- In order to enable facilities to reserve trips with less than forty-eight (48) hours' notice, the Contractor shall assign those trips to the facility's preferred transportation provider and provide the facility with a trip number. The facility will then follow up with that provider to ensure availability of the transportation. This procedure does not change the contractual requirement that all trips be called in

prior to the transportation being provided to allow for gatekeeping of member eligibility, covered medical service, and appropriate mode of transport.

3.7 CALL CENTER REQUIREMENTS

3.7.1 The Contractor shall establish during the Mobilization Period and have operational at its a toll-free Call Center with sufficient dedicated “800” telephone lines to respond to provider, prescriber and beneficiary inquiries concerning the transportation program, in accordance with performance and service standards described in RFP Section 3.9.

3.7.3 As part of its Call Center Services, the Contractor shall provide a language interpreter service and have adequate TTY/TTD capability to ensure that non-English speaking and hearing impaired beneficiaries can access transportation services.

3.7.4 The Contractor shall install and maintain a functioning automatic call distribution system and call reporting system that records and aggregates the following information, at a minimum, on an hourly, daily, weekly, and monthly basis, for the Call Center as a whole and also for individual operators:

- Total number of incoming calls;
- Number of answered calls by Contractor staff;
- Average call wait time;
- Percentage of calls answered in forty-five (45) seconds;
- Average talk time;
- Number of calls placed on hold and the length of time on hold;
- Number of abandoned calls and length of time until call is abandoned;
- Number of outbound calls; and
- Number of available operators by time.

The “hold time” of Sections, 3.7.4 and 3.9.1 refers to the time lapse between the ACD/automated response and the time the call is picked up by a “live” operator.

3.7.5 The Contractor shall develop operations procedures, manuals, forms, and reports necessary for the smooth operation of the Call Center and which must be approved by the State Contract Manager. A demonstration of the telephone system and staffing capability may be required.

3.8 CALL CENTER SERVICE AND PERFORMANCE STANDARDS

3.8.1 The Contractor shall, at all times, adhere to the following performance standards and service levels, to be evaluated by the State Contract Manager on a monthly basis. The Contractor shall develop a process, as a result of real time, automated monitoring by the State Contract Manager or Contractor supervisory personnel, to measure and correct any deficiencies in Call Center performance. This process will ensure that operators adhere to and perform in accordance with the following standards. All Call Center staff or operators must:

- Provide courteous, prompt attention to the caller’s needs;
- Respect the caller’s privacy during all communications and calls;
- Maintain sensitivity to the diversity inherent in New Jersey;
- Maintain a professional demeanor at all times;
- Assure the dissemination of accurate information to all callers;

- Escalate calls from dissatisfied clients to a supervisor and on to a manager if satisfaction cannot be accomplished;
- Report complaints or issues that are resolved within the Call Center (i.e., late or missed pick up); and
- Transfer emergency transportation requests to 9-1-1 or an appropriate local emergency service. **NOTE:** 911 Emergency transportations services are not provided through the contractor under this contract.

3.8.2 The contractor shall adhere to the following performance standards and service levels, which will be evaluated by the State Contract Manager. (Refer to Exhibit A for a full list of performance standards with associated liquidated damages.)

- Call Center Service levels shall be maintained at a minimum of 80% of telephone calls answered within ninety (90) seconds, for calls within the queue;
- Call Center average speeds to answer all calls must not exceed forty-five (45) seconds for all calls within the queue;
- Call Center hold times must not exceed forty-five (45) seconds;
- Call Center busy rate on all incoming calls must not exceed 5%; and
- Call Center abandonment rate shall not exceed 5% of all calls contained in queue;

3.9 CUSTOMER SERVICES

3.9.1 The Contractor shall have in place a Customer Services Unit to coordinate and provide services to eligible Medicaid beneficiaries and network providers. The services include, but are not limited to, assistance with filing of quality of service and access complaints.

3.9.2 This unit shall be adequately staffed to receive the phone calls and respond to beneficiary/network provider concerns. The Contractor shall provide a separate phone line for complaints, with dedicated customer service staff.

3.9.3 The Contractor shall develop a system to ensure that new and current Customer Services Unit staff receives basic and ongoing training and have the expertise necessary to provide accurate information to all eligible Medicaid beneficiaries regarding procedures.

3.9.4 The Contractor shall ensure that Customer Services staff has access to support services that enable communication with beneficiaries whose primary language is not English.

3.9.5 The Contractor shall maintain a Customer Services Manual to serve as a source of information for Customer Services Unit staff. A copy must be provided to the State Contract Manager. On an annual basis, changes shall be incorporated into the Customer Service Manual master copy, which shall be used for making additional distribution copies of the Manual. This manual must include written policies and procedures detailing operation of the complaint process and providing simplified instructions explaining how beneficiaries file a complaint and an appeal. Ideally this manual will be accessible to the Customer Services Unit staff in a searchable electronic format.

3.9.6 The Contractor shall submit any significant and material changes to its customer services policies and procedures to the State Contract Manager for approval prior to implementation.

3.9.7 The Customer Services Unit staff shall be responsible for receiving and responding to all inquiries or complaints – verbal or written – with regard to the delivery of transportation services under the contract from beneficiaries, DMAHS or other sources.

3.9.8 The Customer Services Unit staff shall identify any inquiry patterns and/or trends and report such to the State Contract Manager, along with recommended methods for reversing the trends.

3.9.9 Complaint parameters must include but are not limited to:

- a. A complaint may be filed by a beneficiary verbally or in writing within sixty (60) days of the incident that resulted in the complaint.
- b. The Contractor shall respond verbally to all complaints within one (1) business day of receipt of the complaint. Additionally, the Contractor shall respond to written complaints (in writing) within three (3) business days.
- c. Complaints shall be resolved within ten (10) days.

3.10 COMPLAINT MONITORING AND RESPONSE

3.10.1 The Contractor shall be responsible for the following: receiving and responding to all inquiries and complaints, oral or written, with regard to the delivery of transportation services under the contract, from beneficiaries, providers, DMAHS or other sources. The Contractor should encourage everyone to submit their concerns in writing.

3.10.1.1 The Contractor shall provide beneficiaries and network providers an independent unit of the Customer Services Unit to monitor and address complaints. This unit must be adequately staffed to receive the phone calls and respond to beneficiary/network provider concerns. The Contractor should identify and document any inquiry patterns and/or trends to the State Contract Manager.

3.10.2 The Contractor shall develop written policies and procedures that detail the operation of a complaint process and provide simplified instructions on how to file a complaint, or appeal, for both the beneficiaries and network providers. The policies and procedures must be submitted to and approved by the State Contract Manager prior to implementation.

3.10.3 A complaint may be filed by a beneficiary or a network provider orally or in writing within sixty (60) days of the incident that resulted in the complaint. Complaints shall be resolved within ten (10) days of their filing. The Contractor and the beneficiary/network provider should attempt to resolve any complaint.

- a. The Contractor shall maintain a complaint log and standardized written procedures for the handling all complaints. A summary report categorizing the complaints by type and providing as much factual information as possible must be prepared by the Contractor.
- b. The Contractor shall maintain a log of all complaints and analyze on a monthly basis all complaints received to determine the quality of services provided by a network provider and to beneficiaries, and to identify patterns or trends in the complaints being filed. All complaint documentation and the action(s) taken to resolve the complaint shall be logged, in addition to analyzing the complaint data

for quality improvement as an integral part of the Contractor's quality monitoring function.

- c. The Contractor shall respond/acknowledge verbally to all complaints within one (1) business day of receipt of the complaint. Additionally, the contractor shall respond/acknowledge to written complaints (in writing) within three (3) business days. Upon the receipt of verbal complaints, the Contractor shall offer to respond in writing.

3.11 CONTRACTOR CLAIMS PROCESSING RESPONSIBILITIES

3.11.1 The Contractor shall be responsible for adjudicating transportation claims submitted by approved network providers.

3.11.2 The Contractor shall provide the State with on-line access to all claims and related information.

3.11.3 The Contractor shall meet the following claims processing timeliness standards:

- Ninety percent 90% of all clean claims must be adjudicated within thirty (30) calendar days of receipt by the Contractor. Adjudicated claims include all claims paid (including zero payment), denied and, in the case of certain claims, claims priced and paid but for which the actual issuance of a check is suppressed;
- Ninety-nine percent 99% of all clean claims must be adjudicated within sixty (60) calendar days of receipt by the Contractor;
- Non-clean claims must be adjudicated within twenty-four (24) calendar days of the date of correction of the condition that caused the claim to be non-clean;
- All claims must be adjudicated within twelve (12) months of receipt in the Contractor's mailroom, except for those exempted from this requirement by Federal timely claims processing regulations as cited in the Federal regulations at 42 CFR Part 447.45;
- All provider billing adjustments must be processed for payment or denied within thirty (30) calendar days of receipt by the Contractor;
- All notifications of payment denial must be mailed by the Contractor within two (2) business days after adjudication of the claim by the Contractor; and
- Those circumstances when claim resolution is being handled directly by State staff in accordance with State guidelines or held by the Contractor under State written directive shall not be counted in the calendar day threshold. All claims received regardless of submission method must be assigned an Internal Control Number by the Contractor.

3.12 CONTRACTOR OUTREACH RESPONSIBILITIES

3.12.1 Within fourteen (14) days of Commencement of Operations, the Contractor must develop and mail to all network providers an introductory informational package to include (1) URP procedures; (2) standards; (3) retrospective review procedures; and, (4) how to obtain prior authorizations and claims processing.

3.12.2 The Contractor shall provide information and shall adequately educate the beneficiary population in the State regarding the availability of medical transportation services; eligibility for these services; the authorization process; and how to access and use these services properly. The Contractor shall develop educational information, including but not limited to a promotional brochure, emphasizing ways to access Medicaid transportation services. The Contractor shall educate and manage

beneficiaries who are chronically late, “no-shows,” or abusive. No-shows and abusive behavior of beneficiaries must be documented.

3.12.3 The brochures may be distributed at Medicaid access points to educate beneficiaries regarding available transportation services. Material developed by the Contractor for distribution to beneficiaries or providers must be approved by DMAHS prior to distribution. The Contractor shall produce written materials in English and Spanish.

Prior to project implementation, the State Contract Manager will notify all beneficiaries of the changes in the transportation delivery system and the Contractor’s toll-free number for requesting transportation services.

NOTE: The Contractor is not required to mail material to beneficiaries.

3.13 CONTRACTOR COMPLIANCE AND REPORTING RESPONSIBILITIES

3.13.1 The Contractor shall participate in fair hearings related to the determinations of prior authorization. Fair Hearings must be requested of DMAHS within twenty (20) days of the date of an adverse action. Requests by beneficiaries or providers on their behalf must be received in writing by the DMAHS Fair Hearing Unit, P.O. Box 712, Quakerbridge Plaza, Trenton, N.J. 08625. The Contractor shall print this statement regarding a beneficiary’s right to a fair hearing and the time limitation on adverse action letters.

3.13.2 The Contractor shall monitor utilization and claims payments to detect and report fraud and abuse and the Contractor shall report such findings to the DMAHS and MFD.

3.13.3 The Contractor shall participate in meetings to prepare for the auditing of their functions by State and Federal agencies.

3.13.4 The Contractor, in its role as a consultant to State agencies in matters relating to transportation services, shall participate in various other proceedings, such as testifying at proceedings arising from, but not limited to, audit/review activity.

3.13.5 The Contractor shall submit accurate and complete management reports to the State Contract Manager no later than twenty (20) days after the close of the month so that fully reconciled data is provided to the State. The Contractor shall provide the following management reports to the State Contract Manager on the frequency and in the format specified for each report. All reports must be submitted in electronic format. Informational data reports must be provided on a CD in Microsoft Excel format. In addition, all narrative reports must be provided on a CD in Microsoft Word or Adobe PDF format.

- Transportation Summary Report summarizing all authorizations and denials of transportation services by type of transportation in accordance with RFP Section 3.1.5. The data elements must include beneficiary’s name, ID number, date of service, transportation service provider, service type, pick-up point, and destination. Other data elements may be specified by DMAHS;
- Call Center Report and ACD Report summarizing call volume, nature of calls and information listed in RFP Section 3.7;
- Complaint Log summarizing complaints received and their resolution including any corrective action taken, per RFP Section 3.11.3a; and

- Annual Transportation Report describing the project and contracted services, major problems and issues and how they were addressed, and future plans, as well as a statistical summary of services. A draft of the report shall be submitted to DMAHS within forty (40) business days after the close of each year of operation and the final report shall be submitted to DMAHS within twenty (20) business days of receipt of DMAHS comments.

The Contractor shall provide other operational, management and/or ad hoc reports required by DMAHS, including but not be limited to the following:

- a. Monthly On-Time Performance Report identifying those trips in which the waiting time for pickup and delivery exceeded thirty (30) minutes. Output must include but not be limited to name of network provider, waiting time, service date/time, per RFP Section 3.1.5;
- b. Monthly Bariatric Completion Report that includes trip date, trip status, rider number, pick up and drop office facility, transportation provider and cancellation reason;
- c. Monthly report of staffing changes that includes, but is not limited to: name(s) of staff, position(s) under change, date of change, reason for change, impact on organizational profile and recommend substitutions if available, in accordance with RFP Section 3.2;
- d. Monthly Rider No-Show Report identifying recipients who were “no shows”, and which includes, but is not limited to: recipient name, recipient ID number, provider name, date of service/time, scheduled pick-up/delivery destination;
- e. Upon Commencement of Operations, as part of the credentialing/recredentialing process, the Contractor shall provide a list to DMAHS that includes the name, address and social security number of all escorts authorized by the Contractor to accompany any beneficiary under twenty-one (21) years of age. As part of the credentialing/recredentialing process, the Contractor shall demonstrate that all BLS-FFS providers are Medicare approved. The list shall be updated monthly, per RFP Section 3.4;
- f. The Contractor shall perform a monthly audit of at least thirty 30% of the network provider maintenance and related vehicular records and report its summarized findings to the State Contract Manager within twenty (20) days after the close of the reported-upon calendar month. The report format shall be mutually agreed to by the Contractor and the State Contract Manager, per RFP Section 3.3;
- g. The Contractor shall provide the State Contract Manager a quarterly report summarizing the outcome of annual provider network inspections. This report must be submitted to DMAHS within thirty (30) days after the close of the inspection period. The report format shall be mutually agreed to by the Contractor and the State Contract Manager, per RFP Section 3.3;
- h. Monthly Prompt Payment report identifying all clean claims not fully adjudicated within thirty (30) days of receipt by the Contractor, per RFP Section 3.12;
- i. Monthly Prompt Payment report identifying all claims not fully adjudicated thirty-one to sixty (31-60) days following receipt by the Contractor, per RFP Section 3.12;
- j. A monthly No Vehicle Available (NVA) report identifying transportation requests not responded to by the Contractor within one (1) business day, and that includes, but is not limited to, date of requested services, requested service, and reasons for failure to meet standards;
- k. A Monthly Denial Report identifying all transportation service authorizations denied by the Contractor, and which includes, but is not limited to, recipient name, recipient ID number, date of requested service, requested service, reason for denial, per RFP Section 3.1;

- I. Monthly Exception Report identifying beneficiary evaluation not conducted within seventy-two (72) hours of a transportation request being received by the Contractor, and which includes, but is not limited to, provider name, recipient name, recipient ID number, requested service, reason(s) for the delay in conducting beneficiary evaluation, per RFP Section 3.1;
- m. Upon request, Exception Report identifying MNFs not responded to within five (5) business days of receipt by the Contractor, and which includes, but is not limited to, provider name, recipient name, recipient ID number, requested service, reason(s) for the delay in not responding to MNFs, per RFP Section 3.6.14;
- n. Upon request, MNF Tracking report that identifies the responsiveness of the Contractor to MNFs that have not been returned timely. Output must include, but shall not be limited to, prescriber name, recipient name, recipient ID number, MNF tracking number, date of request(s), type of service, and reasons for failure to follow up, per RFP Section 3.6.14; and
- o. The Contractor shall provide monthly encounter claims using Version 5010A1 837P electronic claim format.

3.13.6 Timely receipt of these reports shall be a prerequisite for authorization of monthly payment to the Contractor. Failure to provide accurate and complete management reports by reporting deadlines may result in a delay or suspension of payment to the Contractor, pursuant to RFP Section 5.15 (Retainage), until the reports are received and approved by the State Contract Manager.

3.14 CONFIDENTIALITY

3.14.1 The Contractor shall maintain the confidentiality of beneficiary information. The Contractor shall ensure that access to beneficiary information is limited to the Contractor. The Contractor shall take measures to prudently safeguard and protect unauthorized disclosure of the confidential information in its possession.

3.14.2 The Contractor and all network providers shall comply with all Federal and State laws and regulations with regard to handling, processing, and using health care data. This includes, but is not limited to, the Federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA) and regulations. These regulations are evolving and are therefore of a dynamic nature. The Contractor must keep abreast of the regulations and be able to reach full compliance within the specified timeframes. Since HIPAA is Federal law and its enacting regulations apply to all health care information, the Contractor and all network providers must comply with HIPAA regulations at no additional cost to the State.

3.14.2.1 The Contractor shall be required to sign a (HIPAA) Business Associate Agreement. This Agreement sets forth the responsibilities of the Contractor with DHS, DMAHS, as a Covered Entity, in relationship to Protected Health Information (PHI), as those terms are defined and regulated by the HIPAA, and the regulations adopted thereunder by the Secretary of the United States Department of Health and Human Services, with the intent that the Covered Entity shall at all times be in compliance with HIPAA and the underlying regulations.

3.14.3 The Contractor shall establish internal policies to ensure compliance with Federal and State laws and regulations regarding confidentiality. In no event may the Contractor provide, grant, allow, or otherwise give access to confidential information to anyone without written permission of DMAHS. The Contractor shall assume all liabilities under Federal and State law in the event that the information is disclosed in any manner.

3.14.4 Upon the Contractor's receipt of any requests for confidential information from any individual, entity, corporation, partnership or otherwise, the Contractor shall notify DMAHS within twenty-four (24) hours. The Contractor shall ensure there is no disclosure of data except through DMAHS. DMAHS will treat such requests in accordance with DMAHS policies. In cases where the information requested by outside sources is releasable under the Freedom of Information Act (FOIA), as determined by DMAHS, the Contractor shall provide support for copying and invoicing such documents at the contractor's expense.

3.14.5 Any use, sale or offering of utilization data in any form by the Contractor, his/her employees or assignees shall be considered a violation of the contract resulting from this RFP, and will be reported to the Attorney General for possible prosecution or other legal action. Violation of such guarantees shall include, but are not limited to, the cancellation of the contract and/or legal action with damages paid to the State.

3.15 SECURITY CLEARANCES

3.15.1 As a condition of performing work for any State agency and for purposes of determining a person's qualifications for employment, the Contractor shall undertake a criminal history record background check for all its employees at the State, Federal, and county levels. This shall pertain to anyone providing services under the contract resulting from this RFP. The Contractor shall undertake a criminal background check for all network providers, subcontractor and subcontractor employees assigned to do work for any State agency pursuant to N.J.A.C. 13:59-1.1 et seq. The Contractor shall bear the cost of the criminal history record background check. The Contractor shall be responsible for ensuring that employees have legal immigration status to be working in the United States.

3.15.2 The Contractor shall follow all instructions for obtaining a criminal history record background check at www.njsp.org/about/serv_chrc.html. The Contractor shall not permit any newly hired, rehired or transferred employee who provides service under the contract resulting from this RFP until the results of the criminal history record background check have been reviewed and cleared to the Contractor.

3.15.3 The Contractor shall retain the result of the individual's criminal history background check for as long as that individual is assigned to work for any State agency. The results of the criminal history background check must be made available to the State Contract Manager upon request. Performance of such background checks with immigration law compliance shall be subject to periodic audits by State auditors. If the Contractor has had a State Police background, criminal and fingerprinting check performed for an employee that satisfies the exact criteria specified above, the State Contract Manager may accept the results of the criminal history background check, provided that the check was performed during the contract period or no earlier than six (6) months prior to the contract start date.

3.16 HEALTH CARE DATA COMPLIANCE

The Contractor shall comply with all Federal and State laws and regulations with regard to handling, processing, and using health care data. This includes but is not limited to, the HIPAA and regulations. These regulations are evolving and are therefore of a dynamic nature. The Contractor must keep abreast of the regulations and be able to reach full compliance within the specified timeframes. Since HIPAA is Federal law and its enacting regulations apply to all health care information, the contractor must comply with the HIPAA regulations at no additional cost to the State.

3.17 ACCESS TO RECORDS

In addition to the terms stated elsewhere in this RFP, the State and appropriate Federal agencies shall have access, upon demand, to any books, documents, papers and records of the Contractor that are directly pertinent to the contract, for the purpose of making audit examinations, excerpts and transcriptions. The Contractor shall insert identical rights of access for the State into any subcontractor agreement the Contractor enters into under the contract resulting from this RFP. Failure to meet the requirements of this section will be considered a violation of the contract by the Contractor. Penalties for such violation will include, but not be limited to, cancellation of the contract with any damages paid to the State.

3.18 STATE RESPONSIBILITIES

3.18.1 Upon contract award, the State will provide the Contractor access to the State's Medicaid Eligibility Verification System (MEVS). This system provides the Contractor read-only, on-line access to Medicaid beneficiary eligibility information.

3.18.2 Fourteen (14) business days after contract award, the Contractor will be provided with a list of network of transportation providers who presently provide transportation service to Medicaid beneficiaries in the State, in addition to a list of transportation providers whose enrollment in this Medicaid program has been terminated by DMAHS during the term of the prior contract.

3.19 PAYMENT TO CONTRACTOR

3.19.1 One (1) rate will be applied to calculate monthly capitation payments. Capitation payments will begin on the first day of the month in which transportation services begin.

NOTE: As described in Section 2.2 **SPECIFIC DEFINITIONS** of this RFP, - The amount paid monthly by DMAHS to the contractor in exchange for the delivery of covered services to enrollees based on a fixed Capitation Rate per enrollee, notwithstanding (a) the actual number of enrollees who receive services from the contractor, or (b) the amount to any particular enrollee.