The State of West Virginia

Bureau for Medical Services

Request for Proposal (RFP) MED13006

Medicaid Management Information System (MMIS) Re-procurement

Receipt Location:

WV Department of Health and Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

WARNING: Prospective Offerors who have received this document from a source other than the Issuing Office should immediately contact the Issuing Office and provide their name and mailing address so that amendments to the RFP or other communications can be sent to them. A prospective Offeror who fails to notify the Issuing Office with this information assumes complete responsibility in the event that they do not receive communications from the Issuing Office prior to the closing date.

Proposals shall be addressed to:

WV Department of Health and Human Resources
Office of Purchasing
ATTN: Donna Smith
One Davis Square, Suite 100
Charleston, WV 25301Phone: (304) 957-0218 | Fax: (304) 558-2892

Exclusion of Vendors Paid for Preparing Solicitations: In accordance with ***West Virginia Code*** §9-2-9b (e) The secretary may employ the services of independent professional consultants to assist in preparing solicitations or for the evaluation of any responses to such solicitations: *Provided*, That the independent professional consultant, or member of his or her immediate family, or business with which he or she is associated may not have any interest in the profits or benefits of the contract for which he or she may participate in the preparation of the solicitation or in the evaluation of the response.

The following vendors have received compensation for and participated in preparing this solicitation and are hereby excluded from bidding as the primary contractor or as a subcontractor on this procurement.

1. Fenwick Technologies Inc.
   - Phil Weikle
2. BerryDunn
   - Tim Masse
   - Laurel Arnold
   - Nicole Becnel
   - Marcey McHatten
   - Brandon Milton
   - Laura Killebrew
   - Laurie Sturgis
   - Judy Higgins
   - Joe Herlihy
   - Chad Snow
   - Seth Hedstrom
   - Charlie Leadbetter
   - Kristan Drzewiecki

By signing and submitting its proposal, the Vendor affirms that it and its representatives are compliant with the requirements of ***West Virginia Code*** §9-2-9b (e) and that it will not subcontract work associated with this contract to any vendors identified above.

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APPENDICES

REQUEST FOR PROPOSAL

Bureau for Medical Services RFP MED13006

PART 1 GENERAL INFORMATION, TERMS AND CONDITIONS

1.1 Purpose

The Bureau for Medical Services, hereinafter referred to as "Bureau" or "BMS," is soliciting proposals to obtain the services of a qualified vendor to provide the fiscal agent services and the Design, Development, and Implementation (DDI); Centers for Medicare and Medicaid Services (CMS) certification; and operation for a replacement Medicaid Management Information System (MMIS) solution. This solicitation serves as notice, pursuant to West Virginia Code §9-2-9b of the services being sought and is to be considered the opportunity for Vendors to indicate their interest in bidding on such services.

1.2 Project

BMS seeks to procure a vendor to provide information technology products and services to design, develop, implement, obtain CMS certification, operate and serve as fiscal agent for a replacement MMIS solution, including but not limited to, the components and functions as listed below and as defined in the business and technical requirements of this RFP (see Appendix E):

Member Management
(Appendix E, Section 1)

- Determine Eligibility
- Enroll/Disenroll Member
- Manage Member Information
- Inquire Member Eligibility
- Perform Population and Member Outreach
- Manage Applicant and Member Communication
- Manage Member Grievance and Appeal

Provider Management
(Appendix E, Section 2)

- Enroll Provider
- Provider Contracts
- Disenroll Provider
- Inquire Provider Information
- Manage Provider Communication
- Manage Provider Appeal
- Manage Provider Information
- Perform Provider Outreach

Operations Management
(Appendix E, Sections 3.1-3.7)

- Service Authorization
- Payment Management, Claims/Encounter Adjudication

- Payment Management, Payment and Reporting
- Payment Management, Capitation and Premium Payments
- Payment Information Management
- Member Payment Information
- Cost Recoveries

Program Management
(Appendix E, Section 4)

- Manage Rate Setting
- Manage 1099s
- Perform Accounting Functions
- Develop and Manage Performance Measures and Reporting
- Monitor Performance and Business Activity
- Manage Program Information
- Maintain Benefit/Reference Information

Care Management
(Appendix E, Section 5)

- Manage Medicaid Population Health
- Establish Case
- Manage Case

Pharmacy Point-of-Sale (POS)
(Appendix E, Section 6)

- General/Technical
- Drug File
- Claims Processing
- Drug Utilization Review (DUR)
- Prior Authorization
- Pricing
- Financial Processes
- Reporting

General/Technical
(Appendix E, Section 7)

- Change Control
- Data Retention, Archival, Retrieval and Purge
- Disaster Recovery and Business Continuity
- Problem Management
- Release Management
- Security Management
- Standards
- Support
- System Integration
- System Interfaces
- Workflow Management
- Test Environments

- Automated Voice Response System (AVRS)
- Call Center
- Contact Management
- EDI Portal
- Electronic Data Management System (EDMS)
- Reports
- User Interface
- Web Portal

Vendor Operational Requirements (Appendix F)

- General
- Member Management
- Benefit Administration
- Provider Management
- Prior Authorization
- Pharmacy Point-of-Sale (POS)
- Reference Data Maintenance
- Claims Processing
- Financial Management
- Management and Administrative Reporting (MAR)
- Drug Rebate
- Contact Management
- Customer Service Support Call Center
- Member Eligibility Verification System (MEVS)
- Automated Voice Response System (AVRS)
- Mail Room
- Web Portal
- Technical

BMS expects a delivered replacement MMIS that aligns with Medicaid Information Technology Architecture (MITA) principles and employs a service-oriented architecture. The proposed MMIS system should achieve the Medicaid goals and objectives and to attain the “To Be” capabilities identified by BMS in the MITA State Self-Assessment (SS-A) (see Appendix B). Therefore, BMS must have an MMIS that is responsive to changes in the State’s program, able to address new regulatory requirements, and readily allows for timely remediation of deficiencies.

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The project will consist of three major phases:

Phase 1 (MMIS Replacement DDI and Certification Planning)

a. Start-up
b. Analysis and Design
c. Development, Testing, Data Conversion, and Training
d. Implementation
e. CMS Certification Planning

Phase 2 (Fiscal Agent Operations)

a. Routine Operations
b. CMS Certification
c. MMIS Modifications and Enhancements

Phase 3 (Turnover and Closeout)

1.3 **Legal Basis**

The procurement process for this RFP will be conducted in accordance with the procurement policies and procedures established by the Secretary of the Department of Health and Human Resources as provided for in West Virginia State Code §9-2-9b.

1.4 **RFP Format**

This RFP has four parts. “Part 1” contains general information, terms and conditions; “Part 2” describes the background and working environment of the project; “Part 3” is a statement of the specifications for the services requested pursuant to this RFP, contractual requirements, and special terms and conditions; and “Part 4” explains the required format of the Bidder’s response to the RFP, the evaluation criteria the Bureau will use in evaluating the proposals received, how the evaluation will be conducted and how the award will be made.

1.5 **Inquiries**

Additional information inquiries regarding specifications of this RFP must be submitted in writing to DHHR Office of Purchasing. The deadline for written inquiries is identified in the Schedule of Events, Section 1.17. All inquiries of specification clarification must clearly identify the RFP MED13006 and be addressed to:

WV Department of Health and Human Resources
Office of Purchasing
ATTN: Donna Smith
One Davis Square, Suite 100
Charleston, WV 25301
Donna.D.Smith@wv.gov
Phone: (304) 957-0218 | Fax: (304) 558-2892

The Vendor, or anyone on the Vendor’s behalf, is not permitted to make any contact whatsoever with any member of the evaluation committee. Violation may result in rejection of the bid. The person named above is the sole contact for any and all inquiries after this RFP has been released.

1.6 **Vendor Registration**

Vendors participating in this process should complete and file a ***Vendor Registration and Disclosure Statement*** (Form WV-1) with the West Virginia Department of Administration (DOA) Purchasing Division and remit the registration fee. Vendor is not required to be a registered vendor in order to submit a proposal, but the **successful bidder must** register and pay the fee prior to the award of an actual purchase order or contract.

1.7 **Oral Statements and Commitments**

Vendor must clearly understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any State personnel is not binding. Only the information issued in writing and added to the Request for Proposal specifications file by an official written addendum are binding.

1.8 **Economy of Preparation**

Proposals should be prepared simply and economically, providing a straightforward, concise description of Vendor's abilities to satisfy the requirements of the RFP. Emphasis should be placed on completeness and clarity of content.

1.9 **Labeling of RFP Sections**

The sections within this RFP contain instructions governing how the Vendor's proposal is to be arranged, submitted and to identify the material to be included therein.

1.9.1 *Mandatory Requirements*

Any specification or statement containing the word "must", "shall", or "will" are mandatory. Part 3 Section 3.1 contains mandatory deliverables required upon contract execution. By signing and submitting a response to this RFP, the Vendor agrees to all mandatory deliverables described herein. Part 4 describes RFP response requirements, which may be mandatory. The Vendor is required to meet all mandatory requirements in order to be eligible for consideration and to continue in the evaluation process. Failure to meet or agree to mandatory items shall result in disqualification of the Vendor's proposal and the evaluation process will be terminated for that vendor. Decisions regarding compliance with any mandatory requirement shall be at the sole discretion of the Bureau.

1.9.2 *Contract Terms and Conditions*

This Request for Proposals contains all the contractual terms and conditions under which the BMS will enter into a contract.

1.9.3 *Informational Sections*

Informational specifications do not require a response from the Vendor. They are intended to aid the Vendor in structuring an effective proposal capable of meeting the needs of the issuing agency.

1.10 **Proposal Format and Submission**

1.10.1 Each proposal should be formatted as per the outline in Part 4 of this RFP. No other arrangement or distribution of the proposal information may be made by the bidder. Failure on the part of the bidder to respond to specific requirements detailed in

the RFP may be the basis for disqualification of the proposal. The BMS reserves the right to waive any informality in the proposal format and minor irregularities.

1.10.2 Bureau procurement policies require that the original technical and the original cost proposal be submitted to DHHR Office of Purchasing. All proposals must be submitted to the DHHR Office of Purchasing **prior** to the date and time stipulated in the RFP as the opening date. All bids will be dated and time stamped to verify official time and date of receipt.

1.10.3 Vendors mailing proposals should allow sufficient time for mail delivery to ensure timely arrival. The Bureau cannot waive or excuse late receipt of a proposal which is delayed and/or late for any reason. Any proposal received after the bid opening date and time will be immediately disqualified in accordance with Bureau procurement policies.

Vendors responding to this RFP shall submit:
One (1) original and twenty (20) convenience copies AND one (1) copy on CD of the Technical proposal; and one (1) original and twenty (20) convenience copies AND one (1) copy on CD of the Cost Proposal, to:

WV Department of Health and Human Resources
Office of Purchasing
ATTN: Donna Smith
One Davis Square, Suite 100
Charleston, WV 25301
Phone: (304) 957-0218 | Fax: (304) 558-2892

The outside of the envelope or package(s) should be clearly marked:

RFP # MED13006

All proposals must be received prior to 1:30 pm on June 21, 2012

1.10.4. **Standard Format**
1.10.4.1 *Proposal Format and Content*: Proposals shall be requested and received in two distinct parts: Technical and Cost. The cost portion shall be sealed in a separate envelope.

1.10.4.2 *Bid Opening*: The DHHR Office of Purchasing will open the proposals based on the Schedule of Events.

1.10.4.3 *Evaluation Committee.* The evaluation committee will be made up of no less than three (3) and no more than seven (7) Subject Matter Experts (SMEs). The number and backgrounds of the SMEs will depend on the complexity and size of the project. These SMEs will be drawn from the BMS and other agencies, as appropriate, and will be approved by the BMS Commissioner or designee. The Evaluation Committee then will review and evaluate all technical proposals received in response to this RFP.

1.10.4.4 *Evaluation Criteria*: Each proposal shall be evaluated, measured and ranked using the evaluation criteria described here. The Bureau hereby reserves the right to evaluate, at its sole discretion, the extent to which each proposal received compares to said criteria. The recommendation of the Evaluation Committee shall be based on the evaluations using the criteria described here.

The following table depicts the scoring methodology that will be used to evaluate proposals.

Description	Maximum Score
Technical	
Vendor Capacity, Qualifications, References, and Experience	10
Staff Capacity, Qualifications, References, and Experience	20
Project Approach and Solution	15
Solution Alignment with BMS' Business and Technical Needs	25
Technical Subtotal:	**70**
Cost	**30**
Maximum Total Points Awarded:	**100**

The Bureau may, if necessary, ask vendors for additional information to clarify their proposals. The Bureau reserves the right to accept or reject any or all of the proposals, in whole or in part, without prejudice, if to do so is felt to be in the best interests of the Bureau. Vendor's failure to provide complete and accurate information at any point in the evaluation process may be considered grounds for disqualification.

1.10.4.5 *Evaluation Committee Recommendation:* After the cost proposals have been opened, the Evaluation Committee completes its review and prepares the final vendor evaluation. The Evaluation Committee's final recommendation to the DHHR Office of Purchasing is based on best value. Cost is considered, but is not the sole determining factor for award.

1.10.4.6 *Minimum Acceptable Score:* Vendors must score a minimum of **70%** of the total technical points possible. The minimum qualifying score on the technical portion is 49 points. All vendors not attaining the Minimum Acceptable Score (MAS) shall be disqualified and removed from further consideration. A vendor's failure to provide complete and accurate information may be considered grounds for disqualification.

1.10.4.7 *Resident Vendor Preference:* DHHR Purchasing Division will make the determination of the Resident Vendor Preference, if applicable. Resident Vendor Preference provides an opportunity for qualifying vendors to request at the time of bid preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the West Virginia Code. A certificate of application is used to request this preference. A West Virginia vendor may be eligible for two 2.5% preferences in the evaluation process.

1.10.4.8 *Oral Presentation:* If included in the Schedule of Events, at the option of the BMS, oral presentations may be required. Vendors will be notified if any oral presentation is required. Any cost incidental to an oral presentation shall be borne entirely by the vendor and the BMS shall not compensate the vendor.

The vendors should present complete, comprehensive proposals without relying on oral presentations, because the BMS reserves the right to award a contract without further discussions or an oral presentation. Presentations will be recorded and any representations made during the oral presentation will become part of the vendor's proposal and are binding if a contract is awarded.

1.10.4.9 *Site Visits:* The BMS may request to review the Vendor's facilities, other Vendor clients or its subcontractors' facilities. This may include, but not be limited to, a review of policies and procedures, and any other area of operation that directly or indirectly affects the provisions of the RFP or contract. Site visits will not be scored separately, but may influence the overall technical scoring.

Any cost incidental to the site visit by the Vendor shall be borne by the Vendor. The BMS will be responsible for its own travel and accommodations.

A readiness review may also be conducted on-site at the selected Vendor's facilities following execution of the contract and before implementation of any project work.

1.10.4.10 *Contract Approval and Award*: After the cost proposals have been opened, the Evaluation Committee completes its review and prepares the final evaluation making its recommendation for contract award based on the highest scoring vendor. The final evaluation must be reviewed and approved by the DHHR Office of Purchasing Director.

1.10.4.11 *Vendor Debrief*: As the evaluation and award process has been described and documented, unsuccessful vendors have the opportunity to request a debriefing. That debriefing will be conducted at BMS facilities, privately, with the requesting vendor, the buyer and appropriate members of the Evaluation Committee. The vendor's proposal will be discussed, and the Evaluation Committee scoring and contract award will be explained. This will help vendors understand the process, be more competitive by improving their proposals, and will increase their potential for winning bids.

1.11 Rejection of Proposals

The Bureau shall select the best value solution according to the evaluation criteria described in this document. However, the Bureau reserves the right to accept or reject any or all proposals, in part or in whole at its discretion. The Bureau reserves the right to withdraw this RFP at any time and for any reason. Submission of, or receipt by the Bureau of proposals confers no rights upon the bidder nor obligates the Bureau in any manner.

A contract based on this RFP and the Vendor's proposal, may or may not be awarded. Any contract resulting in an award from this RFP is not valid until properly approved and executed by the Secretary of the Department of Health and Human Resources.

Unsuccessful vendors, who have requested and participated in a debriefing, can protest an award within 5 business days of the date of the notification of an unsuccessful proposal. Protests will be submitted, in writing, to the DHHR Office of Purchasing Director. Protests will contain appropriate information, including grounds for the protest, supporting documentation, if necessary, and resolution or relief sought. The DHHR Secretary (or his/her designee) will review the protest; conduct a hearing (at the Secretary's discretion); and issue a written decision. Any delay of the procurement will be up to, and at the discretion of the DHHR Secretary.

1.12 **Incurring Costs**

The BMS and any of its employees or officers shall not be held liable for any expenses incurred by any bidder responding to this RFP for expenses to prepare, deliver the proposal, or to attend any mandatory pre-bid meeting or oral presentations.

1.13 **Addenda**

If it becomes necessary to revise any part of this RFP, an official written addendum will be issued by DHHR Office of Purchasing to all bidders of record.

1.14 **Independent Price Determination**

A proposal will not be considered for award if the price in the proposal was not arrived at independently without collusion, consultation, communication or agreement as to any matter relating to prices with any competitor unless the proposal is submitted as a joint venture.

1.15 **Price Quotations**

The price(s) quoted in the bidder's proposal will not be subject to any increase and will be considered firm for the life of the contract unless specific provisions have been provided for adjustment in the original contract.

1.16 **Public Record**

1.16.1 *Submissions are Public Record.*

All documents submitted to the Bureau related to purchase orders or contracts are considered public records. All bids, proposals or offers submitted by bidders shall become public information and are available for inspection during normal official business hours at the DHHR Office of Purchasing after the bid opening.

1.16.2 *Written Release of Information.*

All public information may be released with or without a Freedom of Information request, however, only a written request will be acted upon with duplications fees paid in advance. Duplication fees shall apply to all requests for copies of any document. The fees are determined in accordance with DHHR Policy 2510.

1.16.3 *Freedom of Information/Disclosure.*

All documents in this RFP process are subject to West Virginia's Freedom of Information Act (FOIA) and may be disclosed upon request. The vendor must clearly identify which data are considered proprietary. If the BMS receives a FOIA request for data, labeled by the vendor as proprietary, the BMS will notify the vendor (in writing) of the request to allow the vendor time to obtain the appropriate court order to

prevent the release of the information. Otherwise, the BMS will be compelled by State law to release such information.

If a vendor's proposal includes proprietary language within the technical proposal, an electronic copy omitting any proprietary language for publishing to the DHHR web-site shall be submitted.

1.16.4 *HIPAA Compliance*

BMS contracts require that vendors agree to become a business associate of the BMS, and therefore the vendor must have policies and procedures in place consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for privacy and security of protected health information (45 CFR Parts 160 and 164) and any other applicable State or Federal law related to the privacy or security of information. The West Virginia Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, is hereby made part of the agreement.

1.17 Schedule of Events

The Bureau intends to complete the selection process using the following schedule. However, the BMS reserves the right to modify or reschedule procurement milestones as necessary.

Event	Anticipated Dates
Release RFP to Vendors	April 24, 2012
Vendor Pre-Bid Conference	May 9, 2012
Vendor's Written Questions Submission Deadline	May 23, 2012
Questions Addendum Issued	June 7, 2012
Vendor Proposal Opening Date	June 21, 2012
Oral Presentation	To Be Determined
Cost Bid Opening	To Be Determined

1.18 Pre-Bid Conference

A mandatory pre-bid conference shall be conducted on the date specified above at: 350 Capitol Street, Room 251, Charleston, WV 25301 at 10:30 A.M. All interested bidders are required to be present at this meeting. Any vendor failing to attend the mandatory pre-bid conference will not be considered for award. No one person can represent more than one vendor.

1.19 Purchasing Affidavit

All bidders must submit an affidavit regarding any debt owed to the State. The affidavit must be signed and submitted prior to award. It is preferred that the affidavit be submitted with the proposal.

1.20 **Proposal Withdrawal**

Prior to proposal due date, a Bidder may withdraw their proposal by submitting a written request for its withdrawal signed by the Bidder's authorized agent. The written withdrawal request must be directed to the DHHR Office of Purchasing at the address listed.

1.21 **General Terms and Conditions**

By signing and submitting its proposal, the successful Vendor agrees to be bound by all the terms contained in this RFP.

1.21.1 *Conflict of Interest*

Vendor affirms that it, its officers or members or employees presently have no interest and shall not acquire any interest, direct or indirect, which would conflict or compromise in any manner or degree with the performance or its services hereunder. The Vendor further covenants that in the performance of the contract, the Vendor shall periodically inquire of its officers, members and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the Bureau.

1.21.2 *Prohibition against Gratuities*

Vendor warrants that it has not employed any company or person other than a bona fide employee working solely for the Vendor or a company regularly employed as its marketing agent to solicit or secure the contract and that it has not paid or agreed to pay any company or person any fee, commission, percentage, brokerage fee, gifts or any other consideration contingent upon or resulting from the award of the contract.

For breach or violation of this warranty, the Bureau shall have the right to annul this contract without liability at its discretion or to pursue any other remedies available under this contract or by law.

1.21.3 *Certifications Related to Lobbying*

Vendor certifies that no Federal appropriated funds have been paid or will be paid, by or on behalf of the company or an employee thereof, to any person for purposes of influencing or attempting to influence an officer or employee of any Federal entity, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement.

If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee or any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the Vendor shall complete and submit a disclosure form to report the lobbying.

Vendor agrees that this language of certification shall be included in the award documents for all sub-awards at all tiers, including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements, and that all sub-recipients

shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this contract was made and entered into.

1.21.4 *Vendor Relationship*

The relationship of the Vendor to the Bureau shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by the parties to this contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents.

Vendor shall be responsible for selecting, supervising and compensating any and all individuals employed pursuant to the terms of this RFP and resulting contract. Neither the Vendor, nor any employees or contractors of the Vendor, shall be deemed to be employees of the Bureau or the State for any purposes whatsoever.

Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, and licensing fees, etc. and the filing of all necessary documents, forms and returns pertinent to all of the foregoing.

Vendor shall hold harmless the Bureau and the State, and shall provide the Bureau and the State with a defense against any and all claims including but not limited to the foregoing payments, withholdings, contributions, taxes, social security taxes and employer income tax returns.

The Vendor shall not assign, convey, transfer or delegate any of its responsibilities and obligations under this contract to any person, corporation, partnership, association or entity without expressed written consent of the Bureau.

1.21.5 *Indemnification*

The Vendor agrees to indemnify, defend and hold harmless the State and the Bureau, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data used under the contract in a manner not authorized by the contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees or subcontractors to observe State and Federal laws, including but not limited to labor and wage laws.

1.21.6 *Contract Provisions*

After the successful Vendor is selected, a formal contract document will be executed between the Bureau and the Vendor. In addition, the RFP and the Vendor's response will be included as part of the contract by reference. The order of precedence is the contract, the RFP, and the Vendor's proposal in response to the RFP.

1.21.7 *Governing Law*
This contract shall be governed by the laws of the State of West Virginia. The Vendor further agrees to comply with the Civil Rights Act of 1964 and all other applicable laws and regulations, Federal, State and Local Government.

1.21.8 *Compliance with Laws and Regulations*
The Vendor shall procure all necessary permits and licenses to comply with all applicable laws, Federal, State or municipal, along with all regulations, and ordinances of any regulating body.

The Vendor shall pay any applicable sales, use or personal property taxes arising out of this contract and the transactions contemplated thereby. Any other taxes levied upon this contract, the transaction, or the equipment, or services delivered pursuant here to shall be borne by the contractor. It is clearly understood that the State of West Virginia is exempt from any taxes regarding performance of the scope of work of this contract.

1.21.9 *Subcontracts/Joint Ventures*
The Vendor is solely responsible for all work performed under the contract and shall assume prime contractor responsibility for all services offered and products to be delivered under the terms of this contract. The Bureau will consider the Vendor to be the sole point of contact with regard to all contractual matters. The Vendor may, with the prior written consent of the BMS, enter into written subcontracts for performance of work under this contract; however, the Vendor is totally responsible for payment of all subcontractors.

1.21.10 *Term of Contract & Renewals*
This contract will be effective (date set upon award) for a period of 10 years, at which time the contract may, upon mutual consent, be renewed for up to 2 contingency years to be executed at the Bureau's discretion or until such reasonable time thereafter as is necessary to obtain a new contract. The "reasonable time" period shall not exceed twelve (12) months. During the "reasonable time" period Vendor may terminate the contract for any reason upon giving the Agency ninety (90) days written notice. Notice by Vendor of intent to terminate will not relieve Vendor of the obligation to continue to provide services pursuant to the terms of the contract.

Unless specific provisions are stipulated in the contract document, the terms, conditions and pricing established are firm for the life of the contract.

Contracts that contain renewal provisions may be renewed upon the mutual written consent of the Medicaid Program and vendor. The renewal(s) will be enacted through the Change Order process, as identified in 1.21.13.

Any change in Federal or State law, or court actions which constitute binding precedent in West Virginia, and which significantly alters the Vendor's required activities or any change in the availability of funds, shall be viewed as binding and shall warrant good faith renegotiation of the compensation paid to the Vendor by the Bureau and of such other provisions of the contract that are affected. If such renegotiation proves unsuccessful, the contract may be terminated by the State upon written notice to the Vendor at least thirty (30) days prior to termination of this contract.

1.21.11 *Non-Appropriation of Funds*
If the Bureau is not allotted funds in any succeeding fiscal year for the continued use of the service covered by this contract by the West Virginia Legislature, the Bureau may terminate the contract at the end of the affected current fiscal period without further charge or penalty. The Bureau shall give the Vendor written notice of such non-allocation of funds as soon as possible after the Bureau receives notice. No penalty shall accrue to the Bureau in the event this provision is exercised.

1.21.12 *Contract Termination*
The Bureau may terminate any contract resulting from this RFP immediately at any time the Vendor fails to carry out its responsibilities or to make substantial progress under the terms of this RFP and resulting contract. The BMS shall provide the Vendor with advance notice of performance conditions which are endangering the contract's continuation. If after such notice the Vendor fails to remedy the conditions contained in the notice, within the time period contained in the notice, the Bureau shall issue the Vendor an order to cease and desist any and all work immediately. The BMS shall be obligated only for services rendered and accepted prior to the date of the notice of termination.

The contract may also be terminated by the Bureau with thirty (30) days prior notice.

1.21.13 *Changes*
If changes to the original contract become necessary, a formal contract amendment will be negotiated by the Bureau and the Vendor to address changes to the terms and conditions, and/or costs of work included under the contract. An approved contract amendment is defined as one approved by DHHR Office of Purchasing, encumbered and placed in the U.S. Mail prior to the effective date of such amendment. An approved contract amendment is required whenever the change affects the payment provision or the scope of the work. Such changes may be necessitated by new and amended Federal and State regulations and requirements.

As soon as possible after receipt of a written change request from the Bureau, but in no event more than thirty (30) days thereafter, the Vendor shall determine if there is an impact on price with the change requested and provide the Bureau a written statement to identify any price impact on the contract or to state that there is no impact. In the event that price will be impacted by the change, the Vendor shall provide a description of the price increase or decrease involved in implementing the requested change.

NO CHANGE SHALL BE IMPLEMENTED BY THE VENDOR UNTIL SUCH TIME AS THE VENDOR RECEIVES AN APPROVED WRITTEN CONTRACT AMENDMENT.

1.21.14 *Invoices, Progress Payments, & Retainage*
The Vendor shall submit invoices, in arrears, to the Bureau at the address on the face of the purchase order labeled "Invoice To" pursuant to the terms of the contract. Progress payments may be made at the option of the Bureau on the basis of percentage of work completed if so defined in the final contract. Any provision for progress payments must also include language for a minimum 15% retainage until the final deliverable is accepted.

If progress payments are permitted, Vendor is required to identify points in the work plan at which compensation would be appropriate. Progress reports must be submitted to BMS with the invoice detailing progress completed or any deliverables identified. Payment will be made only upon approval of acceptable progress or deliverables as documented in the Vendor's report. Invoices may not be submitted more than once monthly and State law forbids payment of invoices prior to receipt of services.

1.21.15 *Liquidated Damages*

The Vendor agrees that liquidated damages shall be imposed at the rate of $1,000.00 per day for failure to provide deliverables, meet milestones identified to keep the project on target, or failure to meet specified deadlines. This clause shall in no way be considered exclusive and shall not limit the State or Bureau's right to pursue to any other additional remedy to which the State or Bureau may have legal cause for action including further damages against the Vendor.

1.21.16 *Record Retention (Access & Confidentiality)*

Vendor shall comply with all applicable Federal and State of West Virginia rules and regulations, and requirements governing the maintenance of documentation to verify any cost of services or commodities rendered under this contract by Vendor. The Vendor shall maintain such records a minimum of five (5) years and make available all records to Bureau personnel at Vendor's location during normal business hours upon written request by Bureau within 10 days after receipt of the request.

Vendor shall have access to private and confidential data maintained by the Bureau to the extent required for Vendor to carry out the duties and responsibilities defined in this contract. Vendor agrees to maintain confidentiality and security of the data made available and shall indemnify and hold harmless the State and Bureau against any and all claims brought by any party attributed to actions of breach of confidentiality by the Vendor, subcontractors, or individuals permitted access by Vendor.

The Vendor must comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and must comply with any other applicable (current and future) Federal and State laws regarding privacy and confidentiality.

1.22 **Right of Inspection**

The Vendor shall provide right of access to its facilities to the Bureau or any of its officers at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this contract on behalf of the Bureau.

All inspections and evaluations shall be performed in such a manner that will not unduly interfere with the Vendor's business or work hereunder.

1.23 **Safeguarding of Information**

The Vendor shall not use or disclose any:

- Personal Information gained by reason of this contract, or
- Information that may be classified as confidential for any purpose not directly connected with the administration of this contract except (1) with prior written consent of the Bureau or (2) as may be required by law. The Vendor shall

safeguard such information and shall return or certify destruction of the information upon contract expiration or termination.

1.24 **Business Continuity and Disaster Recovery**

As part of the Vendor's proposed services, the Vendor shall supply, maintain and test disaster recovery and/or a business continuity solution. This will include periodic testing of the proposed solution at intervals as agreed upon by BMS during contract negotiation.

1.25 **Contract Administrator**

Upon approval of a contract, and following execution of said contract, the BMS shall direct the Vendor's Contract Administrator to proceed with the performance of the specified services/deliverables. However, administration of any contract resulting from this RFP implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such contract. That authority is retained by the DHHR Office of Purchasing and other authorized representatives and these appointees are subject to change.

PART 2 CURRENT ENVIRONMENT

2.1 **Location**

The Bureau is located at 350 Capitol Street, Room 251, Charleston, WV 25301-3709.

2.2 **Background**

BMS is responsible for establishing the overall strategic direction and priorities for the West Virginia Medicaid Program. The Bureau is committed to maintaining accountability for the use of resources in a way that assures access to appropriate, medically necessary, and quality health care services for all members. The Bureau is to provide these services in a user-friendly manner to providers and members alike and focus on the future by providing preventive care programs.

The following goals are incorporated into the Bureau's vision:

1. Streamline administration;
2. Tailor services to meet the needs of enrolled populations;
3. Coordinate care, especially for those with chronic conditions; and
4. Provide members with the opportunity and incentives to maintain and improve their health.

The need to procure a replacement Medicaid Management Information System (MMIS) at this time is supported by three primary factors:

1. The new functionality that is needed to provide and support the Bureau's desired business capabilities, as identified through the MITA State Self-Assessment (SS-A);
2. The Bureau's desire to take full advantage of current Health Information Technology (HIT) and Health Information Exchange (HIE), to better serve its members, stakeholders, and providers; and,
3. The need to keep pace with regulatory changes and CMS requirements.

2.3 **Business Environment**

2.3.1 *Organization*

The West Virginia Medicaid program is managed by BMS, a bureau within the Department of Health and Human Resources (DHHR). The total Medicaid expenditures for SFY2011 were approximately $2.7 billion. The Medicaid program provides health care benefits to just over 420,000 people annually (about 330,000+ monthly average) in 55 counties, using a network of approximately 24,000 active providers. The MMIS processes about 17.7 million claims (claim headers) per year: 9.5 million medical/dental claims and 8.2 million pharmacy claims. About 93% of claims are received electronically, of which about 53% are pharmacy claims. These figures include Federal, State only, and Third Party Administrator (TPA) members and claims. Currently there are approximately 2 million encounter records generated per year.

Approximately 165,000 Medicaid members (families with dependent children, low-income children, and pregnant women) are enrolled in three Managed Care Organizations (MCOs). The Medicaid program has historically paid for certain carved-out services for these MCO members, such as pharmacy, children's dental services, long-term care, non-emergency transportation, and behavioral health services.

The Medicaid program also manages a Primary Care Case Management (PCCM) program – the Physician Assured Access System (PAAS). The Bureau's MMIS processes claims for two Home and Community-Based Services (HCBS) waiver programs and several State funded eligibility programs. The Bureau is pursuing the addition of a third HCBS waiver and demonstration project(s). It also functions as a Third Party Administrator (TPA) for other state agencies.

2.3.2 *Program Environment*

West Virginia is focused on offering health care coverage to its citizens and improving their health care outcomes, through both Medicaid and non-Medicaid programs. This section describes the State's multi-faceted and dynamic program environment.

2.3.2.1 *Medicaid Program.* West Virginia Medicaid operates under a combined managed care and fee-for service environment.

2.3.2.1.1 *Mountain Health Trust (Managed Care Organization (MCO) and Physician Assured Access System (PAAS))*

Mountain Health Trust is a managed care program. Eligible members are asked to choose either a PAAS Primary Care Provider (PCP) or an MCO based on their county of residence. If a member does not make a choice, they are automatically assigned by the enrollment broker. MCO-enrolled members are also asked to select a PCP to provide or approve most of their health care needs. Pharmacy, children's dental services, long-term care, non-emergency transportation, and behavioral health services are carved out of the MCO and PAAS programs.

2.3.2.1.2 *Mountain Health Choices (aka Medicaid Redesign)*

West Virginia's "Mountain Health Choices" was implemented in 2007 through a State Plan Amendment and is active in all 55 counties. Its purpose is to ensure that members receive the right care, at the right time, by the right provider. The hallmarks of the program are:

- Prevention;
- Personal Responsibility;
- Care Management; and,
- Establishment of a Medical Home.

Members who are eligible for Mountain Health Choices have the opportunity to choose a Basic or Enhanced benefit plan. At this time, only certain members are eligible to participate in Mountain Health Choices.

2.3.2.1.3 *Medicaid Fee-For-Service*

Services for Medicaid members not eligible for participation in Mountain Health Trust or Mountain Health Choices, such as waiver clients, long-term care residents and foster care children, continue to be paid according to a fee-for-service schedule. Medicaid dual-eligibles (individuals eligible for both Medicaid and Medicare) remain in fee-for-service. Children in foster care have their medical, pharmaceutical, and dental expenses covered by Medicaid.

2.3.2.1.4 *Medicaid Pharmacy Program*

The outpatient pharmacy program is an optional service provided to eligible Medicaid beneficiaries. It is the Bureau's most utilized service with 42% of all clients receiving services monthly. Pharmacy coverage policies are governed by Federal statutes and regulations. The majority of pharmacy claims (99%) are submitted electronically using the pharmacy point-of-sale (POS) system. Claims are adjudicated on-line and are considered either paid or denied at the time of service. In State Fiscal Year 2010, 8.2 million claims were processed by the current POS, with expenditures of $331,666,990 paid to pharmacy providers.

The POS system edits each prescription for appropriateness using prospective drug utilization review, limitations, and prior authorization edits. BMS incorporates a Preferred Drug List developed with the assistance of a vendor and a Pharmaceutical and Therapeutics Committee. Criteria for coverage of non-preferred drugs and other drugs necessitating prior authorization are developed with the assistance of the Drug Utilization Review Board. An automated prior authorization system operates in conjunction with the current POS system. The PA Vendor affiliated with the West Virginia University School of Pharmacy, is the prior authorization vendor. The pharmacy lock-in program is managed by a vendor to address over utilization. Medicaid members are required to pay a co-payment at the time of service with some exceptions. Currently, all Medicaid members have pharmacy benefits in the fee-for-service program, regardless of their enrollment in Medicaid managed care plans.

2.3.2.1.5 *Waiver Programs*

The West Virginia Medicaid Program currently operates Home and Community Based Services (HCBS) waiver programs: Aged Disabled Waiver (AD): This waiver provides a number of services, such as case management, homemaker, transportation, RN assessment and review, for eligible members. Participants may choose to receive these services through a traditional agency model or they may select the personal option, which allows AD members to recruit, hire, and supervise their own workers. For SFY2012 there are 7,253 approved AD Waiver positions.

- Intellectually/Developmentally Disabled Waiver (I/DD): This program serves approximately 4,534 individuals across the state. Services include service coordination, respite care, residential and community habilitation, nursing services, supported employment, and transportation. Participants in the I/DD also may select self-directed options.

- The Traumatic Brain Injury (TBI) Waiver will provide home and community-based services to West Virginia residents who are both medically and financially eligible to participate in the program. Members must also be at least Twenty-two (22) years of age and choose home and community-based services rather than nursing home placement. The purpose of the TBI Waiver is to prevent unnecessary institutionalization by providing cost-effective services in the member's home and community. The goals and objectives of this program are focused on providing services that are person-centered and promotes choice, independence, participant-direction, respect, dignity and community integration. The waiver has been submitted to CMS for approval.

2.3.2.1.6 *Medicaid Work Incentive Network (M-WIN)*

M-WIN is a Medicaid-funded work incentive program that allows working West Virginians with disabilities or chronic health conditions to pay a monthly premium to keep or obtain Medicaid health care coverage. M-WIN eliminates a major barrier to employment – losing current healthcare benefits when you return to work. This program offers Personal Care Employment Support, hands-on assistance with daily activities related to personal hygiene, dressing, eating, environmental support functions, as well as health-related tasks during job-seeking activities and employment.

2.3.2.2 Other *Programs Offering Health Care Coverage*. BMS supports claims processing for a number of other programs which provide a level of coverage for health care services. All programs listed below have their claims processed through the MMIS.

2.3.2.2.1 *Limited Pharmacy Program (aka Ryan White)*
The West Virginia AIDS Drug Assistance Program (ADAP) provides HIV-related prescription drugs to underinsured and uninsured individuals living with HIV/AIDS.

2.3.2.2.2 *Tiger Morton Commission*
The James "Tiger" Morton Catastrophic Illness Commission was created during the 1999 regular session of the West Virginia Legislature. The Commission acts as a last resort for those in dire need of medical assistance once all other resources are exhausted.

2.3.2.2.3 *Children with Special Health Care Needs (CSHCN) Program*
The Office of Maternal, Child and Family Health of the Bureau for Public Health CSHCN Program advances the health and well-being of children and youth with certain chronic, debilitating conditions. It provides specialized medical care and care coordination services to children under 21 years of age who meet eligibility criteria.

2.3.2.2.4 *Juvenile Justice Services*
Services are provided to youth involved or at risk of being further involved in the Juvenile Justice System. Services include comprehensive psychosocial history assessments and reports, medical, pharmacy, and dental services, treatment recommendations, initial service plan, case management, referrals and linkage to community service providers and transportation to necessary appointments, such as probation or mental health.

2.3.2.2.5 *Adult Protective Services*
Medicaid pays for some services provided to adults who are abused or neglected when a case is handled through the Bureau for Children and Families (BCF) Adult Protective Services Program.

2.3.3 *Contract Environment*
BMS has contracts with a number of business entities to perform specific functions in support of the Medicaid program. These contract relationships include the entities described below.

2.3.3.1 *Fiscal Agent (FA).* The FA operates West Virginia's MMIS and the Provider Incentive Payment. The contract between the State and the current FA vendor was issued effective April 1, 2003 with a base term running through March 31, 2007 and the option for four one year renewals. The fourth optional year ended March 31, 2011. With a change order, this contract has been extended for three years beginning April 1, 2011 with a maximum of two contingency years. (5 years in total)

2.3.3.2 *Project Management Services.* BMS has a contract in place to provide project management services for the MMIS Re-procurement Project.

2.3.3.3 *Member Enrollment Broker.* A vendor serves as the enrollment broker for Medicaid members who receive their care through a managed care plan. The vendor is responsible for outreach (letter and telephone) to members already enrolled in managed care, PAAS, and Mountain Health Choices, and provides training regarding managed care options.

2.3.3.4 *Utilization Management (UM) Vendor.* BMS has a contract with a vendor to provide UM services for medical/dental, behavioral health outpatient services and the Intellectually/Developmentally Disabled (I/DD) waiver program, including review and submission of associated prior authorizations based on treatment requests from providers. All functions and provider requests are handled electronically. The UM vendor also provides technical assistance for enrolled licensed behavioral health providers, psychologists, psychiatrists, and I/DD waiver providers through education and training, and quarterly Quality Improvement Council meetings. The vendor reviews and determines medical eligibility for all requests for the AD waiver and nursing home placement, regardless of payment source.

2.3.3.5 *Preferred Drug List (PDL) Vendor.* The PDL vendor reviews new and/or modified National Drug Codes (NDC) for possible inclusion in various Medicaid benefit programs. The vendor is also responsible for the supplemental rebate contracting and generic drug pricing.

2.3.3.6 *Retrospective Drug Utilization Review (Retro-DUR) Agent.* West Virginia has a contract with a vendor to provide Retrospective Drug Utilization Review services. The vendor reviews drug claims data to identify members at risk for drug related events or suboptimal treatment and to provide educational interventions to prescribers and pharmacists aimed at improving patient outcomes. The vendor also manages the pharmacy lock-in program to address over utilization.

2.3.3.7 *Third Party Liability (TPL) Vendor.* A vendor manages all TPL functionality, services and processing, the Health Insurance Premium Payment (HIPP) process, and the Estate Recovery process. The vendor provides the Medicare Automated Premium Payment (MAPP) system to support BMS in processing the Buy-In files and manages the M-WIN Program for client premiums.

2.3.3.8 *Managed Care Administration.* The Managed Care Administration vendor was hired by BMS to develop actuarially sound capitation rates based on age, gender, eligibility type, and other factors. This vendor also maintains encounter data.

2.3.3.9 *External Quality Review Organization (EQRO).* BMS has a contract in place for a vendor to serve as the EQRO for the West Virginia Mountain Health Trust (MHT) Medicaid managed care program. The vendor provides review services that satisfy the federal requirement specified in 42 CFR Parts 433 and 438: Medicaid Program; External Quality Review of Medicaid Managed Care Organizations; Final Rule.

2.3.3.10 *POS Prior Authorization (PA) Services.* BMS has a contract in place to provide clinical prior authorization services for the Pharmacy program. The automated prior authorization system searches drug and medical claims data to provide prior authorizations that meet established criteria without intervention from prescribers or pharmacy providers.

2.3.3.11 *Fiscal Employer Agent (FEA).* BMS has a contract in place for an FEA Vendor to provide fiscal agent and resource consulting services for Medicaid members who choose a self-directed service delivery model.

2.3.3.12 *Psychological Consulting Service.* BMS has a contract in place for psychological assessment for eligibility determinations for specialized service deliver programs that require determination and review by a psychologist.

2.4 Technical Environment

Many systems support West Virginia's Medicaid program. The following sections provide context and a high-level picture of these key systems. Each system interfaces with numerous other systems, gathering and sharing data essential to the Medicaid business processes of numerous State and contractual partners.

2.4.1 *Recipient Automated Payment and Information Data System (RAPIDS)*

RAPIDS is West Virginia's State-maintained mainframe eligibility determination and benefit calculation system. Eligibility for public assistance benefits is determined on-line throughout West Virginia by over 898 workers and supervisors. RAPIDS supports approximately 2,351 active users whose access ranges from inquiry-only to update capability. This system completes eligibility determination for most Medicaid and WV Children's Health Insurance Program (CHIP) members. RAPIDS also processes WVWorks Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP) (formerly food stamps), and other program determinations. Additionally, the system performs financial eligibility for the AD and I/DD waiver programs. RAPIDS assigns eligibility categories and creates a Personal Identification Number (PIN) for each member; the PIN is later used by the MMIS to generate the Medicaid number.

2.4.2 *Families and Children Tracking System (FACTS)*

FACTS is a comprehensive customized Statewide Automated Child Welfare Information System (SACWIS) established by DHHR for the administration of Title IV-E Child Welfare Programs, including child protective services, foster care services, Adult Protective Service programs, independent living services, family preservation services, and adoption services. FACTS assigns eligibility categories for these member groups and creates an individual Client Identification Number (CIN) for each applicant; this CIN is later used by MMIS to generate the Medicaid number.

2.4.3 *Medicaid Management Information System (MMIS) including Pharmacy Point of Sale (POS) System*

The MMIS is the Bureau's core Medicaid claims processing system. It performs most of the MMIS related functions, and serves as a POS system. The MMIS and POS systems are web-enabled solutions built on a foundation of integrated public domain and Commercial-Off-The-Shelf (COTS) software products and are loosely coupled as sets of

independent processes. The MMIS assigns members to specific Medicaid and/or State benefit programs, depending on their eligibility category.

The current system middleware layers are centered on Microsoft.NET™, COM and DCOM sets of libraries and services. The system is installed on an n-tier client/server computing platform from a variety of locations. The Fiscal Agent provides a local and wide area network to support the system, its users, and the customer interfaces. The Fiscal Agent also provides secure Internet Service Provider (ISP) services for West Virginia's MMIS Web users. On the Medical side, the web is currently available to providers only and is password protected. In the case of the POS: (National Council for Prescription Drug Providers (NCPDP) transactions are not currently submitted through the web portal by pharmacy providers.

2.4.4 *RAPIDS and FACTS Interface with the MMIS*

RAPIDS and FACTS send nightly interface files to the MMIS to update the member data store. When the daily eligibility data from RAPIDS and FACTS enters the MMIS, the MMIS generates a rate code for each member. (When eligibility information is entered directly into the MMIS, a BMS employee manually assigns the rate code.) There are approximately 80 different rate codes. A complete reconciliation of RAPIDS data with the MMIS occurs once a month. The State is assessing options in meeting the federal eligibility requirements. Plans have not been finalized at this time regarding the State's decision to implement a Health Insurance Exchange.

2.4.5 *Reporting*

The State's reporting needs are currently handled by the MMIS through production reporting and the MARS DataMart, a static reporting database designed to produce specific monthly, quarterly, and annual reporting (a listing of current reporting may be found in the Procurement Library). Reports are generated using standard enterprise reporting tools such as Structured Query Language (SQL) queries, Data Transformation Services (DTS) packages, Excel spreadsheets, and Crystal Reports. The reports are generated by authorized users and follow HIPAA compliance policies.

BMS plans to implement a Data Warehouse/Decision Support System (DW/DSS) that contains static, reconciled data with full decision support system capability, including System Utilization Review (SUR) reporting; therefore, these services are outside the scope of this solicitation.

2.4.6 *State Environment Networks*

The State's network is operated by the Department of Administration's Office of Technology (OT). More information can be found at http://www.state.wv.us/ot/.

2.4.7 *Procurement Library*

The Procurement Library contains information which should be of use to the vendor in developing their proposed solution. The Procurement Library is being disseminated on a CD at the Pre-bid conference. The CD will only be accessible by a predetermined password distributed under separate cover.

2.5 Project Environment

2.5.1 *MMIS Alignment with Bureau Business Area Goals and Objectives.*

During the MITA State Self-Assessment (SS-A), the Bureau leadership team established goals and associated objectives for the State Medicaid program. The Bureau has since identified several unique initiatives to achieve its Medicaid goals, objectives, and targeted capabilities. Therefore, BMS expects a delivered MMIS that aligns with MITA principles and employs service-oriented architecture to achieve the To-Be business process maturity levels identified by the Bureau.

During the SS-A, BMS solicited input from a wide variety of stakeholders, including its sister agencies, vendors, and business partners. The focus of the initial assessment was on improvements that could be achieved in the near term and those processes for which BMS exercises direct control. Table 2-1 lists the goals and objectives for each of the eight MITA business areas, as well as goals and objectives that apply to multiple business areas or are relevant to the Bureau as a whole. The ID column uses the two-letter business area indicator standardized in the MITA Framework. Overarching goals that apply to multiple business areas are designated with a "Gen" (for general) identifier.

Table 2-1 MITA Business Area Goals and Objectives

ID	Goals & Objectives by Business Area
Gen	**High-Level Administrative and Management Goals and Objectives**
Gen 1.0	Goal: Improve BMS effectiveness and efficiency.
Gen 1.1	Align resources with core business functions.
Gen 1.2	Secure necessary resources.
Gen 1.3	Establish and provide necessary professional education and training to enhance staff performance.
Gen 1.4	Develop MMIS Roadmap to support future business needs.
Gen 1.5	Implement performance management and measurement principles within BMS.
Gen 2.0	Goal: Minimize risk and maximize value from contracted services and products.
Gen 2.1	Streamline and improve procurement business functions.
Gen 2.2	Continuously improve project management capabilities.
Gen 2.3	Implement performance management and measurement principles.
Gen 3.0	Goal: Leverage technology to enhance performance and decision making.
Gen 3.1	Enhance reporting capabilities to allow for more efficient and effective performance monitoring.
Gen 3.2	Improve data access, analysis and reporting to support decision making.
Gen 4.0	Goal: Assess, implement, and monitor compliance with all relevant federal laws and regulations (e.g. PPACA, State Medicaid Manual, HIPAA).
Gen 4.1	Establish a team and process for assessing compliance with new laws and regulations.
Gen 4.2	Establish a team and process for implementation of changes necessary to comply with new laws and regulations.
Gen 4.3	Establish a team and process for monitoring compliance with laws and regulations.

ID	Goals & Objectives by Business Area
Gen 4.4	Verify and monitor MMIS and Fiscal Agent operations to ensure transactions are processed in accordance with all relevant federal laws and regulations.
Gen 5.0	Goal: Ensure program quality.
Gen 5.1	Develop and execute a Quality Management Plan.
Gen 5.2	Design and configure systems and processes to support the Quality Plan.
Gen 5.3	Enhance ability to measure compliance with quality indicators.
Gen 6.0	Goal: Enhance and improve efficient, effective and meaningful outreach and communication.
Gen 6.1	Improve communication with providers and members.
Gen 6.2	Rebrand Medicaid as another provider of healthcare coverage.
OM	**Operations Management**
OM 1.0	Goal: Improve operational efficiency and reduce costs in the healthcare system.
OM 1.1	Document operations management roles, responsibilities and business processes.
OM 1.2	Analyze operations management organization structure to align resources with core business functions.
OM 1.3	Enhance and automate reporting capabilities to measure compliance with operational performance measures.
OM 2.0	Goal: Improve access to information necessary for operations management.
OM 2.1	Enhance cost avoidance capability by improving access to accurate other third party payer information.
OM 2.2	Establish integration with other entities to further reduce the potential for redundancy of service and payment.
OM 3.0	Goal: Improve provider access to real-time data.
OM 3.1	Enhance provider portal to support clinical decisions and to provide real-time access to cost settlement and rebate data.
OM 3.2	Implement real time access to data based on claim adjudication results.
OM 3.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine Pharmacy prior authorizations.
ME	**Member Management**
ME 1.0	Goal: Enhance ability for members to participate in and exercise responsibility for their personal health choices.
ME 1.1	Explore capabilities to establish and allow member access to a personal health record.
ME 1.2	Provide automated administration of a member incentive program as designed by BMS and approved by CMS.
ME 1.3	Provide for automated administration of personal Health Improvement Plans.
ME 1.4	Empower members by providing access to information and tools that can be used to improve their health.
ME 1.5	Simplify and streamline eligibility determination to enhance access to care.
PG	**Program Management**

ID	Goals & Objectives by Business Area
PG 1.0	Goal: Enhance the Bureau's ability to analyze the effectiveness of potential and existing benefits and policies.
PG 1.1	Integrate reconciled claims data with clinical data.
PG 1.2	Improve tools and provide training for data analysis to help improve healthcare decision making.
PG 2.0	Goal: Improve consistency of Program management processes and effective communication of policy.
PG 2.1	Document Program management roles, responsibilities and business processes.
PG 2.2	Establish reporting capabilities to measure compliance with performance measures.
PG 2.3	Design policy management workflow to ensure alignment of law/regulation, policy, system processing and provider communication.
PM	**Provider Management**
PM 1.0	Goal: Simplify process for submission of provider information.
PM 1.1	Improve provider enrollment and administration processes.
PM 1.2	Provide capability for online submission of standard forms and reports by providers.
PM 1.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine prior authorizations. Both the pilot and planned integration of this functionality will apply to pharmacy, not medical/dental.
CM	**Care Management**
CM 1.0	Goal: Improve healthcare outcomes for members.
CM 1.1	Establish access to data from sister-agencies and programs within the Department of Health and Human Resources.
CM 1.2	Improve access to clinical and encounter data.
CM 1.3	Enhance ability to measure quality of healthcare outcomes for members.
CM 1.4	Evaluate alternatives to enhance care management capabilities.
CM 1.5	Establish Health Home for members with chronic conditions.
CM 2.0	Goal: Increase use of evidence based clinical and appropriate services.
CM 2.1	Increase the use of evidence based clinical and appropriate services, including preventive services.
CM 2.2	Provide technical capability for Pay-for-Performance reimbursement model.
CM 2.3	Increase meaningful use of Electronic Health Records among Medicaid providers.
CO	**Contractor Management**
CO 1.0	Goal: Enhance the Bureau's ability to monitor contractor performance against approved measures.
CO 1.1	Establish reporting capabilities to measure contractor compliance with performance measures.
CO 1.2	Create automated functions to establish and monitor corrective action plans for contractors not meeting approved performance measures.

ID	Goals & Objectives by Business Area
CO 1.3	Include deliverable expectations and quality indicators as part of solicitations and resulting contracts in alignment with the Bureau's Quality Management Plan.[1]
PI	**Program Integrity Management**
PI 1.0	Goal: Improve effectiveness and efficiency of Program Integrity Management function.
PI 1.1	Analyze Program Integrity Management business area structure to align roles, responsibilities, identify necessary skill sets and appropriately assign resources.
PI 1.2	Improve tools and provide training to automate and streamline investigations and case management.
PI 1.3	Monitor MMIS security and controls.
BR	**Business Relationship Management**
BR 1.0	Goal: Enhance the security, timeliness and accuracy of data exchanged with authorized and authenticated business partners.
BR 1.1	Document business relationship management roles and responsibilities.
BR 1.2	Standardize processes for data validation and reconciliation.
BR 1.3	Standardize process for capture of report and data exchange requirements.

The SS-A evaluated 80 business processes. The following outcomes were identified by mapping the business environment to the MITA Business Model and assessment of capabilities. The SS-A Model (CMS Template #3) provided in Appendix B lists the CMS-defined business processes, corresponding West Virginia processes, and the As-Is and To-Be business process maturity levels identified by the Bureau.[2]

BMS As-Is Business Processes

- 51 business processes were assessed at As-Is Level One.
- 4 business processes were assessed at As-Is Level Two.
- No business processes were assessed at As-Is Level Three.
- 25 business processes were assessed at As-Is Level TBD.

BMS To-Be Business Processes

- 37 business processes were assessed at To-Be Level One.
- 18 business processes were assessed at To-Be Level Two.
- No business processes were assessed at To-Be Level Three.
- 25 business processes were assessed at To-Be Level TBD.

BMS Goal for Increased Maturity Business Processes

- 14 total business processes were selected for an increase in maturity.
- 2 business processes were not assessed[3].

[1] The BMS Quality Management Plan is currently under development.

[2] NOTE: OM Edit Claim/Encounter and OM Audit Claim/Encounter business processes are blended in WV. The two processes were counted as one.

[3] Two business processes not assessed in depth were the *Prepare HCBS Payment* process and *Contractor Grievance and Appeal*.

The following sections provide additional detail for each MITA business area based on the contents of the table above.

2.5.1.1 *Operations Management.* The Bureau has targeted seven of the Operations Management business processes for improvement from Level One to Level Two capability maturity. Raising the maturity of seven processes represents a significant commitment and requires more than just enhancements to technology. The Bureau's goal for Operations Management is to improve operational efficiency and reduce costs in the healthcare system.

2.5.1.2 *Member Management.* The Member Management goal is to enhance the ability for members to participate in and exercise responsibility for their personal health choices. The Bureau is pursuing a number of objectives in support of these goals. It plans to explore capabilities to establish and allow member access to a personal health record. BMS has conceptualized an incentive program that is intended to reward members for engaging in health improvement activities. Based on CMS guidance, BMS plans to develop a more detailed program design. In the future, the MMIS needs to provide the functionality to administer the incentive program as developed by BMS and approved by CMS. The Bureau also expects to pursue automated administration of personal Health Improvement Plans. Finally, it plans to empower members by providing access to information and tools that can be used to improve their health.

The Bureau has researched the advancements in Member Management in MMIS offerings and implemented by other states. The Bureau plans to use the MMIS Re-procurement Project as a vehicle to enhance their business process practices for Member Management.

2.5.1.3 *Program Management.* The Bureau identified two goals for the Program Management Business Area. The first goal is to enhance the Bureau's ability to analyze the effectiveness of potential and existing benefits and policies. This requires the integration of claims data with clinical data into a single data store. (As noted above, the Bureau is conducting a separate procurement for a DW/DSS). The Fiscal Agent should provide an extract to the DW/DSS.

The second goal is to improve consistency of Program Management processes and effective communication of policy. Several objectives support this goal. The Bureau plans to build on the work conducted during the MITA SS-A to document Program Management roles, responsibilities, and business processes. Reporting capabilities are expected to be established to measure compliance with performance measures. Finally, the Bureau seeks to work with the awarded Vendor to ensure that the policy management and MMIS change management workflows align and synchronize law/regulation, policy, MMIS processing, and provider communication.

Based upon initial review of the HCBS payment process description the Project Team concluded that there is no unique process for *Prepare HCBS Payment* in West Virginia. Transactions and payments for Home and Community Based services are processed just as any other claim type. The Bureau did not designate a level for the Support Contractor Grievance and Appeal process because at the time the assessment was conducted this process was administered by the Department of Administration, Purchasing Division.

2.5.1.4 *Provider Management.* The Bureau intends to simplify the process for submission of provider information. Work conducted under the MMIS Re-procurement Project is expected to improve provider enrollment and administration processes as well as provide the capability for providers to submit standard forms and reports on-line. The Bureau plans to build on work conducted during the SS-A. Processes documented during MITA work sessions are to be further reviewed to reconcile discrepancies, eliminate redundant effort, and address processing gaps.

2.5.1.5 *Care Management.* Care Management supports individual care management, population management, and the promotion of health education and awareness. Like other states, West Virginia is just beginning to build Care Management capabilities. The Mountain Health Choices program was undertaken for this purpose.
The scarcity of Care Management detail provided in MITA Framework 2.0 prevented BMS from designating “As Is” and “To Be” levels for the business area. However, the Bureau discussed the future plans for care management within the Medicaid program. There are two Care Management goals. The first goal is to improve healthcare outcomes for members. The Bureau is addressing this goal by improving access to clinical and encounter data.

The second goal is to increase the use of evidence-based data and appropriate services. Providing technical capability for a Pay-for-Performance reimbursement model supports this goal. BMS plans to achieve this through the MMIS Re-procurement Project, the Patient Care Web Portal Project (see 2.5.3.4.3), the ePrescribing Pilot Project (see 2.5.3.4.1), and the DW/DSS procurement.

2.5.1.6 *Contractor Management.* BMS has contracts with a number of business entities responsible for performing specified functions as described in Section 2.3.3. The Bureau’s goal for this Business Area is to enhance its ability to monitor contractor performance against measureable criteria. The Bureau plans to be able to measure contractor compliance with defined performance measures and to use automated functions to establish and monitor corrective action plans for contractors not meeting approved performance measures.

2.5.1.7 *Program Integrity Management.* In West Virginia, Program Integrity processes, including Surveillance and Utilization Review (SUR), are conducted by the Office of Quality and Program Integrity (OQPI). OQPI is responsible for post-payment review of paid claims to assure that 1) services were provided by eligible providers, to eligible members; 2) services were medically necessary and, appropriate to the patient’s medical condition; and 3) services were provided in conformance with the service definitions set forth in the Medicaid Manuals. OQPI uses tools such as on-site reviews, desk reviews, and analysis of paid claims data to review the claims.

Current processes still rely heavily on manual intervention. The identification and management of cases are supported by multiple applications that are not integrated (Word, State supported e-mail, Excel, Access). Data is pulled from multiple sources and is cross-checked against MMIS claims data.

BMS has identified internal initiatives impacting Program Integrity Management that will be covered under the DW/DSS procurement. BMS intends to improve tools and provide training to automate and streamline investigations and case management. Additionally, the Bureau plans to enhance monitoring of MMIS security and controls.

2.5.1.8 *Business Relationship Management.* BMS works with a number of state partners, including but not limited to the Bureau of Senior Services (BoSS), the Bureau for Children and Families (BCF), the Office of Insurance Commissioner (OIC), and the Office of Technology (WVOT). Future planning efforts are expected to explore opportunities for improvements to processes shared with other State agencies.

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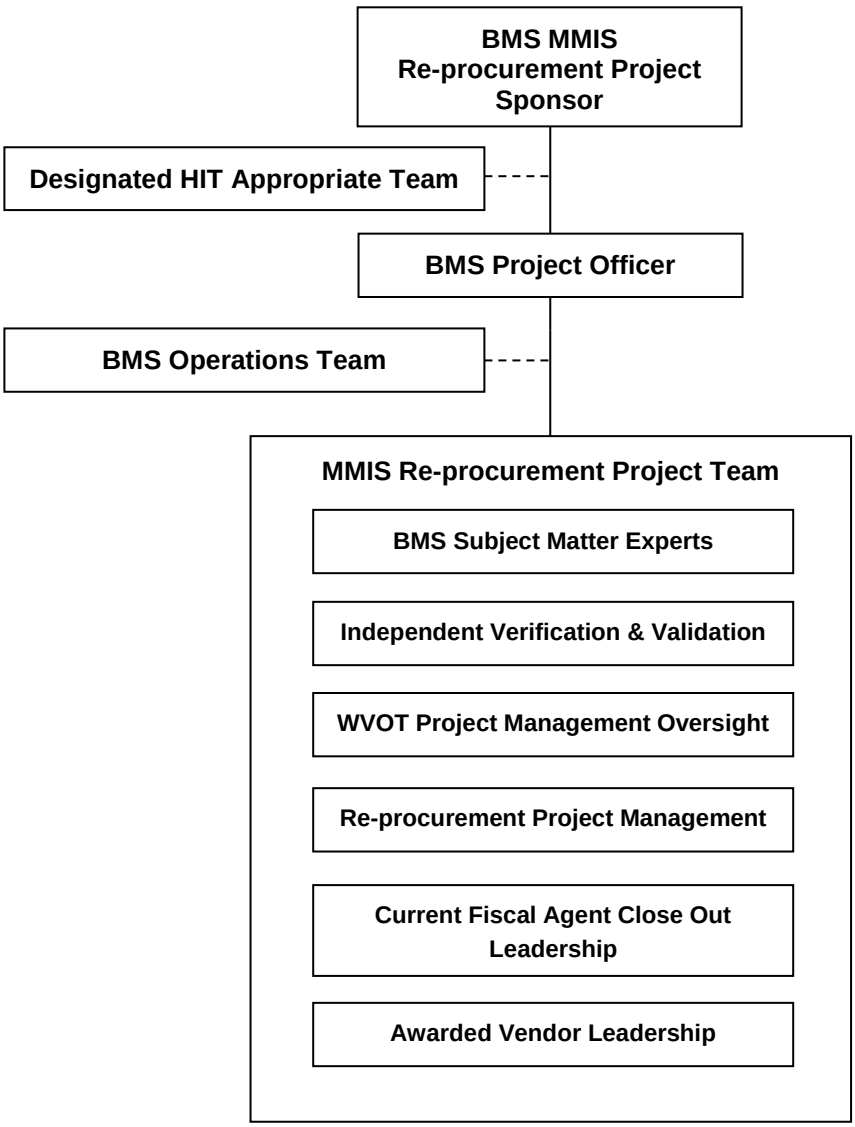
2.5.2 *Project Team Organization.*

2.5.2.1 *MMIS Re-procurement Project Team Structure*
Figure 2-1 describes the MMIS re-procurement team for Design Development and Implementation (DDI) of the replacement MMIS.

Figure 2-1 MMIS Re-procurement Project Team



2.5.2.2 *MMIS Re-procurement Project Team Roles and Responsibilities.* The roles and responsibilities for the MMIS Re-procurement Project have been defined as follows.

2.5.2.2.1 *BMS MMIS Re-procurement Project Sponsor.*
Responsibilities include:

- Serving as the liaison between the MMIS Re-procurement Project and Department and Executive management.
- Making strategic and policy decisions.
- Negotiating and/or provide oversight of vendor contract(s).
- Resolving escalated issues.
- Communicating project information to external stakeholders.
- Convening and chairing the Inter-Agency Advisory Committee meetings.
- Communicating BMS goals and objectives for the MMIS Re-procurement Project.
- Establishing BMS priorities relative to the MMIS Re-procurement Project.
- Setting and communicating expectations for BMS participation, professionalism and teamwork.

2.5.2.2.2 *Designated HIT Appropriate Team.*
The Designated HIT Appropriate Team serves in an advisory capacity. The team convenes at the request of the Project Officer or Sponsor. The team does not have the authority to approve deliverables or to make project decisions or decisions related to BMS contracts. Team member responsibilities include:

- Reviewing project communication and decision documents.
- Serving as a sounding board and advisor to BMS project leadership.
- Participating in scheduled meetings at the request of BMS Project Sponsor or BMS Project Officer.

2.5.2.2.3 *BMS Project Officer.* Responsibilities include but not limited to:

- Modeling and nurturing cooperation, collaboration, professionalism and teamwork. Serving as liaison between the MMIS Re-procurement Project and Bureau management.
- Providing and modeling professional support and facilitation of DHHR and BMS directives, priorities and decisions.
- Communicating project information to BMS Operations Team.
- Communicating DHHR and BMS directives, priorities and decisions to the Re-procurement Project Manager, Fiscal Agent and awarded Vendor management.
- Facilitating discussion of escalated issues and proposed resolutions at BMS Operations Team and IAC meetings.
- Approving change requests that result in additional fees.

- Providing signature acceptance of re-procurement project management vendor, Fiscal Agent and awarded Vendor deliverables.
- Submitting and monitoring progress of change requests arising from maintenance and system enhancement requests.
- Reviewing and approving any modifications or work performed under the change request process.
- Working with the awarded Vendor to develop means to measure the performance levels and methods and format for performance reporting.
- Approving awarded Vendor's staffing of key positions, including review of resumes and background/reference checks of proposed key personnel and written notification of approval or disapproval.
- Serving as BMS point of contact for all external reference and project information requests, State and Federal reviews, certifications and compliance audits.
- Assign and allocate staff to serve as subject matter experts for a project phase or deliverable.
- Recognize or otherwise address project participant performance.

2.5.2.2.4 *BMS Operations Team.*
The BMS Operations Team (OT) is comprised of Office and Program Directors within the Bureau. This body meets to discuss the status of BMS initiatives and operational issues. The BMS Project Officer routinely reports project status to the OT. The BMS Project Officer may use this forum to gather input and/or reach consensus on project issues. The Operations Team may assist with resource issues such as allocation of BMS staff to project tasks, scheduling and communication.

2.5.2.2.5 *MMIS Re-Procurement Project Team.*
The team is made up of Vendor, BMS staff and WV Office of Technology Enterprise Project Management Office (EPMO) Oversight Project Manager.

The team is made up of Vendor and BMS designated staff as defined below.

2.5.2.2.5.1 BMS *Subject Matter Experts*
Team members and participants are expected be called upon to provide expertise in the following areas:

- Documentation and review of business processes, rules and requirements.
- Review of project documents and deliverables.
- Preparation and participation in project meetings.
- Planning and execution of project tasks and action items at the direction of the Project Officer and/or Project Manager.
- Review of test plans, scenarios and outcomes.

2.5.2.2.5.2 *Independent Verification and Validation (IV&V).*
The IV&V role is responsible for verifying and validating that the project related policies, initiatives, and systems are consistent with the Bureaus strategies, comply with Federal mandates, support business needs, and meet contractual requirements. This necessitates the performance of IV&V activities, such as monitoring and assessing system testing, evaluating agency policies, and recommending improvements to deployment processes and training programs.

2.5.2.2.5.3 *WVOT Project Management Oversight*
Pursuant to West Virginia Code §5A-6-4b, the WV Office of Technology Enterprise Project Management Office (EPMO) has the responsibility for managing information technology projects and providing oversight for state agency information technology projects. EPMO uses a project management methodology based on the Project Management Institute, Project Management Body of Knowledge (PMBOK). EPMO offers a methodology to its customers and their vendors that encompass a variety of templates and tools for project management.

Project oversight is an independent review and analysis of project artifacts and processes to determine if the project is on track, to be completed within the estimated schedule and cost, and will provide the functionality required by the sponsoring organization. The EPMO Project Manager performing oversight for the MMIS Re-procurement project will insure the contracted Project Manager utilizes a formalized approach to project management, which is compliant with the PMBOK. Specifically, project oversight;

- Establishes a governance structure for projects (and programs) to evaluate project performance, provide resources, address significant project risks and issues and approve significant changes in scope or objectives;
- Requires formalized project communications to provide accurate, timely communications related to project progress, budget, schedule, scope and changes;
- Identifies and quantifies any issues and risks that could negatively impact the achievement of project objectives;
- Periodically, assesses and confirms the concept, scope, and objectives of the project;
- Validates compliance with the project management methodology and ensures that project management standards and best practices, as appropriate for the given project are followed and documented throughout a project life-cycle; and,
- Evaluates a project team's performance using a prescribed set of checks and balances integral to established processes such as strategic planning, investment management, funding and project execution.

2.5.2.2.5.4 *Project Manager for MMIS Re-procurement.*
The MMIS Re-procurement Project Manager (PM) is a contracted resource dedicated to the MMIS Re-procurement Project and the Medicaid Decision Support System Re-procurement Project on a full-time, 40 hour/week basis. The Project Manager works with BMS, EPMO and awarded and existing Vendor leads to ensure consistent coordination of project activities and quality of services through every project phase. Responsibilities include:

- Providing and modeling professional support and facilitation of DHHR and BMS directives, priorities and decisions.
- Modeling and nurturing cooperation, collaboration, professionalism and teamwork.
- Outlining and validating expectations and applicable standards for deliverables with BMS.
- Working with the Vendor's lead to plan and coordinate project activities and ensure timely delivery and quality of deliverables and services.
- Communicating BMS project assignments, time allocation and participation requirements to BMS Project Officer.
- Facilitating and validating signature approval of project deliverables.
- Providing a project plan containing, the following components: stakeholder register, communication management, budget management, issue management, change management, risk management, and a detailed schedule that includes a detailed description of the task, the type of resources need for the task, start date, end date and any task dependencies (predecessors or successors).
- Working effectively and efficiently with BMS, the awarded Vendor, and EPMO and should work under the direction of BMS while adhering to all governing policies, procedures and standards of each.
- Managing a staffing plan while modeling and nurturing cooperation, collaboration, professionalism and teamwork. The PM will be required to submit an updated work plan at a frequency that is agreed upon by the vendor, the DHHR and WVOT and is documented in the communication plan.
- Planning for and conducting status meetings on a periodic and as needed basis to discuss current project activities and address questions, issues, and concerns. A written status report for high level executives will be required. The status report submission frequency is required to be included in the communication plan. This status report is required to include, a health indicator for budget, scope and schedule along with reporting period accomplishments, issues and upcoming action items.

- Maintaining an issue log, risk log, change log, lessons learned, deliverable log, as well as the execution and management of the project plan.
- Conducting a session for post review of the project. The post review will contain lessons learned, review of issues, review of risks, and review of project team performance.
- Ensuring that accreditation and certification is performed during the closing of the project. Accreditation and certification can be done at the end of each phase of the project.

2.5.2.2.5.5 Current Fiscal Agent Close Out Leadership.
Close Out activities should maintain uninterrupted services to members, providers, the Bureau, CMS, and all other West Virginia Medicaid stakeholders. The Current Fiscal Agent Close Out Leadership is responsible for providing close out support and ensuring a smooth transition of Fiscal Agent services by fully cooperating with BMS, or its designated agent.

2.5.2.2.5.6 *Awarded Vendor Leadership.*
Transition of the MMIS should maintain uninterrupted services to members, providers, the Bureau, CMS, and all other West Virginia Medicaid stakeholders. The Awarded Vendor Leadership is responsible for providing transition support and ensuring a smooth transition of Fiscal Agent services by fully cooperating with BMS, or its designated agent.

2.5.3 *Related BMS Technology Projects*
The MMIS Re-procurement Project is occurring at the same time as several other related BMS technology projects, as described below.

2.5.3.1 *Data Warehouse/Decision Support System Procurement.* As noted in Section 2.4.5, the Bureau is conducting a separate procurement to design, develop and implement a DW/DSS.

2.5.3.2 *Master Data Management Solution*. DHHR has initiated the process of procuring a Master Data Management (MDM) solution. The vision is to provide a single view of data across the breadth of the organization. Management of the Master Data includes clients, providers of services to clients, and many other business objects. In order to unite these business objects across the applications used by the Department, the business objects have to be consolidated, standardized, and cleansed. This requires one- or two-way communications between the various applications and the MDM solution. The first three systems to be tied into the MDM are intended to be Recipient Automated Payment and Information Data System (RAPIDS), On-line Support Collections and Reporting (OSCAR), and Families and Children Tracking System (FACTS).

2.5.3.3 *Health Information Technology (HIT) and Health Information Exchange (HIE).* BMS participated in the development of the initial draft of the West Virginia

Statewide Health Information Technology Plan. The Bureau is in the process of developing a companion plan, the State Medicaid HIT Plan. The Bureau is evaluating Health Information Exchange to complement the functionality within the traditional MMIS, to increase the use of evidence-based clinical services, and to enhance the quality of care provided to members.

2.5.3.4 *Transformation Grants.* BMS is considering industry trends and newer health information technologies to better serve its members, stakeholders, and providers. The CMS Transformation Grant funding was used to implement Pharmacy automated prior authorization, and build a patient web portal. While they have not been part of the six sub-systems comprising the MMIS, BMS recognizes the need to integrate successfully-piloted technologies into the proposed MMIS.

2.5.3.4.1 *Automated Pharmacy Prior Authorization Project.*
This program allows BMS to use an automated Pharmacy PA application to approve routine prior authorizations. This reduces the number of calls to the clinical help desk, reduces administrative costs and allows for tighter management of the program without adding additional administrative burden to healthcare providers. This functionality should be integrated with and part of the solution provided for processing of pharmacy claims.

2.5.3.4.2 *Patient Care Web Portal Project.*
This initiative was undertaken to give providers access to data that could enhance the quality of health care provided to Medicaid members and allow the program to avoid the cost of duplications of medical procedures, diagnostic testing and therapeutic duplications of medications.

2.6 **Regulatory Environment**

The State of West Virginia is required to comply with numerous Federal requirements related to this procurement. Vendors are expected to be aware of those requirements and work with the State to ensure compliance. These include but are not limited to:

2.6.1 *Code of Federal Regulations*
The applicable regulations governing Federal Financial Participation (FFP) for Medicaid are contained in 42 CFR 433.15, Subpart A.
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr433_main_02.tpl

2.6.2 *State Medicaid Manual*
The State Medicaid Manual (SMM) is a guiding document used by States to design and manage its Medicaid program. Part 11 of the SMM relates specifically to the MMIS.
http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927

2.6.3 *Medicaid Information Technology Architecture (MITA)*
The MITA initiative is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program. The CMS Certification Toolkit discussed below is based on the MITA model.
http://www.cms.hhs.gov/MedicaidInfoTechArch/

2.6.4 *CMS Certification*
The West Virginia MMIS developed under this RFP is expected to achieve CMS certification. CMS developed the Medicaid Enterprise Certification Toolkit (Toolkit for short) to assist States in all phases of the MMIS life cycle beginning with the preparation of an Advance Planning Document (APD) through the certification review process. A main feature of the Toolkit is the 20 checklists that were developed for six different Business Areas. The checklists contain the Business Area objectives and related systems review criteria necessary to meet the requirements specified in Federal and State laws and regulations.
http://www.cms.hhs.gov/MMIS/09_MECT.asp#TopOfPage

2.6.5 *Health Insurance Portability and Accountability Act (HIPAA)*
Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II), the Department of Health and Human Services established national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. HIPAA also addressed the security and privacy of health data. Adoption of these standards and the enhanced use of electronic data interchange are improving the efficiency and effectiveness of the nation's health care system.
http://www.cms.hhs.gov/HIPAAGenInfo/

2.6.6 *New Coding Standards*
The Vendor is expected to be aware of new coding standards and ensure that the West Virginia MMIS is current in its ability to accept and appropriately employ new standards and requirements as the changes occur. A current example is the planned implementation of ICD-10 on October 1, 2013.

2.6.7 *WV State Code*
The vendor is expected to be aware of applicable reporting requirements associated with WVC § 9-2-9 (f) (2) which can be found at:
http://www.legis.state.wv.us/WVCODE/09/code/WVC%20%209%20%20-%20%202%20%20-%20%20%209%20%20.htm

2.6.8 *Affordable Care Act (ACA)*
Provisions of the Affordable Care Act passed in March 2010 can be found at:
http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

2.6.9 *Recovery Act/HITECH Act of 2009*
Provisions of the Recovery Act/HITECH Act of 2009 can be found at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/enfifr.pdf

PART 3 PROCUREMENT SPECIFICATIONS

3.1. Mandatory Requirements:

The Vendor will:

3.1.1 Establish a Charleston, West Virginia-based facility within 5 miles of the BMS for DDI and Fiscal Agent operations, where all Key Staff Members designated in Section 3.2.3 will be located. The site will provide space for project team meetings and work sessions, and office space for one BMS staff member.

3.1.2 Ensure the BMS staff member's office space in the Vendor's Charleston facility can be individually locked. This office space must be fully equipped with furniture; telephone service; a personal computer with access to the MMIS, Microsoft Office™ Suite, and the Internet; and access to a printer and copier. The following reserved or paid parking spaces must be provided to accommodate designated BMS staff: one (1) BMS parking space and six (6) general visitor parking spaces.

3.1.3 Provide one named Vendor staff member/position, to be approved by the Bureau, who will be located at the BMS to facilitate communication and coordination between the Bureau and the Vendor. This position requires system, technical/operational and program experience with the ability to facilitate and communicate Bureau needs effectively back to the Fiscal Agent. This position is envisioned to be located onsite at the Bureau 100% through the DDI phase. After DDI, the percentage of time will be determined by the Bureau and the Vendor. The position is not a member of the Key Staff.

3.1.4 Provide the Bureau access to conference space at the Vendor's site that is adequately sized, for ten or more participants, furnished, and equipped to support the DDI review, planning, testing and training sessions required of the Vendor. The conference space must have a computer and projector for displaying Internet-based and Windows PowerPoint™ presentations, and a high-quality speakerphone for multiple remote staff to attend meetings by telephone. Conference space must also accommodate video conferencing and web-based application sharing for attendees.

3.1.5 Provide facilities for the recovery of operations in the event of a disaster that disrupts operations as described in the Fiscal Agent's Disaster Recovery and Business Continuity Plan to be developed by the Vendor and approved by the Bureau. The Vendor will provide resources necessary to: recover critical services in accordance with the Recovery Time Objective and Recovery Point Objectives approved by the Bureau and documented in the Disaster Recovery and Business Continuity Plan; and meet the approved Service Level Agreements listed in Appendix G of this RFP.

3.1.6 Assume all costs related to securing and maintaining the facility for the duration of the contract, including but not limited to hardware and software acquisition necessary to maintain approved performance requirements

throughout the life of the contract, maintenance, lease hold improvements, utilities, office equipment, supplies, janitorial services, security, storage, transportation and insurance.

3.1.7 Agree to incur all costs associated with accessing and acquiring Provider licensure and certification data.

3.1.8 Comply with all current and future security policies and procedures of DHHR, BMS and the WV Office of Technology which can be found at the following:

DHHR:
http://www.wvdhhr.org/mis/IT/index.htm.

BMS:
Procurement Library: This will be provided on a password protected CD at the vendor pre-bid conference.

WV Office of Technology:
http://www.technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx

3.1.9 Perform all work associated with this contract within the continental United States or U.S. Territories.

3.1.10 Host the MMIS and maintain a secure site and secure back-up site within the continental United States.

3.1.11 Warrant that the proposed and implemented MMIS will meet CMS certification requirements and that certification will be available retroactive to the first day of operations of the new West Virginia MMIS to ensure full Federal Financial Participation (FFP).

3.1.12 The Vendor will be responsible for lost enhanced Federal Medical Assistance Percentages (FMAP) for delayed certification due to system deficiencies or deficiencies noted during the certification process that extend beyond the claiming window. The Vendor will be responsible for only the portion of FMAP lost that is determined by BMS to be the fault of the Vendor. The MMIS Vendor will not be responsible for system certification of components that are not included in the scope of this RFP.

3.1.13 Warrant that the proposed and implemented Pharmacy Point-of-Sale (POS) system will be certified with Surescripts to support all available ePrescriptions transaction types, including controlled substances.

3.1.14 Ensure the Point-of-Sale drug file will be independent and not a shared file with other clients.

3.1.15 Provide a system that will support multiple programs, e.g., Medicaid, Tiger Morton, BMS State Programs, Children with Special Health Care Needs (CSHCN), Behavioral Health and Health Families (BHHF)) and multiple Medicaid eligibility categories, including but not limited to the addition of any other State Agency, United States Territory or political subdivision. All programs, eligibility categories and benefit plans are to be supported according to the service level agreements set forth in this RFP.

3.1.16 Ensure all hardware, software and communications components installed for use by Bureau staff are compatible with the most current West Virginia Office of Technology (WVOT) supported versions of the Microsoft™ Operating System, Microsoft Office™ Suite and Internet Explorer™, and current technologies for data interchange which are listed on the below provided link.

(http://www.technology.wv.gov/support/Pages/default.aspx).

3.1.17 Ensure the entire system is installed on the Vendor's hardware and supported through staff at both the Vendor's data center and the Charleston, West Virginia, location.

3.1.18 Align the proposed MMIS with MITA principles and employ service-oriented architecture.

3.1.19 Develop any bridges and integration code necessary for the replacement MMIS to interface with other State software and systems, e.g., DW/DSS, HIE, HIX, and Enterprise Resource Planning (ERP) – none of which are currently interfaced.

3.1.20 Agree to incorporate all requirements mandated through federal and state regulations, including current and future coding standards, to ensure that the MMIS is current in its ability to accept and appropriately employ new standards and requirements as they occur, such as, but not limited to, ICD-10, HIPAA v5010, National Council for Prescription Drug Programs (NCPDP) Claims Processing Standards D.0, the Patient Protection and Affordable Care Act (PPACA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Formalized change control will be used for all such changes, during all phases of the project. This provision extends to all court ordered services requiring system modifications.

3.1.21 Adhere to the current NCPDP version standards, or the most current HIPAA required version for single drug claims and compound prescriptions.

3.1.22 Provide right of access to systems and facilities to the Bureau or its designee to conduct audits and inspections. Provide access to data, systems, and documentation required by auditors.

3.1.23 Update deliverables at the request of BMS to align with major changes in approach or methodology, or to include new or updated information that was not available at the time the deliverable was submitted and approved.

3.1.24 Meet all CMS Certification Requirements as described in Appendix D.

3.1.25 Agree to operate the MMIS and perform all functions described in the RFP and continue all operations from the date of implementation of each component until each function is turned over to a successor Fiscal Agent (FA) at the end of the contract, including any optional additional periods or extensions.

3.1.26 Agree to perform according to approved Service Level Agreements listed in Appendix G of this RFP.

3.1.27 Forfeit agreed-upon retainage as described in Section 4 of this RFP if approved service levels are not achieved.

3.1.28 Ensure the new system functions without interruptions or non-scheduled downtimes. The response time from the new system must be within acceptable limits as defined in Appendix G (Service Level Agreements) of this RFP.

3.1.29 Provide project status information to the MMIS Re-procurement Project Manager in the timeframes and in the agreed-upon format.

3.1.30 Actively use industry-standard professional project management standards, methodologies and processes to ensure the project is delivered on time, within scope, within budget, and in accordance with the Bureau's quality expectations.

3.1.31 Provide a software and hardware solution that is upgradeable and expandable to meet current and future needs.

3.1.32 Employ a Relational Database Management System (RDBMS) or Object Oriented Database Management System (OODMS), to create a data infrastructure that is easily configurable, role-based with 24 X 7 access to data, and use best in class analysis tools.

3.1.33 Ensure that the Pharmacy prior authorization system is available 24 hours per day, seven (7) days per week, except for scheduled maintenance.

3.1.34 Agree that BMS retains ownership of all data, procedures, programs and all materials developed during DDI and Operations, as well as the initial licensing for installed COTS. Manufacturers' support and maintenance for the proprietary COTS software licensing subsequent to the initial install must be provided only for the life of the contract.

3.1.35 Provide role-based access for authorized users, ensuring confidential access to the data at the individual and group security levels.

3.1.36 Ensure that adjudicated claims cannot be changed outside an approved adjustment process. Once a claim is adjudicated and in a final status, the information must remain static while it is displayed, e.g., users may not cut claim information from claim lines/data.

3.1.37 Place the source code in a third-party escrow arrangement with a designated escrow agent who is acceptable to the Bureau, and who shall be directed to release the deposited source code in accordance with a standard escrow agreement approved by the Bureau. That agreement must, at minimum, provide for release of the source code to the Bureau a) when the owner of the software notifies the Bureau that support or maintenance of the Product will no longer be available; b) if the Vendor fails to provide services pursuant to this contract for a continuous period; or c) appropriate individual(s) from the Bureau have directed the escrow agent to release the deposited source code in accordance with the terms of escrow.

Source code, as well as any corrections or enhancements to such source code, shall be updated for each new release of the product within sixty (60) days of being made available in the Bureau's production environment. The Escrow agent and the Vendor shall notify the Bureau in writing when new production versions have been escrowed. The Vendor shall identify the escrow agent upon commencement of the contract term and shall certify annually that the escrow remains in effect and in compliance with the contract. The Vendor shall be responsible for all costs associated with the third-party escrow arrangement.

The Vendor also must place in escrow one (1) paper copy and one (1) electronic copy of all maintenance manuals and additional documentation that are required for the proper maintenance of the software used to develop, test, and implement the MMIS. Revised copies of manuals and documentation must be placed in the escrow account in the event they are changed. Such documentation must consist of logic diagrams, installation instructions, and operation and maintenance manuals, which must be the same documentation as that which the Vendor supplies to its maintenance personnel to maintain its software. All such materials must be provided to the escrow agent within sixty (60) days of its use or applicability to the use of the MMIS.

When source code is provided, it must be provided in the language in which it was written and will include commentary that will allow a competent programmer proficient in the source language to readily interpret the source code and understand the purpose of all routines and subroutines contained within the source code.

In the event that this contract expires and is not renewed or extended, the Bureau has the option to continue the escrow agreement until such time that the Bureau is no longer using the software or documentation covered by this

escrow agreement.

In the case of a COTS product, the medium necessary to reinstall that version as part of the MMIS platform must be kept. Any future versions of COTS products must also be kept and provided upon demand.

3.1.38 Provide increased staffing levels if requirements, timelines, quality or other standards are not being met, based solely on the discretion of and without additional cost to the Bureau. In making this determination, the Bureau will evaluate whether the Vendor is meeting deliverable dates, producing quality materials, consistently maintaining high quality and production rates, and meeting RFP standards without significant rework or revision.

3.1.39 Develop, submit to BMS for approval, and maintain a comprehensive West Virginia MMIS Security, Privacy, and Confidentiality Plan (as described in Section 3.2.6.1.1) that meets or exceeds the current industry standards for such documents, and is compliant with any and all state and Federal mandated security requirements. The Security, Privacy and Confidentiality Plan must be reviewed and updated annually during the operating period.

3.1.40 Deliver systems and services that are compliant with Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, titled “Administrative Simplification” and the rules and regulations promulgated there under.

3.1.41 Ensure that all applications inclusive of internet, intranet and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 U.S.C. §794d, and 36 CFR 1194.21 and 36 CFR 1194.22.

3.1.42 Ensure that data entered, maintained, or generated to meet the requirements of this RFP be retained and accessible according to Federal requirement 42 CFR 431.17 and applicable BMS and State requirements.

3.1.43 Comply with prompt pay regulations in accordance with Federal requirement 42CFR 447.45(d).

3.1.44 Follow formalized change control procedures (as described in Section 1.21.13 Changes and the approved Change Management Plan named in Section 3.2.2.1) for all changes to project scope, including (but not limited to) changes arising during the DDI and operations phases of the project, and changes necessitated as a result of new and amended Federal and State regulations and requirements.

3.1.45 Acknowledge that upon award the Bureau reserves the right to reject any staff proposed or later assigned to the project, and will require the successful Vendor to remove them from the project. In all circumstances, Key Staff shall be replaced only with persons of equal ability and qualifications.

3.1.46 Designate one named individual as the Vendor organization's HIPAA compliance officer.

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3.2 Scope of Work:

This section describes the scope of services to be performed by the awarded Vendor, including milestones and deliverables for all phases of the project. The Vendor's proposal should describe in detail their approach to completing the proposed West Virginia MMIS Project Scope of Work and demonstrate a clear understanding of the Bureau's objectives and the Vendor's responsibilities. Specific Vendor response requirements are clearly marked throughout the Scope of Work.

In preparing its response, the Vendor is advised to consult the Bureau's MITA SS-A goals and objectives presented in RFP Section 2.5.1. The Vendor is directed to the Procurement Library, which will be provided on CD at the Pre-bid conference, for additional information that is referenced but not contained in this RFP document.

3.2.1 Proposed West Virginia MMIS

BMS seeks to procure a vendor to provide Fiscal Agent services and information technology products and services to design, develop, implement, obtain CMS certification, operate, maintain, for a replacement MMIS solution. The current Fiscal Agent will continue to operate the current system until the new MMIS is implemented. The new system should meet the contractual requirements described in this Section and support the following components and capabilities as detailed in Appendix E (Business and Technical Requirements):

1. Designated components of an MMIS, including (but not limited to) Member Management, Provider Management, Program Management, and Operations Management;
2. Pharmacy Point-of-Sale (POS);
3. Drug Rebate Program;
4. Web Portal providing information and functionality to Members, Providers, BMS, and other MMIS users;
5. Operations Systems and Program Performance Monitoring and Reporting;
6. Financial Management, including an integrated accounting system;
7. Call Center, including Automated Voice Response System (AVRS) and live representative customer service for Providers, Members, BMS, and other MMIS users; and
8. Electronic Document Management System (EDMS). (The current vendor uses FileNet).

The proposed MMIS can incorporate Commercial-Off-The-Shelf (COTS) products, COTS with modifications, "ground-up" design and development, transferred system from another state, transferred system with modifications, or any combination of these approaches. BMS does not desire any solution that requires it to be a "beta test site."

The Bureau has based its approach for the Scope of Work on the following objectives, presented here in order of importance:

1. The assumption of Fiscal Agent operations without disruption in provider payments or member access to appropriate care and services.
2. Achievement of Federal MMIS certification and approval for the maximum allowable enhanced FFP within 12 months of cutover to the replacement system retroactively to the day the system becomes operational.
3. Compliance with all HIPAA requirements.
4. Timely design and development of components affecting providers, e.g., web portal, web-based claims submission.
5. MMIS that improves efficiency and convenience for BMS staff through reduction of manual processes, increased automated processes, increased workflow capabilities, and increased system capabilities and efficiency.
6. A design, development and implementation approach that minimizes risk to the Bureau.

3.2.1.1 *Vendor Response Requirements:* The Vendor should provide a description of the proposed solution, which should address the following:

1. Information that indicates an understanding of the overall need for and purpose of the project as presented in this RFP.
2. The proposed technical architecture design, including the topics of scalability, configurability, capacity, extensibility, adaptability, performance, availability, stability and security.
3. The Vendor's experience and working knowledge of the solution and approach.
4. How to meet the following MITA requirements:
    a. Industry based, open architectural standards
    b. Modular components
    c. Relational or object oriented database
    d. Web and real-time processing
    e. Rules Engine management
    f. Data privacy, security, and integrity with access limited by staff role
    g. Interoperable systems that support e-communication and processing among systems
5. The proposed system development methodology, including all tools to be used in conjunction with development activities.
6. The Vendor's estimates for the durations of each Project Phase (as described in Section 3.2.5).
7. A description of any portion of the Vendor's solution that is proposed under a sub-contractor, including identification of each sub-offeror and the work to be performed by each.
8. The Vendor's approach to integrating subcontractors (if any) into the proposed approach in order to ensure a seamless solution.
9. A description of how the proposed approach to design, development and implementation minimizes risk to BMS.
10. The Vendor's proposed plan to develop the POS system in parallel with the Medical/Dental system.
11. The caveats, constraints, risks and/or other issues associated with the Vendor's proposed solution and approach.

3.2.2 **Project Management**

The Bureau places a high priority on project management and establishing comprehensive, practical and meaningful project management processes and procedures, including but not limited to Quality Management and Schedule Management. BMS sees project management not as a separate project component, but as an on-going process that is well-integrated into all project activities, throughout all project phases, and actively practiced throughout the life of the project.

Project Management for the MMIS Re-procurement Project is planned to be a joint effort between the following parties: BMS; the contracted MMIS Re-procurement Project Management Team; the current Fiscal Agent; and the awarded Vendor. Together, these parties develop in-scope deliverables and deliver services that meet or exceed contract requirements. The MMIS Re-procurement Project Manager has overall responsibility for Risk Management and Status Reporting to the Bureau.

The MMIS Re-procurement Project Manager develops an MMIS Re-procurement Project Schedule that includes each party's work plans and integrates the Vendor's project schedule at the Deliverable and Milestone level. The MMIS Re-procurement Project Team uses the Project Management Institute (PMI) project management methodology.

3.2.2.1 Vendor Response Requirements: The Vendor should propose the use of an industry standard project management methodology and describe in detail their plans to apply that methodology to complete all project phases as identified in Section 3.2.5, including integrating with the MMIS Re-Procurement Project Team.

The Vendor should describe the controls, tasks, procedures and communication mechanisms to be used to manage the tasks identified in this RFP, as well as their approach to practicing project management disciplines.

The Vendor should state in writing that their methodology and approach interacts effectively with the overarching BMS Project Plan, which was developed as per industry recognized project management methods, and that the Vendor works cooperatively with the MMIS Re-Procurement Project Team.

The Vendor should propose a process for acquiring deliverable acceptance by BMS and should include (but not necessarily be limited to) the following:

- Establishing a process for agreeing upon measurable acceptance criteria for each deliverable;
- Documenting that those criteria have been met;
- Providing adequate time for BMS review of deliverables; and
- Establishing a timeline and process for remediating deficiencies and the format to be used for BMS signatory approval.

The Vendor should include sample reports, forms and deliverable formats in a separate section at the back of their proposal. Specific reports, forms and deliverable samples should include a representation of the standard items associated with the Vendor's project management approach.

The Vendor should also include in their proposal a comprehensive initial draft deliverable Project Management Plan that describes how they intend to complete each phase of the project. The Project Management Plan will be updated and submitted after project initiation, according to a schedule approved by BMS.

The Project Management Plan should include (but not be limited to) the following:

1. Work Breakdown Structure (showing all project deliverables) and Deliverables Dictionary
2. Project Schedule
   It is recommended that the Vendor propose interim and draft deliverable due dates to facilitate BMS's review of project deliverables. The Vendor may propose additional deliverables to the deliverables specified by this RFP; however, those new deliverables do not have payments associated with them.
3. Staffing Plan as described in Section 3.2.3
4. Facility Plan as described in Section 3.2.4
5. Documentation Management Plan
6. Training Plan
7. Testing Plan
8. Project management sub-plans to include:
   a. Scope Management Plan
   b. Schedule Management Plan
   c. Cost Management Plan
   d. Quality Management Plan
   e. Human Resources Management Plan
   f. Communications Management Plan
   g. Risk Management Plan
   h. Issue Management Plan
   i. Change Management Plan
   j. Integration Management Plan
      All requirements for project management are interrelated. The Vendor should apply integrated project management tools or (COTS) products to consolidate reports required for the management of Projects. The Vendor should execute careful change control on the implementation tasks and throughout the project.
9. Workflow Management Plan
10. Problem Management Plan
    The Problem Management Plan is the plan for addressing problems that impact operations or systems processing in accordance with approved requirements and performance service level expectations.
11. Transition Plan
    The Transition Plan is the plan developed by the awarded vendor to be used for the transition from the current system and operations to the new system and operations at the conclusion of the expiring contract.
12. Weekly Status Report Template
13. Monthly Status Report Template

3.2.3 **Project Staffing**

The Bureau's staffing approach balances the need to apply resources with the appropriate skills and experience for a given project phase, with continuity of project knowledge and leadership across project phases.

Project staffing is divided into four (4) categories:

1. Key Staff;
2. Continuously Dedicated (CD) Staff;
3. Support Staff; and
4. Other Staff.

Key Staff members are assigned to the project on a full-time basis, solely dedicated to the West Virginia account, and located onsite in the Charleston facility. Each Key Staff role is a full-time position, to be filled by one staff member only. Key Staff roles may not be combined or filled by multiple staff members. All Key Staff members will enter the project within 30 days of the contract award.

CD Staff are maintained by the Vendor in agreed-upon quantities by category. These persons are 100% dedicated to the West Virginia account for the time in which their services are required and may not hold any other positions concurrently (on this or any other project). Unless express written approval is obtained from the Bureau.

Support Staff are those staff with specific skills or expertise that support certain stages throughout the life of the contract. These persons are 100% dedicated for the time in which their services are required (unless otherwise noted) to the West Virginia account, hold no other concurrent positions (on this or any other project), and are located onsite in the Charleston facility. Unless express written approval is obtained from the Bureau.

Other Staff are those staff which will be 100% dedicated to the West Virginia account for the time in which their services are required and may not hold any other positions concurrently. Unless express written approval is obtained from the Bureau.

3.2.3.1 *Key Staff:* The DDI activities are led by Key Staff, identified in the list below, to ensure appropriate transition to the operations phase.

1. One (1) MMIS Account Manager
2. One (1) Medical/Dental Deputy Account Manager/Operations Manager
3. One (1) Medical/Dental Application Manager
4. One (1) Medical/Dental Systems Manager
5. One (1) POS System Manager
6. One (1) Pharmacy Manager
7. One (1) Drug Rebate Manager
8. One (1) Provider/Member Services Manager
9. One (1) Medical/Dental Quality Manager
10. One (1) Financial Manager
11. One (1) EDI Manager/Web Portal Manager
12. One (1) Reports Manager
13. One (1) Medical/Dental Project Manager
14. One (1) POS Project Manager

15. One (1) Registered Nurse
16. Two (2) Certified Professional Coders

Table 3-1 Key Staff by Phase

Title	Staff Type	Phase 1 MMIS Replacement DDI and Certification Planning	Phase 2 Fiscal Agent Operations	Phase 3 Close-out and Turnover
1. MMIS Account Manager	Key	X	X	X
2. Medical/Dental Deputy Account Manager/Operations Manager	Key	X	X	X
3. Medical/Dental Application Manager	Key	X	X	X
4. Medical/Dental Systems Manager	Key	X	X	X
5. POS System Manager	Key	X	X	X
6. Pharmacy Manager	Key	X	X	X
7. Drug Rebate Manager	Key	X	X	X
8. Provider/Member Services Manager	Key	X	X	X
9. Medical/Dental Quality Manager	Key	X	X	X
10. Financial Manager	Key	X	X	X
11. EDI Manager/Web Portal Manager	Key	X	X	X
12. Reports Manager	Key	X	X	X
13. Medical/Dental Project Manager	Key	X	X	X
14. POS Project Manager	Key	X	X	X
15. Registered Nurse	Key	X	X	X
16. Certified Professional Coder (2)	Key	X	X	X

Table 3-2 Qualifications and Experience for Key Staff (Each key position should be held by only one distinct individual)

Key Position	Description of Qualifications and Experience	
1. MMIS Account Manager	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as an Account Manager or Deputy Account Manager for a State Medicaid Entity and/or Medicaid Fiscal Agent operations for a State or other US territory.
	Experience (in addition to Qualifications above)	A total of eight years of demonstrated experience in: 1. Management of an organizational unit within a Medicaid Agency in a State or other US territory; and/or 2. Management of an organizational unit within a Medicaid Fiscal Agent which is performing operations in a State of equivalent scope to West Virginia; and/or 3. Experience in other large healthcare claims processing organization. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Account Manager serves as a liaison with the Bureau during all phases of the contract. The Account Manager is available and responsive to Bureau requests for consultation and assistance. The Account Manager,: • Attends, upon request, meetings and hearings of Legislative Committees and interested governmental bodies, agencies, and officers. • Integration management between Medical/Dental and POS. • Oversees the MMIS Replacement DDI and Certification and all sub-phases. • Is responsible for establishing and

Key Position	Description of Qualifications and Experience	
		maintaining a positive client relationship. Provides timely and informed responses to operational and administrative inquiries that arise. • Delegates authority to the Deputy Account Manager when not able to be available. • Meets with BMS staff or such other person as the Bureau may designate on a regular basis to provide oral and written status reports and other information as required.
2. Medical/Dental Deputy Account Manager/ Operations Manager	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as a Medical/ Dental Deputy Account Manager/ operations manager for a State Medicaid Entity and/or Medicaid Fiscal Agent which is performing operations in a State or other US territory.
	Experience (in addition to Qualifications above)	Any combination of five years of Medicaid operations or Medicaid Fiscal Agent operations experience or other large healthcare claims processing organization. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Deputy Account Manager fills the role of Account Manager in that person's absence. The Deputy Account Manager plays an active role in day-to-day management of the Account so as to be knowledgeable and aware of all issues, concerns and requirements including integration management between Medical/ Dental and POS. The Deputy Account Manager also serves as the Operations Manager, managing staff assigned to all operational business activities, day-to-day operations of the MMIS and Fiscal Agent operations.

Key Position	Description of Qualifications and Experience	
		The Deputy Account Manager assists with oversight of the MMIS Replacement DDI and Certification and all sub-phases.
3. Medical/Dental Application Manager	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as a Medical/ Dental Application Manager for a State Medicaid Entity and/or Medicaid Fiscal Agent which is performing operations in a State or other US territory.
	Experience (in addition to Qualifications above)	Experience in setting up provider contracts, member benefits, and reference. Five years of Medicaid MMIS experience. Highly knowledgeable in quality assurance/control procedures, strong documentation and reporting background, demonstrated proactive problem management skills, and experience with change and incident management. Preference will be given to candidates with implementation experience in the system/application being bid.
	Role	The Application Manager is responsible for managing all configuration activities for modifications and enhancements. Modifications include, but are not limited to, routine system maintenance, changes in rate or fee schedules, and changes required to remain compliant with Federal regulations and standards. Enhancements include, but are not limited to, changes initiated by the Bureau to achieve strategic objectives, implement new programs, and mature business capabilities.
4. Medical/Dental Systems Manager	Qualifications	BA/BS degree preferred in Computer Science, Information Systems or related field. Substitution for BA/BS: Four years demonstrated experience as a

Key Position	Description of Qualifications and Experience	
		Medical/Dental Systems Manager for a State Medicaid Entity and/or Medicaid Fiscal Agent which is performing operations in a State or other US territory.
	Experience (in addition to Qualifications above)	A total of eight years of demonstrated experience that can consist of any combination of the below: 1. Manager of an organizational unit within a Medicaid Agency in a State or other US territory; and/or 2. Manager of an organizational unit within a Medicaid Fiscal Agent which is performing operations in a State or other US territory; and/or 3. Experience in another large healthcare claims processing organization.
	Role	The Systems Manager is responsible for planning, developing, testing, implementing, and maintaining the West Virginia MMIS as well as assisting with management of the MMIS Replacement DDI and Certification including all sub-phases.
5. POS Systems Manager	Qualifications	BA/BS preferred computer science related field including but not limited to, business data programming, business systems analysis, computer accounting, computer and information systems, computer servicing technologies, information systems management, data processing, or computer engineering. Substitution for BA/BS: Four years demonstrated experience performing systems and software engineering activities.
	Experience (in addition to Qualifications above)	A total of four years of demonstrated experience in managing or performing systems and/or software engineering activities, two years of which are experience with the Medicaid Pharmacy system being bid.

Key Position	Description of Qualifications and Experience	
	Role	The POS Systems Manager is responsible for planning, developing, testing, implementing and maintaining the West Virginia MMIS Pharmacy POS throughout all phases and life of the contract.
6. Pharmacy Manager	Qualifications	Pharmacy BS/PharmD and unrestricted state pharmacy license. Licensure by the West Virginia Board of Pharmacy should be achieved within one year of the award of contract.
	Experience (in addition to Qualifications above)	A total of five years of demonstrated management experience in a retail pharmacy setting that includes directly supervising staff, and knowledge of outpatient drug dispensing and billing procedures. Preference will be given for additional experience in health care benefits management, including administration of clinical pharmacy benefits and related services; operational experience with state pharmaceutical assistance program(s) or other publicly-financed health program(s) such as Medicaid that includes administration and payment of pharmacy claims.
	Role	The Pharmacy Manager is responsible for analyzing and configuring BMS pharmacy policy, and providing clinical support for policy development. The Pharmacy Manager is also responsible for, but not limited to communication with Pharmacy providers, conducting POS user training, participating in provider workshops, and providing direction to the POS help desk regarding POS inquiries.
7. Drug Rebate Manager	Qualifications	BA/BS, RPH/PharmD preferred Substitution for BA/BS, RPH/PharmD: Five years of management experience in a Medicaid pharmacy or drug rebate program that included direct supervision of program

Key Position	Description of Qualifications and Experience	
		staff.
	Experience (in addition to Qualifications above)	Three years experience as a manager of a Medicaid drug rebate program with direct supervision of program staff. Preference will be given to candidates that have experience in the operation of the product/system being bid.
	Role	The Drug Rebate Manager is responsible for the implementation, maintenance, and all day-to-day operations of the Drug Rebate Program while complying with State and Federal guidelines. The Manager is responsible for the oversight and coordination of the Drug Rebate Program; serves as a direct liaison to the Bureau for the Drug Rebate Program and is responsive and available to Bureau request for consultation and assistance; assists in support of policy development; conducts user training; provides assistance to the help desk on rebate questions; and attends meetings/calls to provide rebate program information to the Bureau or its designees.
8. Provider/Member Services Manager	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as a Provider/ Member Services Manager for a State Medicaid Entity and/or Medicaid Fiscal Agent which is performing operations in a State or other US territory. .
	Experience (in addition to Qualifications above)	Three years experience with a Medicaid fiscal agent or other large healthcare claims processing organization performing provider/member services, e.g., enrollment and provider/member relations activities, e.g., developing and implementing training, communications, outreach programs for a Medicaid Fiscal Agent or private sector health care payer.
	Role	The Provider/Member Services Manager oversees provider enrollment, provider/

Key Position	Description of Qualifications and Experience	
		member relations, provider training and outreach and associated Help Desk business areas for Medical/Dental and POS.
9. Medical/Dental Quality Manager	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as a Medical/Dental Quality Manager for a State Medicaid Entity and/or Medicaid Fiscal Agent which is performing operations in a State or other US territory.
	Experience (in addition to Qualifications above)	A total of four years of demonstrated experience as follows: Experience working for a Medicaid Fiscal Agent or experience with a large health care organization. All four years experience are in development and maintenance of a vigorous ongoing quality control function that encompasses data entry, verification of systems outputs, balancing of jobs, validating the integrity of the data, controlling and accounting for systems inputs, provider communications, finance and accounting, and ensuring adequate internal controls and quality checks throughout all system and operations tasks.
	Role	The Quality Manager oversees all quality assurance functions and responsibilities including deliverable review, accuracy of reports, system enhancement documentation, and review of test results.
10. Financial Manager	Qualifications	BA/BS in accounting, business administration, finance or economics.
	Experience (in addition to Qualifications above)	Five years experience managing an organizational department or unit responsible for the accounting, budget and/or reporting function of a large commercial healthcare claims processing organization, Medicaid agency, or a similar government project;

Key Position	Description of Qualifications and Experience	
		preferred MMIS financial management and accounting experience.
	Role	The Financial Manager manages all financial functions, reporting including daily, monthly and other cyclical financial processes, and supports the budget process for Medical/Dental and POS.
11. EDI Manager/Web Portal Manager	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as an Electronic Data Interchange (EDI) and or Web Portal Manager for a State Medicaid Entity and/or Medicaid Fiscal Agent and/or other large healthcare claims processing organization.
	Experience (in addition to Qualifications above)	A total of five years of demonstrated experience as follows: Three years of which should be in the development, implementation and/or support of EDI functionality within a Medicaid Agency and/or Medicaid Fiscal agent in a State or other US territory. ; and/or Development, implementation and/or providing operational support for ongoing HIPAA transaction compliance for a large healthcare claims processing organization; and/or Development and/or support of policies, processes and/or procedures for the review and maintenance of implementation guides. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The EDI Manager/Web Portal Manager oversees Electronic Data Interchange activities, provides support for HIPAA transaction compliance, and develops and maintains implementation guides for Medical/Dental and POS. The EDI Manager/Web Portal Manager supports expanding health information initiatives for

Key Position	Description of Qualifications and Experience	
		Medical/Dental and POS such as but not limited to: HIE and ePrescribing.
12. Reports Manager	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as Reports Manager for a State Medicaid Entity and/or Medicaid Fiscal Agent and/or other large healthcare claims processing organization.
	Experience (in addition to Qualifications above)	A total of four years of demonstrated experience in: 1. Development, implementation and/or analysis of reports utilized in the support and/or operations of a Medicaid Agency in a State or other US territory; and/or 2. Development, implementation and/or analysis of reports utilized in the support and/or operations of a Medicaid Fiscal Agent which is performing operations in a State of equivalent scope to West Virginia; and/or 3. Development, implementation and/or analysis of reports utilized in the support and/or operations of a large healthcare claims processing organization; and/or 4. Development, implementation and/or monitoring of policies, processes and/or procedures and/or documentation for report development, generation, review and/or loading into a production reports database platform. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Reports Manager is responsible for managing the report development and

Key Position	Description of Qualifications and Experience	
		analysis for Medical/Dental and POS. Responsibilities include but are not limited to: • Recommending establishment of new or modified reporting methods and procedures to improve report content and completeness of information; • Conferring with persons originating, handling, processing, or receiving reports to identify problems and to gather suggestions for improvements; • Examining and evaluating purpose and content of business reports to develop new, or improve existing format, use, and control; • Reviewing reports to determine basic characteristics, such as origin and report flow, format, frequency, distribution and purpose or function of report; • Evaluating findings, using knowledge of workflow, operating practices, record retention schedules; and • Preparing and issuing instructions concerning generation, completion, and distribution of reports according to new or revised practices, procedures, or policies of reports management.
13. Medical/Dental Project Manager	Qualifications	BA/BS Substitution for BA/BS: Four years of project management demonstrated experience in addition to the four years required below can be substituted for a degree. PMP certification or industry recognized project management certification preferred.
	Experience (in addition to Qualifications above)	A total of four years of demonstrated experience in: 1. Project Management of a project that encompassed the full system

Key Position	Description of Qualifications and Experience	
		development life cycle from initiation through post implementation within a Medicaid Agency in a State or other US territory; and/or 2. Project Management of a project that encompassed the full system development life cycle from initiation through post implementation within a Medicaid Fiscal Agent which is performing operations in a State or other US territory. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Project Manager leads the Vendor's project management activities for Medical/ Dental inclusive of integration management with POS.
14. POS Project Manager	Qualifications	BA/BS PMP certification or industry recognized project management certification preferred Substitution for BA/BS: Four years of demonstrated experience in project management activities for a State Medicaid Entity and/or Medicaid Fiscal Agent.
	Experience (in addition to Qualifications above)	A total of five years of project management experience that includes a two years of the management of one Medicaid Fiscal Agent POS project that encompassed the full system development life cycle from initiation through post implementation.
	Role	The Project Manager leads the Vendor's project management activities for POS including, but not limited to, oversight of DDI, implementation, CMS certification, integration management with Medical/Dental system, system enhancements, upgrades, implementation of new requirements to assure that deliverables are timely, meetings and action items are documented, and proper

Key Position	Description of Qualifications and Experience	
		resources are identified in order to meet BMS requirements and timelines.
15. Registered Nurse	Qualifications	Possession of the legal requirements to practice as a Registered Nurse in West Virginia and a Bachelor of Science in Nursing , Master's Degree preferred.
	Experience (in addition to Qualifications above)	Knowledge of: professional nursing principles and techniques; medical terminology; hospital routine and equipment; and medications including narcotics. Experience in utilization review preferred.
	Role	The Registered Nurse identifies significant opportunities for clinical or financial improvement in medical/medication management, develops and designs interventions that improve or maintain the quality of care while reducing the overall cost of care when possible, assists in evaluating the effectiveness of interventions, and serves as a clinical consultant for the West Virginia MMIS for Medical/Dental and POS.
16. Certified Professional Coder (2 positions)	Qualifications	An Associate's or Bachelor's degree preferred. American Health Information Management Association (AHIMA) certification preferred.
	Experience (in addition to Qualifications above)	The Certified Coding Specialist should have experience with bundling software. Diseases, pharmacology and general medical terminology expertise is preferred. Understands the surgical section of Current Procedural Terminology (CPT) and the International Classification of Diseases Clinical Modification in order to properly convert the terminology into numerical codes. Proficiency in assigning accurate medical codes throughout a wide range of services and have experience in integrating coding and reimbursement rule changes, as well as experience with AHA Coding Clinic guidelines. Knowledge of anatomy, physiology and

Key Position	Description of Qualifications and Experience	
		medical terminology necessary to correctly code provider services and diagnoses is important.
	Role	The Certified Coding Specialist leads the Procedure Code Workgroup, reviews and advises on all Medical/Dental and POS coding updates released quarterly, and is responsible for interpreting medical terminology in order to create numerical codes for insurance and medical statistics purposes for Medical/Dental and POS.

3.2.3.2 *Continuously Dedicated Staff:* CD Staff positions are to be maintained in agreed upon quantities by category. The CD Staff categories are as follows:

1. POS Quality Manager
2. Data Conversion Specialist
3. Interface Specialist

Table 3-3 Continuously Dedicated Staff by Phase

Title	Staff Type	Phase 1 MMIS Replacement DDI and Certification Planning	Phase 2 Fiscal Agent Operations	Phase 3 Close-out and Turnover
1. POS Quality Manager	CD	X	X	X
2. Data Conversion Specialist	CD	X		
3. Interface Specialist	CD	X		

Table 3-4 Qualifications and Experience for CD Staff

CD Position	Description of Qualifications and	Experience
1. POS Quality Manager	Qualifications	BA/BS Substitution for BA/BS: Four years of demonstrated experience in quality control activities for a State Medicaid

CD Position	Description of Qualifications and Experience	
		Entity and/or Medicaid Fiscal Agent
	Experience (in addition to Qualifications above)	A total of five years of demonstrated experience in quality control of a claims billing system, three of which are with a State Medicaid Entity and/or Medicaid Fiscal Agent pharmacy claims billing system. Experience includes, but is not limited to, data entry, verification of systems outputs, balancing of jobs, validating the integrity of the data, controlling and accounting for systems inputs, provider communications, claims payment, ensuring adequate internal controls and quality checks throughout all system and operations tasks.
	Role	The POS Quality Manager oversees all quality assurance functions and responsibilities including, but not limited to deliverable review, accuracy of reports, system enhancement documentation, and review of test results.
2. Data Conversion Specialist	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as a claims conversion analyst or specialist.
	Experience (in addition to Qualifications above)	Five years experience managing data conversion for MMIS implementation projects or health care information systems. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Data Conversion Specialist manages all data conversion activities for Medical Dental and POS.
3. Interface Specialist	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as an interface analyst or specialist

CD Position	Description of Qualifications and Experience	
	Experience (in addition to Qualifications above)	Three years experience in systems integration, messaging components, and interface development for MMIS implementation projects or health care information systems. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Interface Specialist manages all interface development and implementation activities for Medical/Dental and POS.

3.2.3.3 *Support Staff:* Support Staff are those staff with specific skills or expertise that supports certain stages throughout the life of the contract, as identified below.

1. Trainer and Documentation Specialist
2. Medical/Dental Ad Hoc Reporting Analyst (2 Full Time Equivalent (FTEs))
3. POS Reporting Analyst
4. Finance Report Analyst
5. Drug Rebate Analyst

Table 3-5 Support Staff by Phase

Title	Staff Type	Phase 1 MMIS Replacement DDI and Certification Planning	Phase 2 Fiscal Agent Operations	Phase 3 Close-out and Turnover
1. Trainer and Documentation Specialist	Support	X	X	X
2. Medical/Dental Ad Hoc Reporting Analysts (2 FTEs)	Support	X	X	X
3. POS Reporting Analyst (1 FTE)	Support	X	X	X
4. Finance Report Analyst	Support	X	X	X
5. Drug Rebate Analyst	Support	X	X	X

Table 3-6 Qualifications and Experience for Support Staff

Support Staff Position	Description of Qualifications and Experience	
1. Trainer and Documentation Specialist	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience in training multiple classes and in documenting various letters, statements of work, manuals, etc.
	Experience (in addition to Qualifications above)	Two years experience in the creation and production of technical and/or user documentation; one year experience in the management of documentation version control procedures and web-based documentation experience. Projects may involve preparing individual sections of the MMIS Systems manuals or other technical documents, or organizing the production of a basic manual, such as a user manual. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Trainer and Documentation Specialist is responsible for developing training curricula, training materials, facilitating training sessions and technical and/or user documentation for Medical/Dental and POS.
2. Medical/Dental Ad Hoc Reporting Analysts (2 FTEs)	Qualifications	BA/BS Substitution for BA/BS: Four years demonstrated experience as Data and/or Reports Analyst for a State Medicaid Entity and/or Medicaid Fiscal Agent and/or other large healthcare claims processing organization.
	Experience (in addition to Qualifications above)	A total of three years of demonstrated experience as follows: Development, and/or support of data analysis within a Medicaid Agency and/or Medicaid Fiscal agent in a State of equivalent scope to West Virginia; and/or

Support Staff Position	Description of Qualifications and Experience	
		Development and/or generation of reports and analysis of the same in support of a large healthcare claims processing organization; and/or Development and/or support of policies, processes and/or procedures for the review and maintenance of billing manuals. Preference given to candidates with Medicaid Fiscal Agent operations experience.
	Role	The Medical/Dental Ad Hoc Reporting Analyst is responsible for analyzing report data for trending purposes and reporting those variances to BMS. The Medical/Dental Ad Hoc Reporting Analyst is also responsible for gathering business requirements, report development, QA and delivery of reports to BMS for approval.
3. POS Reporting Analyst (1 FTE)	Qualifications	BA/BS Substitution for BA/BS: Four years of demonstrated accounting or financial reporting experience
	Experience (in addition to Qualifications above)	A total of three years demonstrated experience supporting data analysis for Medicaid or other health care programs. Preference will be given to those with experience in the product being bid.
	Role	The POS Reporting Analyst is responsible for analyzing report data for trending purposes and reporting those variances to BMS. The POS Reporting Analyst is also responsible for gathering business requirements, report development, QA and delivery of reports to BMS for approval.
4. Finance Reporting Analyst	Qualifications	BA/BS degree preferred Substitution for BA/BS: Four years experience as a financial reporting

Support Staff Position	Description of Qualifications and Experience	
		analyst for a State Medicaid program, Medicaid fiscal agent, or other healthcare program.
	Experience (in addition to Qualifications above)	Three years experience preparing financial analysis for a Medicaid program or other healthcare program. Preference will be given to those with experience working in the product being bid.
	Role	The Finance Reporting Analyst is responsible for analyzing report data for trending purposes and reporting those variances to BMS. The Finance Reporting Analyst is also responsible for gathering business requirements, report development, QA and delivery of reports to BMS for approval.
5. Drug Rebate Analyst	Qualifications	BA/BS Substitution for BA/BS: Four years of data analysis and reporting experience in a Medicaid program, Medicaid fiscal agent or other healthcare program.
	Experience (in addition to Qualifications above)	Three years demonstrated experience performing data analysis and reporting in the product being bid.
	Role	The Drug Rebate Analyst is responsible for loading, organizing, and analyzing rebate system data and reports. The Drug Rebate Analyst is responsible for gathering business requirements; report development; QA; delivery of reports and data to BMS or its designee as required; and rebate invoicing activities. The Analyst is responsible for promptly reporting any variances and means of resolution to BMS and the Rebate Manager.

3.2.3.4 Other Staff

In addition to positions named above, the Vendor should supply the following staff types and maintain sufficient numbers of staff to fully perform the requirements of this RFP and the resulting contract. These persons are 100% dedicated to the West Virginia account for the time in which their services are required and may not hold any other positions concurrently. Exceptions to these requirements must be approved by the Bureau.

1. *Systems Management Lead and Team* – Sufficient industry-qualified staff to perform release management, version control, extracts, documentation maintenance, network and database management, and other technical personnel as required to maintain all other system components. Lead Qualifications: A Bachelor's Degree and two years of experience in the application to which the individual is assigned. Experience in the application to which the individual is assigned can be substituted for the Bachelor's Degree on a year-for-year basis.
2. *Claims Lead and Team* – Staff assigned to the management of claims business activities. Lead Qualifications: Five years of experience in medical claims processing.
3. *Mail Room Lead and Team* – Staff assigned to management of mail room business activities. Lead Qualifications: Two years of experience in mail room processing.
4. *Provider Enrollment and Relations* – Sufficient staff to perform all Provider enrollment and relations duties, including:
   a. Provider Field Representatives – Qualifications: Two years of experience in the health care billing or health care public relations field.
   b. Provider Relations Representatives – Qualifications: Two years of experience in the health care billing or health care public relations field.
5. *Quality Assurance (QA) Team Personnel* – Assist in QA activities. Qualifications: A Bachelor's Degree and two years of Medicaid or health care quality assurance support experience. Quality Assurance Support experience can be substituted for the Bachelor's Degree on a year-for-year basis.
6. *Systems and Business Analysts* – Assist with modifications and future enhancements. Qualifications: A Bachelor's Degree and three years of experience in analyzing business requirements for Medicaid, Medicare or a large health payor. Experience in analyzing business requirements for Medicaid, Medicare or a large health payor can be substituted for the Bachelor's Degree on a year-for-year basis.
7. *Sterilization/Hysterectomy* – Sufficient staff to review and/or enter Sterilization/Hysterectomy information from Physician Certification Statements. Qualifications: One year of Medicaid or health care experience.
8. *Member Services* – Sufficient staff to perform all Member Services duties.
9. *Member Payment* – Sufficient staff to support member premium invoicing.

10. *Pharmacy POS Clinical Lead and Team* – Sufficient staff to support clinical programs for the Pharmacy POS such as criteria development for auto prior authorization, Drug Utilization Review (DUR) parameters. BMS would prefer a registered Pharmacist with two years of experience. *Pharmacy POS Technical Lead and Team* – Sufficient staff to support technical aspects of the Pharmacy POS including but not limited to the auto prior authorization program, clinical web portal, Drug Utilization Review (DUR) program, etc. Qualifications: BA/BS degree preferred in Computer Science, Information Systems or related field. Four years of directly relevant experience.
11. *Pharmacy Benefit Technicians* – Sufficient staff to perform POS related duties such as but not limited to, provider communication, operation, and claims reconciliation. Registered with West Virginia Board of Pharmacy and two years of experience in pharmacy operations.
12. *Reporting* – Sufficient staff to develop and maintain current and ongoing reports for the MMIS.
13. *Drug Rebate Technical Lead* – This position will be responsible for all technical aspects of the Rebate System, which includes, but is not limited to, the development, testing, implementation, and maintenance of a system that will accommodate all rebate activities. ***This position will not be required to be on-site or full-time.*** Qualifications: BA/BS degree in Computer Science, Information Systems, or related field. Four years of demonstrated experience performing systems and/or software engineering activities, two years of which are direct experience related to the system being proposed.

3.2.3.5 *Vendor Response Requirements:* The Vendor's staffing plan should include highly skilled team members who bring a breadth and depth of MMIS and Medicaid knowledge, skills, and experience. In their proposal, the Vendor should describe how their staffing plan provides all the skills needed to fulfill the requirements throughout all the Scope of Work phases. The Bureau considers the Key Staff resumes as a key indicator of the bidder's understanding of the skill mixes required for each staffing area.

The Vendor's proposed staffing plan should include, but not necessarily be limited to, the following components:

1. Organizational Chart for each phase of the project. Each organizational chart should show all staff to be used for the Phase including staff that work off-site from the local work site as well as subcontractor staff. Off-site staff and subcontractor staff should be clearly identified on each organizational chart.
2. Description of the roles, responsibilities, and skill sets associated with each position on the organization chart.
3. Brief summary description of the roles and responsibilities of each Key Staff member and the experience which qualifies them for their role in this project. If any of the work is performed off-site, including work of subcontractor(s), the bidder should describe the assurance of quality and timeliness of the work done off-site.

4. Completion of Attachment III: Staff Matrix
5. Approach to staff retention and ensuring continuity of staff among key project phases.
6. Approach to personnel management, including:
   a. Hiring and firing and employee relocation.
   b. Staff training, both initial and on-going, including transfer of system and business knowledge, project management methodologies and processes, and project status, to new staff and for incumbent staff transitioning between project roles or phases.
   c. Staff performance monitoring.
   d. Succession planning, staff replacement, and staff backup.
   e. Procedures for obtaining additional staffing support.
7. A process for transitioning essential knowledge to BMS' technical staff.

3.2.4 **Project Facilities**

The following Vendor functions should be performed at the Vendor's Charleston facility:

1. Business operations;
2. Claims receipt (hard copy) and pre-screening;
3. Mail room (including the print fulfillment functions such as, printing, sorting, inserting and mailing);
4. Data entry (paper claims);
5. Imaging operations;
6. Exception claims processing;
7. All call center operations, excluding the POS Pharmacy (Provider) Help Desk operations (see below);
8. Provider enrollment and re-enrollment;
9. Provider relations;
10. Member relations;
11. Account Management;
12. Quality Assurance;
13. Designated system modification and enhancement activities described in Section 3.2.7.3, including staffing requirements; and,
14. Financial Management.

POS Pharmacy (Provider) Help Desk operations should be located in the State of West Virginia.

3.2.4.1 *Vendor Response Requirements*: The Vendor's proposal should describe its approach to securing all workspaces and meeting the facility requirements, by project phase and activity as described above including:

- Description of the work site(s) proposed, inclusive of offsite facilities, for work during each of the three project phases listed in Section 3.2.5.
- Description of any work to be performed off site. If any of the work is performed offsite, including work of subcontractor(s), the bidder should describe the assurance of quality and timeliness of work.

3.2.5 **Project Phase Overview**

The MMIS Re-Procurement Project is comprised of a phased implementation, and is divided into project phases as follows (including respective RFP section number for each):

Phase 1: MMIS Replacement DDI and CMS Certification Planning	*(3.2.6)*
Phase 1a: Start-Up	(3.2.6.1)
Phase 1b: Analysis and Design	(3.2.6.2)
Phase 1c: Development, Testing, Data Conversion, and Training	(3.2.6.3)
Phase 1d: Implementation	(3.2.6.4)
Phase 1e: CMS Certification Planning	(3.2.6.5)
Phase 2: Fiscal Agent Operations	*(3.2.7)*
Phase 2a: Routine Operations	(3.2.7.1)
Phase 2b: CMS Certification	(3.2.7.2)
Phase 2c: MMIS Modifications and Enhancements	(3.2.7.3)
Phase 3: Turnover and Close-Out	*(3.2.8)*

Each phase-related section that follows provides a brief summary of the phase and Vendor response requirements. Required deliverables and milestones are located in Appendix C (Deliverables, Milestones and Payments).

The Bureau expects some contract phases to overlap in the time schedules. Formal Notice to Proceed is required from BMS before the start of each phase. The Bureau has offered a draft timeline in the Advanced Planning Document (APD) (see the Procurement Library) for comparative purposes.

The Vendor should consider phased deployment of business functions to reduce risk. The Vendor should also consider such functions as provider enrollment, production of manuals and handbooks, creation of the web portal, infrastructure creation, quality assurance processes, performance reporting and paper claims data entry as possible candidates to develop prior to MMIS implementation.

3.2.6 **Phase 1: MMIS Replacement DDI & CMS Certification Planning**

Phase 1 commences upon execution of the Vendor contract. This phase includes all Design, Development and Implementation (DDI) activities included in the project and is divided into five sub-phases:

3.2.6.1 *Phase 1a: Start-Up*: Phase 1a signifies project initiation. During this phase, the foundation for successful design, development and implementation should be established. This phase also includes finalization and BMS approval of project management documents.

3.2.6.1.1 *Phase 1a: Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Start-Up Phase, including the proposed:

1. Approach to the completion of the Phase 1a Deliverables and Milestones (as listed in Appendix C), including methodology for updating deliverables throughout the lifecycle of the project.

2. Approach to obtaining BMS approval of the completion of Phase 1a, including proposed Acceptance Criteria for each Milestone throughout Phase 1a.
3. Approach to initial risk assessment and mitigation during the Project Start-Up Phase.

The Vendor should also include in their proposal initial drafts of the following plans and their components (all of which are to be submitted in updated form following project initiation, according to a schedule approved by BMS):

4. Comprehensive, initial draft deliverable Security, Privacy, and Confidentiality Plan which addresses potential security issues and the steps to be taken to ensure these issues do not compromise the operation of the MMIS and the data stored therein. The Plan should be an overarching plan for all levels of security. It is expected that data is only viewable by those who are explicitly permitted to view or receive it. The security model developed to support the MMIS should be one that is based upon security access roles and organizational affiliation. It is critical that the BMS have a method for tracking access to, use of, and changes to data. Data should be physically safe and adequately protected at all times. The Plan should detail how the Vendor is fully compliant with HIPAA requirements, including Administrative, Physical and Technical safeguards, and how the Vendor is compliant with National Institute of Standards and Technology (NIST) security controls. The security plan should include:
    a. Security administration for all proposed networks and platforms:
        i. Computer and data security policies and responsibilities;
        ii. Physical security policies, equipment use, inventory and audit, and network access; and
        iii. Software policies, copyright, COTS change management controls, platform systems software, distributed systems.
    b. Responsibility of key information security positions:
        i. Details of security roles and responsibilities.
    c. Incident monitoring and reporting:
        i. Incident monitoring, violation reporting and notification.
        ii. Management of responses and security follow-up.
    d. Physical security for all proposed facilities:
        i. Facility access controls to buildings and spaces; power, HVAC (Heating Ventilation Air Conditioning), and fire detection/suppression.
        ii. Physical access management.
        iii. Environmental controls.
    e. Information security/access control for all proposed applications:
        i. Security software for all proposed platforms.

ii. Information access management (logon ID procedures) for all proposed platforms, databases, and applications.

f. Education and training for Vendor and BMS staff and users, including user security manuals.

5. Comprehensive, initial draft deliverable Configuration Management Plan, which describes the following components:
   a. Configuration Management Methodology.
   b. Development, implementation and use of an Integrated Test Environment (ITE) that includes, the following multiple isolated test environments: development test, User Acceptance Testing (UAT), training, and production test. The Vendor should describe the separate test environments to be used during the testing phase of DDI and during production.
   c. Promotion and version control procedures that include the performance of regression tests whenever a code change or new software version is installed, including maintaining an established baseline of test cases to be executed before and after each update to identify differences.
   d. Multiple environment controls including the management of simultaneous activities across multiple environments.
   e. Tools and business processes to control software development, including check in/checkout procedures and a responsibility audit trail.
   f. Business processes and procedures for controlling the migration of code from design through coding, testing phases, e.g., unit, integration, acceptance, and promotion into production.
   g. Organizational structure to control all system development and maintenance.
   h. Approach to maintaining documented, proven code promotion procedures from the initiation of unit testing through the final implementation to production.

6. Comprehensive, initial draft deliverable Data Conversion Plan which details, the following:
   a. Methodology and approach to the following:
      i. Updating the Data Conversion Plan as necessary to meet the current BMS business and technical environment.
      ii. Development and/or use of conversion programs, tools, or existing extract routines to extract data from the current system.
      iii. Validation of the data conversion software, including description of a system test of all conversion software to demonstrate its functionality and performance before conversion.

iv. Contingency planning to mitigate data conversion risks, including development of a Data Conversion Risk Identification and Contingency Plan.
v. Conducting parallel system and subcomponent runs to validate data conversion results.
vi. Data cleansing, including development of a Data Conversion Specifications Document containing the specific data cleansing and conversion criteria for all data elements.
vii. Development and use of data conversion test scripts.
viii. Support for UAT of converted data.
ix. Updating the Data Conversion Requirements Document, including the use of the MMIS Requirements Specification Document (RSD) and the Detailed Systems Design (DSD) documents to determine which data elements are required for the conversion process, and working with BMS to establish the requirements for data conversion.

b. Approach to data conversion reconciliation, including methodologies for:
i. Trial conversions.
ii. Results reporting and analysis, including reports to assure that there are adequate checks and balances in the data conversion process.
iii. Verification of pilot implementation data.
iv. Verification of system-wide implementation data.
v. Strategy for any data that does not convert.
vi. Approach to development and use of Data Conversion Test Scripts.

7. Comprehensive, initial draft deliverable Disaster Recovery and Business Continuity Plan, which details, the following:
a. Back-up and protection plans and procedures, to include files, software, hardware, and network connectivity.
b. Description of any proposed alternate hot site(s), including proposed plans and procedures for failover testing.
c. Description of off-site storage procedures, including a detailed schedule for back-up operations and any proposed clustering methodology for high availability.
d. Proposed recovery time and recovery point objectives.
e. Risk analysis and risk mitigation for each core business process.
f. Processes and procedures for testing and reporting of the DR/Business Continuity Plan to include:
i. Failover/Fallback functionality.
ii. Back Up/Recovery functionality.
iii. Business Continuity.
iv. Process for updating the plan (as necessary) through the life of the contract.

8. Comprehensive, initial draft deliverable Data and Records Retention Plan, which includes the following:
    a. Detailed schedules, to ensure that data maintained on the MMIS or in other system/manual files is properly and routinely purged; archived; and protected from loss, unauthorized access, or destruction in accordance with all relevant State policies and procedures.
    b. Retention methodology for all data and records associated with each of the project phases described herein.

3.2.6.2 *Phase 1b: Analysis and Design*: Phase 1b Analysis and Design commences upon BMS's issuance of Formal Notice to Proceed. The Bureau foresees this phase to include the development of the detailed specifications required to construct and implement the proposed West Virginia MMIS.

3.2.6.2.1 *Phase 1b: Vendor Response Requirements*. The Vendor should propose an approach to review, validate and update requirements specified in this RFP. In their description, the Vendor should include the proposed approach to working with BMS staff to fully understand the scope, purpose, and implications of each requirement, and the thorough review of all appropriate BMS programs and policies.

The Vendor should describe their process for identifying and resolving gaps between the proposed system and the BMS system in order to meet the Bureau's business and technical requirements.

The Vendor should propose an approach describing how the MMIS Replacement design integrates with ancillary systems and activities as defined by BMS and how design decisions are coordinated across all functional areas.

The Vendor's proposal should also present a narrative description of the Vendor's proposed approach to completion of the Analysis and Design Phase, including the Vendor's:

1. Approach to the completion of the Phase 1b Deliverables and Phase 1b Milestones (as listed in Appendix C), including methodology for updating deliverables throughout the lifecycle of the project.
2. Approach to obtaining BMS approval of the completion of Phase 1b, including proposed Acceptance Criteria for each Milestone.
3. Description of how the proposed solution meets the following MITA requirements:
    a. Industry based, open architectural standards.
    b. Modular components.
    c. Relational or object oriented database.
    d. Web and real-time processing.
    e. Rules Engine management.
    f. Data privacy, security, and integrity with access limited by staff role.

g. Interoperable systems that support e-communication and processing between systems.

4. Design Documentation: Approach to the development and use of the following deliverables and their components.
   a. System RSD including methodologies for:
      i. BMS review to finalize requirements.
      ii. Requirements updates, to include the evaluation of business model/process changes and approved changes to the current Medicaid system since the RFP release date and identification of corresponding requirements.
      iii. Means of measurement determining satisfaction of requirement.
   b. Requirements Traceability Matrix (RTM) to ensure that the RSD requirements are traceable back to the requirements specified in this RFP (including all Appendices).
   c. Requirements Management and Tracking System to maintain and report on requirements throughout the development life cycle, from requirement specification through production deployment including CMS certification.
   d. Detailed Systems Design (DSD) document, including, but not limited to, the following components:
      i. BMS review, including walkthroughs of the Design Documents and demonstrations during the development of the design specification to enhance BMS's understanding and to facilitate the approval process.
      ii. Identification of system files and processing architecture.
      iii. A general narrative of the entire system and the flow of data through the system.
      iv. Detailed description and diagram of the system architecture identifying how components are integrated to meet RFP requirements.
      v. General and detailed subsystem narratives describing each function, process, and feature.
      vi. Security design description for each business area that defines access control including specifying roles, role locations, and a matrix of roles by inputs/outputs.
      vii. Flow diagram of each subsystem, identifying all major inputs, processes, and outputs.
      viii. Lists of all inputs and outputs by subsystem.
      ix. Hardware/software detail.
      x. High level data model and a detailed and physically specific data model.
5. Demonstration of the creation of validated data models.

3.2.6.3 *Overview of Phase 1c: Development, Testing, Data Conversion and Training*

The primary objective of Phase 1c is the development and thorough testing of the replacement MMIS. The magnitude and relative importance of the work associated with this Phase necessitates presentation according to the four major task groups: Development, Testing, Data Conversion, and Training.

Phase 1c task groups may overlap with one another and with other Project Phases, and instances of possible overlap are noted in the following descriptions. The Vendor is advised that Phase 1c may be addressed as separate task groups or in its entirety, so long as the requirements of this RFP are addressed in full.

3.2.6.3.1 *Development Task Phase 1c*: Development, Testing, Data Conversion and Training commences upon BMS's issuance of Formal Notice to Proceed.

3.2.6.3.1.1 *Phase 1c: Development Task Vendor Response Requirements:* The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Development Task, including the Vendor's proposed:

1. Approach to the completion of the Development Task Deliverables and Milestones (as listed in Appendix C), including methodology for updating deliverables throughout the lifecycle of the project.
2. Approach to obtaining BMS approval of the completion of Phase 1c, including proposed Acceptance Criteria for each Milestone.
3. Software/Hardware Configuration: Software/hardware solution, including a description of the solution's ability to accommodate the current and future needs of the West Virginia Medicaid Program, e.g., changes in the Program, changes in standards and transactions, and increased transaction volumes. The solution should also describe the methodology and approach for the following:
    a) Regular system maintenance, performance optimization, resource capacity utilization, capacity planning and capacity expansion.
    b) Compatibility of all hardware, software or communications components installed for use by BMS staff with WVOT currently supported versions of the Microsoft™ Operating System, Microsoft Office™ Suite and Internet Explorer™; and current technologies for data interchange.
4. Systems Documentation: Methodology and approach for implementing and maintaining MMIS systems documentation, including data structures, Entity Relationship Diagrams (ERD), user manuals, business rules, and all other documentation appropriate to the MMIS platform, operating system and programming language.

5. User Documentation: Methodology and approach to preparing, maintaining and distributing user documentation for each business process including a description of how it is to be used as the basis for User Acceptance Testing and training, as well as the use of final versions for training before the start of operations.
6. Provider Documentation: Methodology and approach to preparing, maintaining, and distributing Provider documentation, including a description of how the documentation is be used in conjunction with provider training.
7. Development and Unit Testing: Methodology and approach to programming and unit testing on all system functions to ensure that a single component is resilient and can function correctly on a stand-alone basis.
8. Ensure that the developed solution meets design criteria and satisfies the intended purpose.
9. Ensure installation and enhancement or modification of the components of the proposed system meets specifications developed and approved by BMS in the Analysis and Design Phase.
10. Development of all standard output reports.

3.2.6.3.2 *Testing Task*: The Bureau envisions the Testing Task occurring concurrently with the Development Task, with appropriate testing for each Development iteration. It is imperative to BMS that testing occurs at appropriate points during the entire development process and that initial planning for the testing activities occur early in the Project. BMS suggests that planning for the Testing Task occur as early in the Project as possible in order to ensure successful testing results.

3.2.6.3.2.1 *Testing Task Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Testing Task, including the Vendor's proposed:

1. Approach to the completion of the Testing Task Deliverables and Milestones (as listed in Appendix C), including methodology for updating deliverables throughout the lifecycle of the project.
2. Approach to obtaining BMS approval of the completion of Testing Task, including proposed Acceptance Criteria for each Milestone.
3. Approach to:
   a. Working with the BMS MMIS Re-procurement team during all testing phases.
   b. Development of test cases and test scripts to thoroughly test system functionality and contingency planning to address risks that may be encountered during MMIS testing.

c. Providing documentation of each test phase.

4. Methodologies for the following testing activities:
   a. Data Validation Test
   b. System Test
   c. Integration Test
   d. Regression (Baseline) Test
   e. Load/Stress Test, including testing to the point of system failure
   f. Parallel Testing
   g. User Acceptance Test (UAT) including support of UAT activities for users as defined by BMS.
   h. Operational Readiness Test (ORT), including pilot testing of actual claims processing in a full operational environment, and disaster recovery processing.
   i. Pilot Tests, including testing of system components that affect external users, such as Web Portals, Web-based claims submission, claims software, and data entry by other vendors. Pilot Testing is a part of the Operational Readiness Testing Period.
5. Test Environment(s), including approach to creating data to drive load/stress testing, UAT, and operational readiness testing, as well as data for user training prior to implementation.
6. Test Plan methodologies for:
   a. Management of the testing processes
   b. Use of the Requirements Traceability Matrix (RTM), Requirements Specification Document (RSD), and Detailed Systems Design document (DSD) to validate linkage from testing to requirements.
   c. Automation of functional tests.
   d. Test data development though the use of a sample of preliminary converted files.
   e. COTS products testing (if applicable).
   f. Defect identification, tracking and resolution.
   g. Documentation updates.
   h. Problem handling, including procedures for notifying BMS of problems discovered in testing, testing progress, adherence to the test schedule, etc.
   i. Test results reporting.
7. UAT Support: Approach to providing BMS User Acceptance Testing support, including methodologies for:
   a) User Acceptance Test (UAT) Plan development, including documentation of UAT scripts, procedures, timelines, and processes.
   b) Test data development, including formal notification that all data necessary to perform UAT has been provided.
   c) Results analysis, including identification of necessary corrections.

d) Defect tracking and repair, including the use of a defect-tracking tool, UAT reporting, and RTM updating.
e) UAT Final Report development, including a summary of results, a written certification letter certifying that UAT was successfully completed, and a list of all issues ranked as critical by the Bureau have been corrected.

8. Operational Readiness Test Reporting: Approach to Operational Readiness Test reporting, including details of the results of the operational readiness assessments, and certification that the MMIS, its subsystems, functions, processes, operational procedures, staffing, telecommunications, and all other associated support is in place and ready for operation.
9. Validated traceability of requirements throughout the full testing process

3.2.6.3.3 *Data Conversion Task*: The Data Conversion Task should begin early in the life of the Project. Therefore, BMS anticipates this task to overlap with other project Phases. This task includes the timely and accurate conversion of two years of historical and active data elements for operations in the current system needed to meet MMIS requirements unless otherwise specified by BMS.

3.2.6.3.3.1 *Data Conversion Task Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Data Conversion Task, including the Vendor's proposed:

1. Approach to the completion of the Data Conversion Task Deliverables and Milestones (as listed in Appendix C), including methodology for updating deliverables throughout the lifecycle of the project.
2. Approach to obtaining BMS approval of the completion of Data Conversion Task, including proposed Acceptance Criteria for each Milestone.
3. Process to update the Data Conversion Plan as defined in Section 3.2.6.1.1.

3.2.6.3.4 *Training Task*: Training should persist throughout the life of the project. The major objective of the Training Task in Phase 1 prepares for and commences training of providers, MMIS users, trainers, administrators, managers, MMIS test teams, and others as defined by BMS.

3.2.6.3.4.1 *Training Task Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Training Task, including the Vendor's proposed:

1. Approach to the completion of the Training Task Deliverables and Milestones (as listed in Appendix C), including methodology for updating deliverables throughout the lifecycle of the project.
2. Approach to obtaining BMS approval of the completion of Training Task, including proposed Acceptance Criteria for each Milestone.
3. Approach to development, maintenance and implementation of the Training Plan, including methodologies addressing:
    a. Assessment of internal and external training needs, including gap analysis.
    b. Approach to BMS user training, supporting all MMIS business processes as identified in the RFP.
    c. Approach to provider training, including but not limited to training on the topics of claim submission, claim processing and edits, prior authorization, provider enrollment, and use of the Web Portal.
    d. Delivery of ongoing training throughout the DDI and Operations phases.
    e. Development and use of on-line tutorials, on-line help, on-line policy and procedure manuals, and hard copy user manuals for the delivery of training.
    f. Development and use of Web seminar and video-based training for providers.
    g. Version control and maintenance of training documentation.
    h. Training evaluation, including the use of evaluation survey tools to determine whether the trainings produced the expected results.
    i. Training results reporting, including information such as, but not limited to, the number of training sessions, type of training, training locations, number of trainees, and information regarding the actual training results and recommendations for follow up training.

3.2.6.4 *Phase 1d: Implementation Readiness*: During Phase 1d Implementation Readiness, the Vendor should plan and prepare to assume all West Virginia Fiscal Agent responsibilities. A number of the activities associated with Phase 1d should be initiated in and are described in previous Phases or Tasks. Therefore, the Implementation Readiness Phase includes the finalization of these activities.

3.2.6.4.1 *Phase 1d Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Implementation Phase, including the Vendor's proposed:

1. Approach to the completion of the Implementation Readiness Phase Deliverables and Milestones (as listed in Appendix C),

including methodology for updating deliverables throughout the lifecycle of the project.

2. Approach to obtaining BMS approval of the completion of Implementation Readiness Phase, including proposed Acceptance Criteria for each Milestone.
3. Approach to development and deployment of an Implementation Plan, including methodologies for:
   a. Implementation scheduling, including plan to phase in operations on a schedule to minimize risk.
   b. Assessment of Implementation (go-live) Readiness.
   c. Preparation and delivery to BMS all documentation necessary to assess implementation readiness.
   d. Demonstration that the new MMIS satisfies requirements specified in the RFP (including all Appendices) and all requirements documented during the requirements analysis and systems design activities.
   e. Creation of an Integrated Testing Environment (ITE) as detailed in the Configuration Management Plan referenced in Section 3.2.6.1.1.
   f. Demonstration that BMS users can access the new West Virginia MMIS according to the established system accessibility and performance requirements.
   g. Ensuring the cutover to the new MMIS is transparent to the member and provider communities.
   h. Conducting system walkthroughs and system demonstrations for BMS and designated staff.
   i. Providing an Implementation Certification Letter that certifies that the system is ready for production.
   j. Obtain written approval from BMS to start operations.
   k. Begin operations (as described in RFP Part 3.2.7.1 Routine Operations).
4. Methodology and approach to completing and finalizing (per the Bureau's approval) the following deliverables initiated prior to the Implementation Phase:
   a. Operational Readiness Testing, repeating portions of these testing activities as requested by BMS.
   b. Emergency Back Out Strategy.
   c. Pilot Testing.
   d. System Documentation.
   e. User Documentation.
   f. Provider Documentation.
   g. Standard output and BMS-specific reports.
   h. Report Distribution Schedule.
   i. Security, Privacy and Confidentiality Plan.
   j. Production environment including final production schedule.
   k. Business Continuity Plan including backup and recovery procedures.
   l. Data conversion.
   m. Pre-Implementation training.

n. Update of Phase 1 Project Management Plans for Phase 2.
o. Modifications and Enhancements Plan is ready to implement, including BMS approval of management and staffing plan that includes detailed proposed staffing for managing future modifications and enhancements.
p. Confirmation of stakeholder readiness for new system implementation (where stakeholders are defined as the vendor, BMS, providers, and others are determined by BMS).

3.2.6.5 *Phase 1e: CMS Certification Planning*: The objective of Phase 1e initiates planning activities associated with Federal certification of the MMIS. Planning activities should ensure the system meets all CMS requirements and performance standards to qualify for the highest eligible FFP rate retroactive to the first day of operation. While certification application activities should occur during Phase 2b: CMS Certification, the Vendor should start preparation at the beginning of the contract and continue through each step of the design, development, testing and implementation of the MMIS.

3.2.6.5.1 *Phase 1e Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the CMS Planning Phase, including the Vendor's proposed:

1. Approach to the completion of the Certification Planning Phase Deliverables and Milestones (as listed in Appendix C), including methodology for updating deliverables throughout the lifecycle of the project.
2. Approach to obtaining BMS approval of the completion of Certification Planning Phase, including proposed Acceptance Criteria for each Milestone.
3. Approach and methodology to:
   a. Adhering to the preparation guidelines in the Medicaid Enterprise Certification Toolkit (MECT), or its successor, in preparing the MMIS and BMS for the Certification Review.
   b. Coordinating tasks between the BMS Re-procurement Team and Vendor Certification Lead Subject Matter Expert (SME) to plan to obtain CMS certification for the new West Virginia MMIS within 12 months of the production start date, in accordance with the following:

      Title 42 U.S.C. section 1996 b (a)(3)(B) provides seventy-five percent (75%) Federal Financial Participation (FFP) for operation of mechanized claims payment and information retrieval systems approved by CMS. Up to ninety percent (90%) FFP is available for MMIS-related development costs prior to approval by CMS in BMS's APD and at contract signing.

   c. Ensuring traceability to CMS Certification requirements through design, development, and testing.

d. Preparing a Certification Readiness Plan to be used during the Certification Phase (Phase 2b) to prove fulfillment of all Federal and state requirements for certification and submit to BMS for approval no less than nine (9) months prior to system implementation.
e. Updating the Certification Readiness Plan to provide contingencies for any system or business defects identified during system testing and UAT.
f. Certification scheduling, including the creation of a schedule for certification activities.

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3.2.7 **Phase 2: Fiscal Agent Operations**
Upon completion of Phase 1 design, development and implementation activities and BMS approval, the Vendor commences fiscal agent operation activities of the West Virginia Medicaid Program. Phase 2 consists of the following three sub-phases (including RFP section number):

Phase 2a: Routine Operations	(3.2.7.1)
Phase 2b: CMS Certification	(3.2.7.2)
Phase 2c: MMIS Modifications and Enhancements	(3.2.7.3)

All Fiscal Agent Operations activities should be conducted in accordance with the CMS State Medicaid Manual, all Federal mandates, and all BMS requirements, State and Federal statutes and regulations.

3.2.7.1 *Phase 2a: Routine Operations:* Phase 2a begins upon completion of all Phase 1 design, development and implementation activities and the approval of BMS for the Vendor to commence fiscal agent operation of the new system. Routine Operations encompass both automated and manual procedures necessary to manage the West Virginia Medicaid Program.

The main objective of Phase 2a is the fiscal agent operation of the new system, where the detailed Vendor Operations Requirements are as referenced in Appendix F.

3.2.7.1.1 Phase *2a: Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Routine Operations Phase, including the Vendor's proposed:

1. Methodology and approach to:
    a. Supporting operations as indicated in Appendix F (Vendor Operations Requirements), from the date of implementation of each component until each function is turned over to a successor Fiscal Agent at the end of the contract period, including any optional additional periods or extensions.[4]
    b. Maintaining adequate staff and infrastructure to manage and support ongoing operations.
    c. Operating the MMIS with minimal disruption to all supported end users.
    d. Providing proactive system performance monitoring and maintenance.
    e. Providing ongoing training throughout the operations and maintenance stage for new staff and staff who change positions.

[4] Note that the Vendor's proposal should contain a narrative description of the proposed approach to supporting operations for each component area listed in Appendix F. The Vendor's proposal **is <u>not</u> expected** to address the individually numbered operations requirements one-by-one.

2. Post Implementation Monitoring and Quality Control: Approach to monitoring and quality control activities immediately following implementation, for a time period to be determined by the Bureau, including, but not limited to:
    a. Monitoring the implemented MMIS for quality control and verification that all activities are functioning properly.
    b. Expeditious repair or remedy of any function that does not meet standards set during system definition and the quality planning process including notification of significant issues to BMS.
    c. Weekly reporting of any problem identified, the proposed repair or remedy, and impact of the repair or remedy and the scheduled implementation date.
    d. Assigning Vendor resources to conduct a post-implementation evaluation to validate customer service satisfaction (where customers are defined as Providers, Members, BMS staff and other stakeholders as defined by BMS).
    e. Archiving all first-run Federally required reports for inclusion in the CMS Certification documentation (see Phase 1e: CMS Certification Planning and Phase 2b: CMS Certification).
    f. Producing a Post Implementation Report detailing the results of all implementation activities.

3.2.7.2 *Phase 2b: CMS Certification*: Phase 2b occurs in parallel with Phase 2a: Routine Operations. The major objective of the CMS Certification Phase obtains Federal certification of the replacement West Virginia MMIS by demonstrating the system meets all CMS requirements and performance standards and qualifies for the highest eligible FFP rate retroactive to the first day of operation.

CMS Certification planning activities should be initiated in Phase 1 (see Section 3.2.6.5, Phase 1e: CMS Certification Planning), and should persist throughout the design, development, and implementation activities that follow. Phase 2b is the post-implementation continuation of these activities, and completes upon CMS Certification of the new West Virginia MMIS.

3.2.7.2.1 *Phase 2b: Vendor Response Requirements*. The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the CMS Certification Phase, including the Vendor's proposed:

1. Approach to the completion of the Phase 2b Deliverables and Milestones (as listed in Appendix C) within the specified time period.
2. Approach to obtaining BMS approval of the completion of Phase 2b, including proposed Acceptance Criteria for each Milestone.
3. Methodology and approach to:
    a. Updating the Certification Readiness Plan, including contingencies for any system or business defects identified during system testing and UAT.

b. System remediation in the instance that CMS determines that the MMIS (including all component parts) does not meet certification standards.
c. Maintaining appropriate resource levels to achieve CMS Certification while performing fiscal agent operations.

4. Certification Support: Approach to providing support to BMS including (but not limited to):
   a. Preparing and submitting BMS' request for CMS certification review and approval.
   b. Preparing all documentation and operational examples to demonstrate criteria are met and system and fiscal agent operations address all business functions and performance standards and business model expectations for certification.
   c. Shared electronic document storage where certification materials and supporting documentation can be uploaded, organized and accessed by CMS during onsite review.

3.2.7.3 Phase 2c: MMIS Modifications and Enhancements: Phase 2c occurs during Phase 2a (Routine Operations), with modifications implemented as necessary throughout the Phase 2a and enhancements implemented only following the completion of Phase 2b (CMS Certification). For purposes of this contract, modifications and enhancements are defined as follows:

> Modification. Change arising from normal business operations including, but not limited to, system maintenance, changes in rate or fee schedules, changes required to remain compliant with Federal regulations and standards, and correction of system deficiencies. To occur ongoing throughout Routine Operations, implemented at BMS approval.
>
> Enhancement. Change initiated by the Bureau to achieve strategic objectives, implement new programs, and mature business capabilities. To occur following Phase 2b: CMS Certification, implemented at BMS approval.

BMS maintains a pool of twenty-five thousand (25,000) hours per year for Vendor modifications and enhancements. The Vendor is reimbursed for BMS-approved hours for system analysts and programmers at the Vendor's all-inclusive hourly rate proposed in Section 4. The approach should also include maintaining a separate pool of $50,000, per year for services that translate to costs rather than hours, which would be approved by BMS in the same way it approves the hours used for modification and enhancements.

3.2.7.3.1 *Phase 2c Vendor Response Requirement*: The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Modifications and Enhancements Phase, including the Vendor's proposed:

1. Methodology and approach to:
    a. Change Request process to provide a framework for submitting, reviewing, approving, prioritizing, and monitoring all modifications and enhancements.
    b. Managing development and implementation of modifications and enhancements, including methodologies for project management and application development.
    c. Implementing modifications and enhancements with minimal disruption to users.
    d. Monitoring and reporting on the development and implementation of enhancements or modifications to the new West Virginia MMIS.
    e. Tracking, reviewing and reporting.

3.2.8 **Phase 3: Turnover and Close-Out**

Phase 3 begins during the Operations Phase (Phase 2), approximately 18 months prior to the end of the contract period, and includes all activities necessary to transfer Fiscal Agent responsibilities and the complete and current MMIS, including all enhancements, to BMS or its agent. Turnover is initiated by written notice from BMS to the Vendor at least 18 months prior to the end of the contract period. BMS notifies the incumbent Fiscal Agent as to the BMS's intent to transfer responsibility of the MMIS to a new Fiscal Agent contract or enter into an alternative agreement.

The major objective of Phase 3 provides an orderly, complete, and controlled transition to a new Fiscal Agent contract period, minimizing any disruptions of processing and services provided to Members, Providers, and operational users of the system.

3.2.8.1 *Phase 3 Vendor Response Requirements:* The Vendor's proposal should present a narrative description of the Vendor's proposed approach to completion of the Turnover and Closeout Phase, including the Vendor's proposed:

1. Approach to the completion of the Phase 3 Deliverables and Milestones (as listed in Appendix C).
2. Approach to obtaining BMS approval of the completion of Phase 3, including proposed Acceptance Criteria for each Milestone.
3. Methodology and approach to:
    a. Turnover and close-out management.
    b. Working cooperatively with the successor Fiscal Agent, other vendors, and BMS to create and carry out a plan that is designed to ensure a smooth and orderly transition to the new vendor.
    c. Providing the necessary resources to ensure a smooth turnover while performing fiscal agent operations through the close-out of the Vendor's contract, including the development of a Staff Transition Plan.
4. Approach to contract close-out financial reconciliation, including methodologies for:
    a. Final settlement of all Vendor invoices.
    b. Final reconciliation of all accounts receivable.

c. Final assessment of payment for retainage and damages.

3.2.9 **Drug Rebate Solution**
The Vendor should propose drug rebate system functionality and operational services that ensures compliance with all State and Federal guidelines.

3.2.9.1 *Drug Rebate System Vendor Response Requirements:* The Vendor's proposal should include a detailed description of the Vendor's proposed Drug Rebate solution, including the following:

1. System features required to support the Drug Rebate operations as indicated in Appendix F (Vendor Operations Requirements), including:
    a. Interface capabilities, e.g., CMS, MCOs, drug manufacturers, supplemental rebate vendor.
    b. Integration with the proposed MMIS solution including but not limited to access/use of claims data, drug data file, provider data; integration with system components such as financial processing, and EDMS.
    c. Data conversion and integration of existing system data.
    d. Integration of supplemental rebate pricing and utilization data from current/previous vendors.
    e. Integration and maintenance of historical rebate data.
    f. Financial reconciliation process to ensure all expenditure data is captured for invoicing.
    g. Electronic document management.
    h. Call management.
    i. Interest calculations.
    j. System query capabilities.
    k. Reporting capabilities, including Federally mandated and State defined and ad hoc.
    l. Invoice processing and mailing operations including Statement of Accounts.
    m. Payment posting and reconciliation.
    n. Dispute Resolution/AR Management.
    o. Providing and updating user guides, including operational and technical documents.

2. Methodology and approach to data conversion and integration of existing system data[5], including:
    a. Integration of supplemental rebate pricing and utilization data from current/previous vendors.
    b. Integration and maintenance of historical rebate data.

[5] Historical Drug Rebate data dates back to program inception in 1991, and spans multiple programs and vendors. Historical data includes separate rebate program invoices for federal, supplemental rebate, physician-administered rebate, AIDS Drug Assistance Program (ADAP) rebate invoices, and Managed Care Organizations (MCO) rebates. Vendors by timeframe are as follows: 1991 through June 1993 – First Health; June 1993 through May 2005 – Consultec/ACS; thereafter through present – Unisys/Molina.

c. Proposed timeline for loading historical data.

3. *Optional Drug Rebate Services:* The Bureau is considering the transition of certain optional drug rebate operational services duties to the Vendor, including but not limited to, the following:

    a. Program Management – Provide sufficient staff to perform current and historical drug rebate dispute resolution activities, including researching discrepancies by reviewing the claims level detail, contacting providers or BMS/vendor staff as necessary in regards to questionable claims or issues, and communicating with the drug manufacturers to resolve the disputes in a timely manner agreed upon by BMS. This would include managing aging of the accounts receivable balances as well as documentation of all rebate dispute resolution activities and keeping logs of all contacts.
    b. Accounts Receivable Management – Provide sufficient staff to perform AR activities which include, but are not limited to, receiving, processing, posting, and reconciling drug rebate payments from drug manufacturers for the rebate programs, at the NDC level. This would include processing any documentation (i.e. ROSI (Reconciliation of State Invoice) or PQAS (Prior Quarter Adjustment Statement) sent by the manufacturers with the payments.

    The Vendor's proposal should include a description of the Vendor's proposed approach and staffing capabilities to meet these operational services. The Vendor's proposed solution for the Drug Rebate system and operational services will be included in the Technical Approach evaluation. As described in Section 4.1.15, the costs of these services will **be excluded from** the cost bid evaluation scoring. Optional operational drug rebate services will be initiated through an approved Statement of Work.

3.2.10 **Other Optional Services**

BMS has identified a group of desired services where requirements exist only at a conceptual level. Detailed requirements are not available at this time. BMS is interested in exploring the Vendor's proposed solution to these items, with no obligation to procure any under this contract. Vendors should propose technology and services to meet these objectives

The Vendor is asked to provide a description of their proposed solution for each of the following enhancements

1. Care Management (above and beyond the functionality and/or services described in this RFP).
2. Care Management registry management.
3. Healthy Rewards Program Management.
4. Personal Health Records.

5. Personal Health Improvement Plans Management.
6. HITECH: Electronic Health Records (EHR) Incentives Program Management.
7. HITECH: Health Information Exchange (HIE) Models.
8. Eligibility Determination System (Vendor would be responsible for providing subject matter experts to assist the Bureau with system design, development and implementation).
9. Permanent Member cards.
10. Real time (date/time) Member eligibility.
11. Member web portal functionality.
12. Interfaces with external data stores (e.g., daily extract to a Personal Health Record data warehouse).

The Vendor's response should describe for each enhancement:

1. Brief title.
2. Solution scope description. Planned project tasks and deliverables.
3. Indication whether the proposed system is currently capable of providing the service, whether the functionality will have to be purchased or the proposed solution will not support the desired service.

If BMS elects to procure any of the listed services, payment will derived from the pool of 25,000 hours and the all-inclusive hourly rate.

3.3 **Special Terms and Conditions**

3.3.1 *Bid and Performance Bonds*: Non-applicable.

3.3.2 *Insurance Requirements:*
The Vendor, as an independent contractor, is solely liable for the acts and omissions of its employees and agents. Proof of insurance shall be provided by the Vendor at the time the contract is awarded. The Vendor shall maintain and furnish proof of coverage of liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the Vendor, its agents and employees in the following amounts:

a) For bodily injury (including death): $500,000.00 per person, up to $1,000,000.00 per occurrence.
b) For property damage and professional liability: Up to $1,000,000.00 per occurrence.

3.3.3 *License Requirements*:
Provide certification that Vendor is registered with the Secretary of State's Office to do business in West Virginia; provide evidence that Vendor is in good standing with the State Agency of Employment Programs as to Unemployment Compensation coverage and Worker's Compensation coverage or exempt from such coverage.

3.3.4 *Litigation Bond*: Non-applicable.

3.3.5 *Debarment and Suspension:*
Vendor will not be considered in proposal process if debarred or suspended. Vendor must certify that they are not debarred or suspended. Successful Vendor must certify that no entity, agency or person associated with the Vendor is debarred or suspended.

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PART 4 PROPOSAL FORMAT AND RESPONSE REQUIREMENTS

4.1 **Technical Proposal Format.**

Only proposals meeting the Mandatory Proposal Requirements will have their Technical Proposals reviewed. This review includes:

- Vendor Capacity, Qualifications, References and Experience
- Staff Capacity, Qualifications and Experience
- Project Approach and Solution
- Solution Alignment with BMS' Business and Technical Needs

The Technical Proposal should be limited to three-hundred (300) pages, including all charts and attachments, excluding the following:

- Annual audited financial reports (may be submitted via hyperlink in the Technical Proposal, but must be submitted in full in the CD).
- Appendix E: Business and Technical Requirements.
- "Business Organization" document (as referenced in RFP Section 4.1.5).
- Description of the roles, responsibilities, and skill sets associated with each position on the organization charts (as referenced in RFP Section 3.2.3.5 (#2)), limited to one (1) page each.
- Key Staff resumes (as referenced in RFP Section 4.1.8), limited to two (2) pages each.
- Timeline or Gantt chart (as referenced in RFP Section 4.1.9).
- The following Project Management Plan subsidiary documents:
    a. Work Breakdown Structure;
    b. Deliverables Dictionary; and
    c. Project Schedule.
- RFP Requirements Checklist (Attachment II).
- Skills Matrix (Attachment III).
- Sample reports, forms, and deliverables formats (as referenced in Section 3.2.2.1).
- Initial draft deliverables (as referenced in RFP Sections 3.2.2.1 and 3.2.6.1.1).
- Appendix L – Special Terms and Conditions (as described in RFP Section 4.1.12).
- Signed forms (as described in RFP Section 4.1.13) and addenda.
- Other Optional Services (as referenced in RFP Section 3.2.10).
- Additional materials describing company offerings that may be of value to BMS (as referenced in RFP Section 4.1.10).

Vendors should place all items excluded from the three-hundred (300) page limit as separate sections at the back of their Technical Proposal. Proposals in excess of the three-hundred (300) page limit specified above will result in a reduction in technical score. Each item should be labeled in accordance with the information provided, e.g., "Appendix E: Business and Technical Requirements," "Key Staff Resumes," "Signed Forms and Addenda."

The following items are excluded from the three-hundred (300) page limit, but should be placed in the proposal as described in RFP Sections 4.1.1., 4.1.2 and 4.1.3:

- Title page (as described in RFP Section 4.1.1).

- Transmittal Letter (as described in RFP Section 4.1.2).
- Table of Contents (as described in RFP Section 4.1.3).

The proposal should be formatted in the same order shown here, providing the information specified as follows:

4.1.1 **Title page.** Should state the RFP Subject and number, the name of the Vendor, Vendor's business address, telephone number, name of authorized contact person to speak on behalf of the Vendor, dated and signed by a person authorized to commit the vendor. Such authorization to commit will be included in writing, such as Board of Directors minutes, Delegation of Authority, etc.

4.1.2 **Transmittal Letter.** A transmittal letter signed in blue ink by an official authorized to bind the Vendor to proposal provisions must accompany the proposal. The transmittal letter must be placed immediately behind the Title Page of the General Technical section. The letter must include a statement that the RFP terms are accepted. Vendors must also include a statement in the letter certifying that the price was arrived at without any conflict of interest.

4.1.3 **Table of Contents**. Clearly identify the material by section and page number. RFP responses should follow the same order as the RFP and use the same titles.

4.1.4 **Executive Summary.** Vendor should affirm their ability and capability to provide experienced personnel to accomplish each mandatory requirement of Part 3.1.1 through 3.1.49. The Executive Summary should not exceed three pages.

4.1.5 **Vendor's Organization.** The following items must be included in a document titled "Business Organization":

- Business name and address;
- Licenses (as described in Section 3.3.3);
- Subcontractor detail; and
- Financial information, such as annual audited financial reports.

4.1.6 **Location.** Indicate the site or sites from which the Vendor and subcontractors, if any, will perform the relevant tasks listed in the proposal.

4.1.7 **Vendor Capacity, Qualifications, References and Experience.** Proposals should provide a comprehensive profile of the organization that includes a description of the management structure and ownership. Proposals should include at least three (3) business references that demonstrate the Vendor's prior experience in the Medicaid program. Each reference should include the contact name, address, telephone number and email address of the client, organization, and the responsible project administrator familiar with the organizations performance, and brief description of services that are provided to the reference.

4.1.8 **Staff Capacity, Qualifications and Experience.** The purpose of this section is to provide the Bureau with a comprehensive description of the Vendor's proposed project team. Section 4.1.8 should demonstrate the Vendor's ability and capability to provide

knowledgeable, skilled, and experienced personnel to accomplish the Scope of Work as described in Section 3.

The following components should be included in the Vendor's proposal Section 4.1.8:

- A detailed proposal for providing all resources necessary to fulfill the requirements as specified in this RFP, as detailed in Section 3.2.3 Staffing. The Vendor's proposal should clearly identify Key Staff (e.g., represented in bold font in the organizational charts). Attachment III - Staff Matrix should be completed, and include the percentage of time each Support Staff and Continuously Dedicated Staff role is to be dedicated to this project.
- Resumes (not to exceed two pages each) for the Key Staff members assigned to this project, including their licenses, credentials and experience.
- A letter of intent for each proposed staff member not currently employed by the Vendor. Each letter of intent should be signed by the named individual, indicating that they are to accept employment if the Vendor is awarded the contract.

4.1.9 **Project Approach and Solution.** The purpose of this section is to provide the Bureau with a thorough understanding of the Vendor's proposed approach and methodologies for completing the work of this project. Section 4.1.9 should exhibit the Vendor's understanding of the Scope of Work, the project objectives, and the project timeline.

This section should describe how the Vendor plans to commence providing services upon award of contract and continue to provide those services over the anticipated duration of the contract. Services described are expected to include (but not necessarily be limited to) Project Management Services, modifications and enhancements services, and all services associated with routine Fiscal Agent Operations (as described in Section Appendix F Vendor Operations Requirements).

The following components should be included in the Vendor's proposal Section 4.1.9:

- A "Statement of Understanding" (not to exceed 3 pages) that provides a high-level summary of the work requested by the Bureau for Medical Services in this RFP.
- A detailed proposal for providing the services as described in the following Part 3 Procurement Specifications sections:
    - 3.2.2 Project Management;
    - 3.2.4 Project Facilities;
    - 3.2.7 Phase 2: Fiscal Agent Operations;
    - 3.2.8 Phase 3: Turnover and Close-Out; and
    - 3.2.9 Drug Rebate Solution.
- A timeline or Gantt chart for the activities required and planned milestones. The timeline/Gantt chart is excluded from the three-hundred (300) page limit, and should be placed in the back of the Vendor's Technical Proposal in the section containing the list of excluded items named in RFP Section 4.1. The Vendor

should include a reference to the timeline/Gantt in proposal Section 4.1.9 to direct the reader to the appropriate proposal section.

- Attachment II - Requirements Checklist completed to crosswalk each RFP requirement to where it is addressed in the Vendor's proposal (Attachment II may be recreated for inclusion in the vendor's proposal, so long as the table remains intact and formatting is maintained). Attachment II is excluded from the three-hundred (300) page limit, and should be placed in the back of the Vendor's Technical Proposal in the section containing the list of excluded items named in RFP Section 4.1. The Vendor should include a reference to Attachment in proposal Section 4.1.9 to direct the reader to the appropriate proposal section.

4.1.10 **Solution Alignment with BMS' Business and Technical Needs.** The purpose of this section is to describe in detail how the proposed solution provides the functionality identified in this RFP as necessary to meet BMS' current business needs. Section 4.1.10 should describe in detail how the Vendor's proposed technical solution addresses the technical/architectural criteria as defined in this RFP. The Vendor should also describe how the proposed solution provides the foundation that enables BMS to move toward its vision for its future MITA-oriented Medicaid Enterprise.

The Vendor is to demonstrate how the proposed components integrate to support operations, workflow and achievement of specified service levels, and are maintainable and supportable. The Vendor is to describe their development and operating environments and facilities, and how support services are to be provided. Services described are expected to include those related to DDI, including (but not necessarily limited to) systems analysis, systems architecture, systems design, system development and testing, and ongoing data reconciliation.

The following components should be included in the Vendor's proposal Section 4.1.10:

- A detailed proposal addressing the Vendor response requirements set forth in the following Part 3 Procurement Specifications sections:
  - 3.2.1 Proposed West Virginia MMIS; and
  - 3.2.6 Phase 1: MMIS Replacement DDI and CMS Certification Planning.
- Completed checklist Appendix E, Business and Technical Requirements, which will be used to determine "level of fit" of the proposed solution with stated BMS technical needs. Appendix E may be recreated for inclusion in the Vendor's proposal, so long as the table must remain intact as shown, i.e., table formatting, including all header and requirements text, must be preserved and presented as shown in this RFP.

The Vendor may include additional materials, in a separately labeled section at the back of the proposal, which describes company offerings that may be of value to BMS. **This section will not be reviewed as a formal section of the RFP and will not be included in the Technical evaluation and scoring.**

4.1.11 **Subcontracting.** Identify the required services that you intend to subcontract, if any.

4.1.12 **Special Terms and Conditions.** Describe any special terms and conditions required to fulfill this contract. The Bureau must be informed of any terms, conditions, and/or limitations of the Vendor prior to entering into contract negotiations.

Special Terms and Conditions for MED13006 are limited to Appendix L – Special Terms and Conditions. The Vendor is to complete the form provided in Appendix L and include it with Section 4.1.13 Signed Forms, this is excluded from the three-hundred (300) page limit. The Vendor's proposal should include a reference to Appendix L in Section 4.1.12 to direct the reader to the appropriate proposal section.

4.1.13 **Signed Forms.** Complete and sign all necessary forms, such as the MED-96 and Purchasing Affidavit forms. The successful vendor shall be required to comply with the HIPAA Business Associate Addendum (BAA). If applicable, sign and submit a Resident Vendor Preference Certificate with the proposal. Signed forms are excluded from the three-hundred (300) page limit, and should be placed in the back of the Vendor's Technical Proposal in the section containing the list of excluded items named in RFP Section 4.1. The Vendor's proposal should include a reference to the signed forms in Section 4.1.13 to direct the reader to the appropriate proposal section.

4.1.14 **Cost Summary**

The Vendor must complete the attached Cost Summary Bid Sheet (Attachment I). **Vendors shall not alter the Cost Summary Bid Sheet in any way without explicit acceptance by the Bureau**. The Cost Summary Bid Sheet, with the bidder's name, title, date and signature, must be in a separately sealed envelope and be included with the technical proposal or attached there to.

All amendments, modifications, alterations or changes to the scope of work in the contract shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made without the express written approval of the Bureau for Medical Service Project Sponsor or his/her designee.

Costs for purchases that do not translate to an hourly rate (as referenced in Sections 3.2.7.3 and 4.1.14.3), such as licenses or software, are to be approved by the Bureau, and may not exceed $50,000 per each contract year,

The proposal should be formatted in the order shown here, providing the information specified as follows:

4.1.14.1 Phase *1 MMIS Replacement DDI Costs*
The total proposed should be an all-inclusive cost that includes all general and administrative resources and travel expenses. Percentage allocations for each milestone should not be modified by the Vendor as part of the proposal response.

4.1.14.2 *Phases 2a and 2b, and Phase 3 (Routine Fiscal Agent Operations, CMS Certification, Close-Out and Turnover) Costs*

Operational phases will be reimbursed utilizing a tiered PMPM approach for MCO and FFS populations. BMS has provided enrollment projections, located in the Procurement Library, to assist in development of a cost bid.
The Vendor should estimate operations costs for Year 1 and Year 2 at zero dollars ($0), and also assume a full year of operating cost beginning at Year 3. These assumed values are to be used for purposes of consistency in proposal and evaluation ***only***, and do not imply a Bureau-recommended or favored approach to implementation and go-live.

Operational costs will be billed monthly for the actual tiered PMPMs incurred during the previous month as defined in Section 4.1.14.3. BMS and the Vendor will agree upon the report used for invoicing upon award of the contract.

To assist Vendors in understanding the level of effort required for MCO enrollees the Vendors will be responsible for supporting eligibility and claim processing for carved out services.

Costs incurred by the Vendor for postage are considered a pass through reimbursement and should not be included in the Cost Proposal.

4.1.14.3 *Phase 2c MMIS Modifications and Enhancements Costs*
Vendors must propose a composite billing rate for up to 25,000 hours of modifications and enhancements to the MMIS during each operational and optional year exercised by the Bureau. The billing rate proposed by the Vendor, will be multiplied by 25,000 and will serve as the not-to-exceed annual cost each year, for modification and enhancement work to the MMIS. During the year, as enhancements are worked on, the Bureau requires that each enhancement be documented with a formal “Enhancement Request” worksheet (and approved by the Bureau) prior to modification and enhancement work beginning by the Vendor. The all-inclusive hourly rate should include all general and administrative resources and travel expenses.

A separate pool of $50,000, per year will be maintained for additional costs related to equipment, hardware, additional COTS licenses necessary to implement the enhancement will need to be broken out separately by component.

The Enhancement Request worksheet should document the Bureau staff that submitted the request for the modification, describe the necessary work that will be required, and estimate the number of hours that will be utilized out of the annual 25,000 hour pool. Once approved by the Bureau, the Vendor can begin modification and enhancement work. The Bureau will only reimburse for actual time utilized up to the approved amount to complete an enhancement and will expect to be invoiced upon successful completion and migration of the modification into the production environment. The Bureau desires a single composite rate that will be utilized for each operational year, and could be utilized for both optional years, should the Bureau execute either optional year. Only BMS-approved hours for system analysts and programmers will be included in the hours counted against the pool of enhancement hours. Hours expended by

Key Staff, Continuously Dedicated or Support Staff will not count toward the pool of hours expended for Enhancements. Costs associated with such personnel will not be separately reimbursable and must be included in the operations prices bid.

4.1.14.4 *Drug Rebate Optional Services Costs*
Vendors must propose a composite billing rate for staffing the Optional Drug Rebate Services described in Section 3.2.9. Annual staffing rates must be provided separately for Drug Rebate Program Management services and Drug Rebate Accounts Receivable Management services, for each operational and optional year exercised by the Bureau. These costs will be considered in the cost bid evaluation scoring.

4.1.14.5 *Total Not to Exceed Cost of Contract*
The cost proposal will be evaluated based on the Total Cost of Phases 1, 2, and 3 for the 10 base year period plus two additional one-year contingency periods submitted on the cost bid sheet. Optional Drug Rebate Services will not be considered in the cost bid evaluation scoring. The Cost bid should include all anticipated training, travel and related expenses, including supplies and general administrative expenses. The Total Not to Exceed Cost is to contain all direct and indirect costs including administrative, travel, training and out-of-pocket expenses necessary to perform all services within Part 3.2 of this RFP.

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4.1.15 **Invoicing and Retainage**

The following section describes invoicing and retainage practices for use during each phase of the project. This section is informational, and does not require a response in the Vendor's proposal.

4.1.15.1 *Phase 1 (MMIS Replacement DDI).*
With the exception of the first project milestone (Contract Execution), which is invoiced by the Vendor immediately upon contract execution, the Vendor will invoice monthly for the Deliverables and Milestones formally accepted by the Bureau during the previous month. Partial or progress payments on Deliverables or Milestones not yet accepted by BMS is not acceptable during Phase 1 (MMIS Replacement and Certification) of this contract.

4.1.15.2 *Deliverable and Milestone Acceptance Process.*
Each project deliverable and milestone identified in Appendix C (Deliverables, Milestones and Payments); will undergo an approval process for BMS acceptance including, the following:

1. Acceptance Criteria
2. Supporting documentation proving completion of deliverable or milestone
3. Deliverable and/or Milestone review meetings with BMS and the Vendor

4.1.15.3 *During Operational Phases 2 and 3 (Fiscal Agent Operations and Close-out and Turnover).*
Appendix G (Service Level Agreements) and Appendix H (Performance Metrics), identifies the list of service level agreement and performance metrics the Bureau and the Vendor will utilize in order to have a clear, mutual understanding for how adequate Operational performance is defined for this project. Appendix G, identifies Key Performance Metrics, that indicate a "retainage percentage" greater than 0%. If these Key Performance Metrics are not met, the "retainage percentage" column of the spreadsheet will be utilized to determine what percentage of the monthly invoice should be retained by the Bureau. At anytime, including during the operational phase, the Bureau reserves the right to modify the list of Key Performance Indicators (KPIs) and/or Performance Metrics with thirty days notice to the Vendor. The Bureau will work with the Vendor to modify the list of KPIs and/or Performance Metrics if deemed necessary, but all changes will be subject to final approval by the Bureau. Formalized change control will be used for all such changes.

As described in Section 4.1.15.2, during Operational Phases, a monthly payment will be made to the Vendor based on the tiered PMPMs. Each month, the vendor will be responsible for submitting a "KPI Report Card" along with the invoice. The KPI Report Card will be used by the Bureau to determine which KPIs have been met during the month, and which have not. In the event that the Vendor fails to meet established KPIs during the month, the Bureau will retain payments according to the schedule identified in Appendix G (Service Level Agreements).

FIRM PRICING ONLY WILL BE ACCEPTED

Each cost proposal cost will be evaluated by use of the following formula for all vendors who attained the Minimum acceptable score only:

Lowest price of all proposals
---------- X 30 = Price Score
Price of Proposal being evaluated

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ATTACHMENT I: COST SUMMARY BID SHEET

Phase 1 Costs *(Phase 1. MMIS Replacement DDI)*	
Item	**Total**
Total Phase 1 Costs *(See Appendix C: Deliverables, Milestones and Payments)*	**$** _____

Phases 2a and 2b, and Phase 3 Costs *(Phase 2a. Routine Fiscal Agent Operations; Phase 2b. CMS Certification; Phase 3. Close-Out and Turnover)*					
Period	**Estimated FFS Member Months**	**Estimated MCO Member Months**	**FFS PMPM Fee[1]**	**MCO PMPM Fee[1]**	**Total[2]**
Year 1[3]	**173,900**	**165,624**	*NA*[3]	*NA*[3]	*NA*[3]
Year 2[3]	**175,297**	**166,955**	*NA*[3]	*NA*[3]	*NA*[3]
Year 3[3]	**221,990**	**168,300**	$	$	$
Year 4	**278,525**	**169,659**	$	$	$
Year 5	**281,520**	**171,031**	$	$	$
Year 6	**284,531**	**172,418**	$	$	$
Year 7	**287,557**	**173,819**	$	$	$
Year 8	**290,597**	**175,234**	$	$	$
Year 9	**293,654**	**176,664**	$	$	$
Year 10	**296,749**	**178,109**	$	$	$
Contingency Year 1	**299,885**	**179,569**	$	$	$
Contingency Year 2	**303,061**	**181,043**	$	$	$
Total Phases 2a, 2b, & 3 Costs *(Sum of Years 1 through 10 Totals + Contingency Years 1 and 2 Totals)*	**$** _____				

[1] Vendors are required to submit the PMPM rate in the FFS PMPM Fee and MCO PMPM Fee columns.

[2] Yearly Total calculated as follows:
*(Estimated FFS Member Months * FFS PMPM Fee * 12) + (Estimated MCO Member Months * MCO PMPM Fee * 12)*

[3] For purposes of proposal and evaluation, all vendors should estimate operations costs for Year 1 and Year 2 at zero dollars ($0). In order to provide consistent evaluation of all cost bids, vendors should also assume a full year of operating cost beginning at Year 3.

Phase 2c Costs *(Phase 2c. MMIS Modifications and Enhancements)*			
Period	**(A) All Inclusive Hourly Rate**	**(B) Maximum Hours**	**(C) Total** *(Column A * Column B)*
Year 1	$ _____ / hr		N/A
Year 2	$ _____ / hr		N/A
Year 3	$ _____ / hr	**25,000**	$
Year 4	$ _____ / hr	**25,000**	$
Year 5	$ _____ / hr	**25,000**	$
Year 6	$ _____ / hr	**25,000**	$
Year 7	$ _____ / hr	**25,000**	$
Year 8	$ _____ / hr	**25,000**	$
Year 9	$ _____ / hr	**25,000**	$
Year 10	$ _____ / hr	**25,000**	$
Contingency Year 1	$ _____ / hr	**25,000**	$
Contingency Year 2	$ _____ / hr	**25,000**	$
Year 3	N/A	N/A	$ 50,000.00
Year 4	N/A	N/A	$ 50,000.00
Year 5	N/A	N/A	$ 50,000.00
Year 6	N/A	N/A	$ 50,000.00
Year 7	N/A	N/A	$ 50,000.00
Year 8	N/A	N/A	$ 50,000.00
Year 9	N/A	N/A	$ 50,000.00
Year 10	N/A	N/A	$ 50,000.00
Contingency Year 1	N/A	N/A	$ 50,000.00
Contingency Year 2	N/A	N/A	$ 50,000.00
Total Phase 2c Costs *(Sum of Years 1 through 10 Totals + Contingency Years 1 and 2 Totals + 50,000 for each year 3 through 10 + 50,000 for Contingency Years 1 and 2)*			**$** _____

Optional Drug Rebate Services Costs *(Refer to Section 3.2.9.2)*			
Period	**(A) All Inclusive Hourly Rate**	**(B) Maximum Hours**	**(C) Total** *(Column A * Column B)*
Program Management Year 1	$ _____ / hr		N/A
Program Management Year 2	$ _____ / hr		N/A
Program Management Year 3	$ _____ / hr	4,500	$
Program Management Year 4	$ _____ / hr	4,500	$
Program Management Year 5	$ _____ / hr	4,500	$
Program Management Year 6	$ _____ / hr	4,500	$
Program Management Year 7	$ _____ / hr	4,500	$
Program Management Year 8	$ _____ / hr	4,500	$
Program Management Year 9	$ _____ / hr	4,500	$
Program Management Year 10	$ _____ / hr	4,500	$
Program Mgt Contingency Year 1	$ _____ / hr	4,500	$
Program Mgt Contingency Year 2	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 1	$ _____ / hr	N/A	N/A
Accounts Receivable Mgt Year 2	$ _____ / hr	N/A	N/A
Accounts Receivable Mgt Year 3	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 4	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 5	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 6	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 7	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 8	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 9	$ _____ / hr	4,500	$
Accounts Receivable Mgt Year 10	$ _____ / hr	4,500	$
Accounts Rec Mgt Contingency Year 1	$ _____ / hr	4,500	$
Accounts Rec Mgt Contingency Year 2	$ _____ / hr	4,500	$
Total Optional Drug Rebate Services	$_____		

Total Not to Exceed Cost of Contract	
Total Not to Exceed Cost of Contract *[Where **Total Not to Exceed Cost of Contract** = (Total Phases 1 Costs) + (Total Phases 2a, 2b, and 3 Costs) + (Total Phase 2c Costs) + (Optional Drug Rebate Services*	**$** _____

Note:

1. *Member months estimates were developed based on the best information available at the time of the solicitation. The member months are to be used for purposes of cost proposal and evaluation only.*
2. *The cost proposal will be evaluated based on the Total Not to Exceed Cost of Contract. The cost bid should include all anticipated training, travel and related expenses including supplies and general administrative expenses.*
3. *The Total Hours referenced in the Optional Drug Rebate Services are for purposes of cost proposal and evaluation only.*
4. *Vendors **shall not** alter Attachment I, Cost Summary Bid Sheet, in any way without explicit acceptance by the Bureau. The Cost Summary Bid Sheet must be completed and submitted using the form provided. Attachment I will **not** be provided in electronic format (Excel, Word, etc.). The vendor may **not** recreate Attachment I.*

Authorized Vendor signature:

_____

Date

_____

If applicable, sign and submit the attached Resident Vendor Preference Certificate with the proposal.
The Cost Proposal will be evaluated based on the total phases 2a, 2b, and 3 Costs for the ten base year period plus two additional one year contingency periods submitted on the Cost Summary Bid Sheet.

ATTACHMENT II

RFP REQUIREMENTS CHECKLIST

The RFP Requirements Checklist is a detailed listing of every general, technical, functional, staffing, and performance requirement. The Vendor is to crosswalk each RFP requirement (A) to the site where it is addressed in its proposal (Columns B and C). The RFP Requirements Checklist may be recreated by the vendor, but must be presented in the format shown here, i.e., formatting, including all header and Column A information, must be preserved and presented as shown here. The Vendor is not expected to restate requirements verbatim in Column A, but may include an abbreviated reference to requirements for the sake of ease of preparation and review.

A		B	C
MMIS RFP Requirements		**Proposal Section**	**Proposal Page No.**
3.1			
3.1.1			
3.1.2			
3.1.3			
3.1.4			
3.1.5			
3.1.6			
3.1.7			
3.1.8			
3.1.9			
3.1.10			
3.1.11			
3.1.12			
3.1.13			
3.1.14			
3.1.15			
3.1.16			
3.1.17			
3.1.18			
3.1.19			
3.1.20			
3.1.21			
3.1.22			
3.1.23			
3.1.24			
3.1.25			
3.1.26			
3.1.27			
3.1.28			
3.1.29			

A		B	C
MMIS RFP Requirements		Proposal Section	Proposal Page No.
3.1.30			
3.1.31			
3.1.32			
3.1.33			
3.1.34			
3.1.35			
3.1.36			
3.1.37			
3.1.38			
3.1.39			
3.1.40			
3.1.41			
3.1.42			
3.1.43			
3.1.44			
3.1.45			
3.1.46			
3.2	NA – OMITTED FROM THIS TABLE	NA	NA
3.3	NA – OMITTED FROM THIS TABLE	NA	NA
4.1			
4.1.1			
4.1.2			
4.1.3			
4.1.4			
4.1.5			
4.1.6			
4.1.7			
4.1.8			
4.1.9			
4.1.10			
4.1.11			
4.1.12			
4.1.13			
4.1.14			
4.1.15			

ATTACHMENT III

STAFF MATRIX

The following Staff Matrix is a listing of all Continuously Dedicated and Support Staff roles. The Vendor is to use this table to provide the percent of time each staff role will be dedicated to the project (Column A), indicate if the role will be located onsite, i.e., at the Vendor's Charleston facility (Column B), and attest to the fact that the individuals fulfilling each role will meet the qualifications outlined in Section 3.2.3.2 (Column C).

Role	A. Project % Dedicated*	B. Onsite (Y/N)	C. Meets Qualifications (Y/N)
Continuously Dedicated Staff			
1. POS Quality Manager			
2. Data Conversion Specialist			
3. Interface Specialist			
Support Staff			
1. Trainer & Documentation Specialist			
2. Medical/Dental Ad Hoc Reporting Analyst (2 FTEs)			
3. POS Reporting Analyst			
4. Finance Reporting Analyst			
5. Drug Rebate Analyst			

**Project % Dedicated is to be used to define percentage on a 100% scale amount of time staff role will be dedicated to project.*

APPENDIX A
Summary of RFP Acronyms

AAPC.....American Association of Professional Coders
ACA ..... Affordable Care Act
AD or ADW..... Aged/Aging and Disabilities Waiver
ADAP.....AIDS Drug Assistance Program
AHA ..... American Hospital Association
AHIMA .....American Health Information Management Association
AICPA.....American Institute of Certified Public Accountants
APD .....Advance Planning Document
AVRS ..... Automatic Voice Response System

BA..... Bachelor of Arts
BAA .....Business Associate Addendum
BCF.....Bureau for Children and Families
BHHF
BOSS..... Bureau of Senior Services
BMS..... Bureau for Medical Services
BS.....Bachelor of Science
BU.....Billable Units

CD.....Continuously Dedicated Staff
CDC .....Centers for Disease Control
CFR..... Code of Federal Regulations
CHIP ..... Children's Health Insurance Program
CIB..... Continuous Information Bulletin
CIN .....Client Identification Number
COTS .....Commercial off the Shelf
CMS.....Centers for Medicare and Medicaid Services
CPC ..... Certified Professional Coder
CPC-H..... Certified Professional Coder - Hospital
CPC-P.....Certified Professional Coder – Payer
CPM..... Certified Project Manager
CPT..... Current Procedural Terminology
CSHCN ..... Children with Special Health Care Needs

DAF.....Deliverable Acceptance Form
DDI .....Design, Development and Implementation
DED ..... Data Element Dictionary
DHHR..... Department of Health & Human Resources
DLP.....Desk Level Procedures
DMERC..... Durable Medical Equipment Regional Carrier
DOA.....Department of Administration
DRG.....Diagnosis-related Group
DSD ..... Detailed Systems Design
DTS.....Data Transformation Services
DUR .....Drug Utilization Review
DW/DSS..... Data Warehouse/Decision Support System

EDB ..... Enrollment Data Base
EDI ..... Electronic Data Interchange
EDMS ..... Electronic Document Management System
EHR ..... Electronic Health Records Incentives Program Management
EOMB ..... Explanation of Member Benefits
EPLS ..... Excluded Parties List System
EPMO ..... Enterprise Project Management Office
EPSDT ..... Early Periodic Screening, Diagnosis, and Treatment
EQRO ..... External Quality Review Organization
ERD ..... Entity Relationship Diagrams
ERP ..... Enterprise Resource Planning

FA ..... Fiscal Agent
FACTS ..... Families and Children Tracking System
FEA ..... Fiscal Employer Agent
FFP ..... Federal Financial Participation
FFS ..... Fee for Service
FMAP ..... Federal Medical Assistance Percentages
FOIA ..... Freedom of Information Act
FTE ..... Full-Time Equivalent

GAAP ..... Generally Accepted Accounting Principles
GAAS ..... Generally Accepted Auditing Standards
GSA ..... General Services Administration

HCBS ..... **H**ome and Community Based Services
HCPCS ..... Healthcare Common Procedure Coding System
HHS ..... Health and Human Services
HID ..... Health Information Designs
HIE ..... Health Information Exchange
HIPAA ..... Health Insurance Portability and Accountability Act of 1996
HIPP ..... Health Insurance Premium Payment
HIT ..... Health Information Technology
HITECH ..... Health Information Technology for Economic and Clinical Health Act
HIX ..... Health Insurance Exchange
HMO ..... Health Maintenance Organization

IAC ..... Inter-Agency Advisory Committee
ICD ..... International Classification of Diseases
ICN ..... Internal Control Number
I/DD ..... Intellectually Developmentally Disabled
IRG ..... Innovative Resource Group
ISP ..... Internet Service Provider
ITE ..... Integrated Test Environment
IV&V ..... Independent Verification and Validation

JAD ..... Joint Application Design
JCL ..... Job Control Language

K ..... Key Staff
KPI ..... Key Performance Indicator

LAN ..... Local Area Network
LEIE ..... List of Excluded Individuals/Entities
LLC ..... Limited Liability Corporation

MAF ..... Milestone Acceptance Form
MAPP ..... Medicare Automated Premium Payment
MAR ..... Management and Administrative Reports
MAS ..... Minimum Acceptable Score
MCO ..... Managed Care Organization
MDM ..... Master Data Management
MDS ..... Minimum Data Set
MECT ..... Medicaid Enterprise Certification Toolkit
MHT ..... Mountain Health Trust
MITA ..... Medicaid Information Technology Architecture
MITA SS-A ..... MITA State Self-Assessment (SS-A)
MMIS ..... Medicaid Management Information System
M-WIN ..... Medicaid-Work Incentive Network

NCID ..... National Crime Information Database
NCPDP ..... National Council on Prescription Drug Programs
NDC ..... National Drug Code
NIST ..... National Institute of Standards and Technology

OCI ..... Office of Insurance Commissioner
OIG ..... Office of Inspector General
OODMS ..... Object Oriented Database Management System
OQPI ..... Office of Quality and Program Integrity
ORT ..... Operational Readiness Testing
OSCAR ..... On-line Support Collections and Reporting
OT ..... BMS Operations Team
OT or WVOT ..... Office of Technology

PA ..... Prior Authorization
PAAS ..... Physician Assured Access System
PDR ..... Physician's Desk Reference
PIN ..... Personal Identification Number
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Provider
PDL ..... Preferred Drug List
PM ..... Project Manager
PMBOK ..... Project Management Body of Knowledge
PMI ..... Project Management Institute
PMO ..... Project Management Office
PMP ..... Project Management Professional
PMPM ..... Per Member Per Month

POS ..... Point-of-Sale
POS ..... Place of Service
PPACA ..... Patient Protection and Affordable Care Act
PPS ..... Prospective Payment System
PQAS ..... Prior Quarter Adjustment Statement
PRC ..... Provider Relations Consultant

QA ..... Quality Assurance
QIO ..... Quality Improvement Organization

RAPIDS ..... Recipient Automated Payment and Information Data System
RBRVS ..... Resource-Based Relative Value Scale
RDBMS ..... Relational Database Management System
RDTP ..... Rational Drug Therapy Program
Retro-DUR ..... Retrospective Drug Utilization Review
RFP ..... Request for Proposal
RHIA ..... Registered Health Information Administrator
ROSI ..... Reconciliation of State Invoice
RSD ..... Requirements Specifications Document
RTM ..... Requirements Traceability Matrix

SACWIS ..... Statewide Automated Child Welfare Information System
SAS70 ..... Statement on Auditing Standards No. 70
SDM ..... System Development Methodology
SLA ..... Service Level Agreement
SQL ..... Structured Query Language
SS-A ..... *State Self-Assessment (see MITA)
SSAE16 ..... Standard for Attestation Engagements No. 16
SSI ..... Supplemental Security Income
SME ..... Subject Matter Expert
SMM ..... State Medicaid Manual
SNAP ..... Supplemental Nutrition Assistance Program (formerly food stamps)
SRM ..... Software Release Manager
SUR ..... Surveillance and Utilization Review

TANF ..... Temporary Assistance to Needy Families
TPA ..... Third Party Administrator
TPL ..... Third Party Liability

UAT ..... User Acceptance Testing
UM ..... Utilization Management
USC ..... United States Code

WAN ..... Wide Area Network
WBT ..... Web Based Training
WV ..... West Virginia
WVDHHR ..... West Virginia Department of Health & Human Resources

APPENDIX B
West Virginia MITA State Self-Assessment as of 09/24/2009*(CMS Template #3)
***(will be reviewed and updated at least annually)**

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Member Management (ME)	Member Management (ME)				
Member Mgmt (ME)	Member Mgmt (ME)	Determine Eligibility	Determine Eligibility (ME 1.1)	1	1
Member Mgmt (ME)	Member Mgmt (ME)	Enroll Member	Enroll Member (ME 2.1)	1	1
Member Mgmt (ME)	Member Mgmt (ME)	Disenroll Member	Disenroll Member (ME 2.2)	1	1
Member Mgmt (ME)	Member Mgmt (ME)	Manage Member Information	Manage Member Information (ME 3.1)	1	1
Member Mgmt (ME)	Member Mgmt (ME)	Inquire Member Eligibility	Inquire Member Eligibility (ME 3.2)	1	2
Member Mgmt (ME)	Member Mgmt (ME)	Perform Population and member Outreach	Perform Population and member Outreach (ME 4.1)	1	1
Member Mgmt (ME)	Member Mgmt (ME)	Manage Applicant and Member Communications	Manage Applicant and Member Communications (ME 4.2)	1	1
Member Mgmt (ME)	Member Mgmt (ME)	Manage Member Grievance and Appeal	Manage Member Grievance and Appeal (ME 4.3)	1	1
Provider Management (PM)	Provider Management (PM)				
Provider Mgmt. (PM)	Provider Mgmt. (PM)	Enroll Provider	Enroll Provider (PM 1.1)	1	1
Provider Mgmt. (PM)	Provider Mgmt. (PM)	Disenroll Provider	Disenroll Provider (PM 1.2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Provider Mgmt. (PM)	Provider Mgmt. (PM)	Manage Provider Information	Manage Provider Information (PM 2.1)	1	2

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Provider Mgmt. (PM)	Provider Mgmt. (PM)	Inquire Provider Information	Inquire Provider Information (PM 2.2)	1	2
Provider Mgmt. (PM)	Provider Mgmt. (PM)	Manage Provider Communication	Manage Provider Communication (PM 3.1)	1	2
Provider Mgmt. (PM)	Provider Mgmt. (PM)	Manage Provider Grievance and Appeal	Manage Provider Grievance and Appeal (PM 3.2)	1	2
Provider Mgmt. (PM)	Provider Mgmt. (PM)	Perform Provider Outreach	Perform Provider Outreach (PM 3.3)	1	2
Contractor Management (CO)	Contractor Management (CO)				
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Manage Health Services Contract	Manage Health Services Contract (CO 1.1)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Award Health Services Contract	Award Health Services Contract (CO 1.2)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Close-Out Health Services Contract	Close-Out Health Services Contract (CO 1.3)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Produce Health Services RFP	Produce Health Services RFP (CO 1.4)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Manage Administrative Contract	Manage Administrative Contract (CO 2.1)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Award Administrative Contract	Award Administrative Contract (CO 2.2)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Close-Out Administrative Contract	Close-Out Administrative Contract (CO 2.3)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Produce Administrative Services RFP	Produce Administrative Services RFP (CO 2.4)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Manage Contractor Information	Manage Contractor Information (CO 3.1)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Inquire Contractor Information	Inquire Contractor Information (CO 3.2)	1	1
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Perform Potential Contractor Outreach	Perform Potential Contractor Outreach (CO 4.1)	1	2
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Manage Contractor Communication	Manage Contractor Communication (CO 4.2)	2	2
Contractor Mgmt. (CO)	Contractor Mgmt. (CO)	Support Contractor Grievance and Appeal	Support Contractor Grievance and Appeal (CO 4.3)	Not rated by BMS[6].	Not rated by BMS.
Operations Management (OM)	Operations Management (OM)				
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Authorize Treatment	Authorize Treatment (OM 1.1)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Authorize Referral	Authorize Referral (OM 1.2)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Authorize Service	Authorize Service (OM 1.3)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Edit Claim/Encounter	Edit/Audit Claim (OM 2.1 and 2.3)	1	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Price Claim/Value Encounter	Price Claim/Value Encounter (OM 2.2)	2	2

[6] Effective April 2009 BMS became exempt from WV Department of Administration Purchase oversight of health care services procurements. As of this report, BMS is developing internal procedures for conducting such procurements including processes for Contractor Grievance and Appeal.

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Audit Claim/Encounter	See Edit/Audit Claim (OM 2.3)	*The Edit/Audit Claim process is a blended process in WV, see OM 2.1 and 2.3 combined process	*The Edit/Audit Claim process is a blended process in WV, see OM 2.1 and 2.3 combined process
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Apply Claim Attachment	Apply Claim Attachment (OM 2.4)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Apply Mass Adjustment	Apply Mass Adjustment (OM 2.5)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare Remittance Advice/Encounter Report	Prepare Remittance Advice/ Encounter Report (OM 3.1)	1	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare COB	Prepare COB (OM 3.2)	1	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare HCBS Payment	Prepare HCBS Payment (OM 3.3)	Waivers are treated like any other type of claim	
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare EOB	Prepare EOMB (OM 3.4)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare Provider EFT/Check	Prepare Provider EFT/Check (OM 3.5)	2	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare Premium EFT/Check	Prepare Premium EFT/Check (OM 3.6)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare Health Insurance Premium Payment	Prepare Health Insurance Premium Payment (HIPP) (OM 4.1)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare Medicare Premium Payment	Prepare Medicare Premium Payment (OM 4.2)	2	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare Capitation Premium Payment	Prepare Capitation Premium Payment (OM 4.3)	1	1

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Manage Payment Information	Manage Payment Information (OM 5.1)	1	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Inquire Payment Status	Inquire Payment Status (OM 5.2)	1	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Calculate Spend-Down Amount	Calculate Spend-Down Amount (OM 6.1)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Prepare Member Premium Invoice	Prepare Member Premium Invoice (OM 6.2)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Manage Recoupment	Manage Recoupment (OM 7.1)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Manage Estate Recovery	Manage Estate Recovery (OM 7.2)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Manage TPL	Manage Third Party (OM 7.3)	1	1
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Manage Drug Rebate	Manage Drug Rebate (OM 7.4)	1	2
Operations Mgmt. (OM)	Operations Mgmt. (OM)	Manage Settlement	Manage Settlement (OM 7.5)	1	1
Program Management (PG)	Program Management (PG)				
Program Mgmt. (PG)	Program Mgmt. (PG)	Designate Approved Service/Drug Formulary	Designate Approved Service/Drug Formulary (PG 1.1)	1	1
Program Mgmt. (PG)	Program Mgmt. (PG)	Manage Rate Setting	Manage Rate Setting (PG 1.2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Develop and Maintain Benefit Package	Develop and Maintain Benefit Package (PG 1.3)	1	2
Program Mgmt. (PG)	Program Mgmt. (PG)	Develop and Maintain Program Policy	Develop and Maintain Program Policy (PG 2.1)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Program Mgmt. (PG)	Program Mgmt. (PG)	Maintain State Plan	Maintain State Plan (PG 2.2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Develop Agency Goals and Initiatives (Objectives)	Develop Agency Goals and Objectives (PG 2.3)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Manage Federal Financial Participation (FFP) for MMIS	Manage Federal Financial Participation (FFP) for MMIS (PG 3.1)	1	1
Program Mgmt. (PG)	Program Mgmt. (PG)	Formulate Budget	Formulate Budget (PG 3.2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Manage State Funds	Manage State Funds (PG 3.3)	1	1
Program Mgmt. (PG)	Program Mgmt. (PG)	Manage F-MAP	Manage F-MAP (PG 3.4)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Manage FFP for Services	Manage FFP for Services (PG 3.5)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Draw and Report FFP	Draw and Report FFP (PG 3.6)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Manage 1099s	Manage 1099s (PG 4.1)	1	1
Program Mgmt. (PG)	Program Mgmt. (PG)	Perform Accounting Functions	Perform Accounting Functions (PG 4.2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Develop and Manage Performance Measures and Reporting	Develop and Manage Performance Measures and Reporting (PG 5.1)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Monitor Performance and Business Activity	Monitor Performance and Business Activity (PG 5.2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Program Mgmt. (PG)	Program Mgmt. (PG)	Manage Program Information	Manage Program Information (PG 6.1)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Mgmt. (PG)	Program Mgmt. (PG)	Maintain Benefit/Reference Information	Maintain Benefit/Reference Information (PG 6.2)	1	1
Program Mgmt. (PG)	Program Mgmt. (PG)	Generate Financial and Program Analysis Report	Generate Financial and Program Analysis Report (PG 6.3)	1	1

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Care Management (CM)	Care Management (CM)				
Care Mgmt. (CM)	Care Mgmt. (CM)	Manage Medicaid Population Health	Manage Medicaid Population Health (CM 1)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Care Mgmt. (CM)	Care Mgmt. (CM)	Establish Care	Establish Care (CM 2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Care Mgmt. (CM)	Care Mgmt. (CM)	Manage Case	Manage Case (CM 3)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Care Mgmt. (CM)	Care Mgmt. (CM)	Manage Repository	Manage Repository	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Program Integrity Management (PI)	Office for Quality and Program Integrity (OQPI)				
Program Integrity Mgmt. (PI)	Office for Quality and Program Integrity (OQPI)	Identify Candidate Case	Identify Candidate Case (PI 7.1 or PI 1)	1	1
Program Integrity Mgmt. (PI)	Office for Quality and Program Integrity (OQPI)	Manage Case	Manage Case (PI 7.2 or PI 2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Business Relationship Management (BR)	Business Relationship Management (BR)				
Business Relationship Management (BR)	Business Relationship Management (BR)	Establish Business Relationship	Establish Business Relationship (BR 1)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Business Relationship Management (BR)	Business Relationship Management (BR)	Manage Business Relationship	Manage Business Relationship (BR 2)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.

1 MITA Business Area	2 State Business Area	3 MITA Business Process	4 State Business Process	5 As-Is Level of Business Capability	6 To-Be Level of Business Capability
Business Relationship Management (BR)	Business Relationship Management (BR)	Manage Business Relationship Communication	Manage Business Relationship Communication (BR 3)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.
Business Relationship Management (BR)	Business Relationship Management (BR)	Terminate Business Relationship	Terminate Business Relationship (BR 4)	TBD. Criteria not yet issued by CMS.	TBD. Criteria not yet issued by CMS.

APPENDIX C
Deliverables, Milestones and Payments

#	Type	Deliverables and Milestones	% of total DDI price
Phase 1a – Start Up			
1	**MILESTONE**	**Contract Execution**	**5.0%**
2	Deliverable	Project Kick-Off Meeting within 10 calendar days of contract execution	-
3	Deliverable	Project Charter within 15 calendar days of contract execution	-
4	Deliverable	Stakeholder Analysis within 15 calendar days of contract execution	-
5	Deliverable	Updated* Facility Plan within 15 calendar days of contract execution	-
6	Deliverable	Updated* Staffing Plan within 30 calendar days of contract execution	-
7	Deliverable	Updated* Documentation Management Plan within 30 calendar days of contract execution	-
8	Deliverable	Updated* Training Plan within 30 calendar days of contract execution	-
9	Deliverable	Updated* Workflow Management Plan within 30 calendar days of contract execution	-
10	Deliverable	Updated* Problem Management Plan within 30 calendar days of contract execution	-
11	Deliverable	Updated* Integrated Test Environment (ITE) Plan within 30 calendar days of contract execution	-
12	Deliverable	Updated* Testing Plan within 30 calendar days of contract execution	-
13	Deliverable	Updated* Scope Management Plan within 45 calendar days of contract execution	-
14	Deliverable	Updated* Work Breakdown Structure and Deliverables Dictionary within 45 calendar days of contract execution	-
15	Deliverable	Updated* Project Schedule within 45 calendar days of contract execution	-
16	Deliverable	Updated* Schedule Management Plan within 45 calendar days of contract execution	-
17	Deliverable	Updated* Cost Management Plan within 45 calendar days of contract execution	-
18	Deliverable	Updated* Quality Management Plan within 45 calendar days of contract execution	-
19	Deliverable	Updated* Human Resources Management within 45 calendar days of contract execution	-

#	Type	Deliverables and Milestones	% of total DDI price
20	Deliverable	Updated* Communication Management Plan within 45 calendar days of contract execution	-
21	Deliverable	Updated* Risk Management Plan within 45 calendar days of contract execution	-
22	Deliverable	Updated* Issue Management Plan within 45 calendar days of contract execution	-
23	Deliverable	Updated* Change Management Plan within 45 calendar days of contract execution	-
24	Deliverable	Updated* Integration Management Plan within 45 calendar days of contract execution	-
25	Deliverable	Updated* Security, Privacy and Confidentiality Plan within 30 calendar days of contract execution	-
26	Deliverable	Updated* Configuration Management Plan within 30 calendar days of contract execution	-
27	Deliverable	Updated* Data Conversion Plan within 30 calendar days of contract execution	-
28	Deliverable	Updated* Disaster Recovery and Business Continuity Plan within 45 calendar days of contract execution	-
29	Deliverables	Updated* Data and Records Retention Plan within 45 calendar days of contract execution	-
30	Deliverable	Updated* Transition Plan within 30 calendar days of contract execution	-
31	Deliverable	Updated* Weekly Project Status Report Template within 30 calendar days of contract execution	-
32	Deliverable	Weekly Project Status Report	-
33	Deliverable	Updated* Monthly Project Status Report Template within 30 calendar days of contract execution	-
34	Deliverable	Monthly Project Status Report	-
35	**MILESTONE**	**Project Site Facility Established**	**5.0%**
36	**MILESTONE**	**Completion and BMS Approval of Phase 1a**	**5.0%**
Phase 1b – Analysis and Design			
37	Deliverable	Business Process Mapping Document	-
38	Deliverable	Edit Rule Documentation	-
39	Deliverable	Requirements Traceability Matrix (RTM)	-
40	Deliverable	Requirements Specification Document (RSD)	2.5%
41	Deliverable	Gap Analysis Design Document	-
42	Deliverable	Detailed Systems Design (DSD) Document	2.5%
43	Deliverable	List of All Standard Output Reports	-

#	Type	Deliverables and Milestones	% of total DDI price
44	Deliverable	List of BMS-Specific Reports	2.0%
45	Deliverable	MMIS Glossary	-
46	Deliverable	Weekly Project Status Report	-
47	Deliverable	Monthly Project Status Report	-
48	**MILESTONE**	**Completion and BMS Approval of Phase 1b**	**15.0%**
Phase 1c – Development, Testing, Data Conversion, and Training			
Development Task			
49	Deliverable	Updated Business Processing Mapping	-
50	Deliverable	Updated Edit Rules Documentation	-
51	Deliverable	Updated Requirements Traceability Matrix (RTM)	-
52	Deliverable	Updated Requirements Specification Document (RSD)	-
53	Deliverable	Updated Gap Analysis Design Document	-
54	Deliverable	Updated Detailed Systems Design (DSD) Document	-
55	Deliverable	Updated list of BMS-Specific Reports	-
56	Deliverable	System Documentation	-
57	Deliverable	Draft User Documentation	-
58	Deliverable	Draft Provider Documentation	-
59	Deliverable	Unit Test Cases/Scripts	-
60	Deliverable	Unit Test Results	-
61	**MILESTONE**	**Completion and BMS Approval of Unit Testing**	**2.0%**
62	Deliverable	Weekly Project Status Report	-
63	Deliverable	Monthly Project Status Report	-
64	**MILESTONE**	**Completion and BMS Approval of Standard Output Reports**	**2.0%**
65	**MILESTONE**	**Completion and BMS Approval of BMS-Specific Reports**	**3.0%**
Testing Task			
66	Deliverable	Test Risk Identification and Contingency Plan	-
67	Deliverable	Finalized Proposed Test Environment(s) Specifications	-
68	Deliverable	System Integration Test Cases/Scripts	-
69	Deliverable	System Integration Testing Results	-
70	**MILESTONE**	**Completion and BMS Approval of System Integration Testing**	**3.0%**
71	Deliverable	Regression Test Cases/Scripts	-
72	Deliverable	Regression Testing Results	-

#	Type	Deliverables and Milestones	% of total DDI price
73	**MILESTONE**	**Completion and BMS Approval of Regression Testing**	**3.0%**
74	Deliverable	Load/Stress Test Cases/Scripts	-
75	Deliverable	Load/Stress Testing Results	-
76	Deliverable	Capacity Analysis Report	-
77	**MILESTONE**	**Completion and BMS Approval of Load/Stress Testing**	**3.0%**
78	Deliverable	User Acceptance Testing Plan	-
79	Deliverable	User Acceptance Test Cases/Scripts	-
80	Deliverable	User Acceptance Testing Results	-
81	**MILESTONE**	**Completion and BMS Approval of User Acceptance Testing**	**3.0%**
82	Deliverable	Operational Readiness Test Cases/Scripts	-
83	Deliverable	Operational Readiness Testing Results	-
84	**MILESTONE**	**Completion and BMS Approval of Operational Readiness Testing**	**3.0%**
85	Deliverable	Weekly Project Status Report	-
86	Deliverable	Monthly Project Status Report	-
Conversion Task			
87	Deliverable	Conversion Risk Identification and Contingency Plan	-
88	Deliverable	Data Cleansing and Conversion Specification Document	3.0%
89	Deliverable	Data Conversion Requirements Document	-
90	Deliverable	Conversion Software Readiness Certification Letter	-
91	Deliverable	Conversion and Reconciliation Test Cases/Scripts	-
92	Deliverable	Conversion and Reconciliation Testing Results	-
93	**MILESTONE**	**Completion and BMS Approval of Data Conversion and Reconciliation for Implementation**	**4.0%**
94	Deliverable	User Acceptance Testing of Converted Data	-
95	**MILESTONE**	**Completion and BMS Approval of User Acceptance Testing**	**4.0%**
96	Deliverable	Weekly Project Status Report	-
97	Deliverable	Monthly Project Status Report	-
Training Task			
98	Deliverable	Training Assessment and Gap Analysis	-
99	Deliverable	Final Training Plan/Schedule	2.0%
100	Deliverable	Electronic Training Documentation	-

#	Type	Deliverables and Milestones	% of total DDI price
101	Deliverable	Training Database and Application Software	-
102	Deliverable	Letter Certifying Training Database Is Built and Software Is Operational	-
103	Deliverable	Document Version Control Plan	-
104	Deliverable	Letter Certifying Completion of Training	-
105	Deliverable	Evaluation Survey Tools	-
106	Deliverable	Training Report	-
107	Deliverable	Weekly Project Status Report	-
108	Deliverable	Monthly Project Status Report	-
109	**MILESTONE**	**Completion and BMS Approval of Provider Training**	**1.0%**
110	**MILESTONE**	**Completion and BMS Approval of Pre-Implementation System User Training**	**1.0%**
111	**MILESTONE**	**Completion and BMS Approval of Phase 1c**	**2.0%**
Phase 1d – Implementation Readiness			
112	Deliverable	Implementation Plan	-
113	Deliverable	Report Distribution Schedule	-
114	Deliverable	Software Release Plan	-
115	Deliverable	Emergency Back Out Plan	-
116	Deliverable	Backup and Recovery Plan	2.0%
117	Deliverable	Business Continuity Plan	1.0%
118	Deliverable	System Modification and Enhancement Plan	-
119	Deliverable	Final User Documentation	-
120	Deliverable	Final Provider Documentation	-
121	Deliverable	Implementation Checklist	-
122	Deliverable	Updated Project Management Plan (including all subsidiary plan and other associated artifacts)	-
123	Deliverable	Weekly Project Status Report	-
124	Deliverable	Monthly Project Status Report	-
125	**MILESTONE**	**Completion and BMS Approval of Provider Re-enrollment**	**3.0%**
126	**MILESTONE**	**Completion and BMS Approval of Phase 1d (Replacement MMIS becomes the system of record)**	**3.0%**
Phase 1e – Certification Planning			
127	Deliverable	CMS Certification Readiness Plan	-
128	Deliverable	Weekly Project Status Report	-

#	Type	Deliverables and Milestones	% of total DDI price
129	Deliverable	Monthly Project Status Report	-
130	**MILESTONE**	**Completion and BMS Approval of Phase 1e**	-
Phase 2b – CMS Certification			
131	Deliverable	Updated CMS Certification Readiness Plan	-
132	Deliverable	Completed Certification Protocols and Checklists	-
133	Deliverable	CMS Certification Documentation and Operational Examples	-
134	Deliverable	Shared Electronic Document Storage for Certification Artifacts	-
135	Deliverable	System Remediation	-
136	**MILESTONE**	**Completion and BMS Approval of Certification Readiness Planning Meetings**	-
137	**MILESTONE**	**Pre-Certification Meeting and/or CMS Call**	-
138	**MILESTONE**	**CMS Certification (This is considered the final deliverable for DDI)**	**15.0%**
Phase 3 – Turnover and Closeout			
139	Deliverable	Turnover Plan	-
140	Deliverable	Turnover Project Schedule	
141	Deliverable	MMIS Requirement Statement	-
142	Deliverable	MMIS Software, Files, and Operations and User Documentation	-
143	Deliverable	MMIS Inventory Report	-
144	Deliverable	Turnover Results Report	-
145	**MILESTONE**	**Completion and BMS Approval of Turnover Training**	-
146	**MILESTONE**	**Completion and BMS Approval of Turnover and Contract Close-out**	-
		TOTAL	**100%**

****** Deliverables #5-31 and #33 are to be submitted with the vendor's proposal, as specified in Section 3.2. Updated deliverables will be submitted after project initiation, according to a schedule approved by BMS.***

APPENDIX D
CMS Certification Requirements

Req#	Requirement	Type
BENEFICIARY MANAGEMENT BUSINESS AREA: BENEFICIARY MANAGEMENT (BE) CHECKLIST		
BE1 – COLLECT AND MANAGE INFORMATION ABOUT THE BENEFICIARY POPULATION		
BE1.1	Supports a Beneficiary data set that contains all required data elements.	SMM
BE1.2	Processes all transactions that update the Beneficiary data set on a timely basis as determined by the State, edits fields for reasonableness, and controls and accounts for transactions with errors.	SMM
BE1.3	Supports management of Beneficiary information, including archives, with reports, transaction and transaction error tracking, etc.	SMM
BE1.5	Receives and processes Beneficiary eligibility information from external sources (such as through the State's Integrated Eligibility System or SSAs State Data Exchange) for a given period of time; produces total and details information that supports error correction and synchronization. Applies reconciliation changes to master file. Produces a file of changed records to be sent to originating source.	SMM
BE1.6	Archives Beneficiary data sets and updates transactions according to State provided parameters.	IBP
BE1.7	If the EPSDT reporting process is performed by the MMIS, provides Beneficiary data to support case identification, tracking, and reporting for the EPSDT services covered under Medicaid (optional).	SMM
BE1.8	Provides an indicator to suppress generation of documents containing Beneficiary identification for confidential services or other reasons.	SMM
BE1.9	Maintains clinical, utilization and other indicators of special population, special needs status for such programs as lock-in, disease management, outcomes, and high dollar case management files.	IBP
BE1.10	Maintains record/audit trail of a Beneficiary's requests for copies of personal records (including time/date, source, type, and status of request).	PRI
BE1.12	Allows for authorized users to update Beneficiary records online.	IBP
BE2 − MAINTAIN INFORMATION ON BENEFICIARY'S MEDICAID BENEFITS		
BE2.1	Provides data storage and retrieval for Third Party Liability (TPL) information; supports TPL processing and update of the information.	SMM
BE2.1	Supports the assignment of Beneficiaries to Medicaid benefits/benefit packages based on Federal and/or State-specific eligibility criteria.	IBP
BE2.2	Maintains record of benefit assignment(s) for Beneficiaries.	IBP
BE2.3	Applies appropriate benefit limitations for Beneficiaries based on Federal and/or State-specific criteria.	IBP
BE2.4	Maintains record of Beneficiary benefit limitation information.	IBP

Req#	Requirement	Type
BE2.5	Calculates and applies Beneficiary cost-sharing (including premiums and co-pays) for particular benefits based on Federal and/or State-specific criteria.	IBP
BE2.6	Maintains record of Beneficiary cost-sharing.	IBP
BE3 – PROVIDE/ALLOW VERIFICATION OF MEDICAID ELIGIBILITY INFORMATION TO EXTERNAL USERS		
BE3.1	In response to an eligibility inquiry made through the MMIS, provides eligibility status for the date(s) queried, and tracks and monitors responses to the queries (SMM11281.1B).	SMM
BE3.2	In response to an eligibility inquiry made through the MMIS, provides notification of third-party payers who must be billed prior to Medicaid (SMM 11281.1B).	SMM
BE3.3	In response to an eligibility inquiry made through the MMIS, provides notice of participation in a managed care program (SMM 11281.1B).	SMM
BE3.4	In response to an eligibility inquiry made through the MMIS, provides notification of program and service restrictions, such as lock-in or lock-out (SMM 11281.1B).	SMM
BE4 – COMPLY WITH HIPAA REQUIREMENTS		
BE4.1	Supports system transmission and receipt of all current version X12N and NCPDP eligibility verification transactions.	HIPAA
BE5 – MANAGE THE MEDICARE BUY-IN PROCESS (OPTIONAL)		
BE5.1	Identifies and tracks potential Medicare Buy- In Beneficiaries according to State and CMS-defined criteria.	CFR
BE5.2	Transmits State-identified Buy-In Beneficiary information for matching against CMS-specified Federal Medicare Beneficiary database(s).	CFR
BE5.3	Accepts Buy-In Beneficiary response information from CMS-specified Federal Medicare Beneficiary database(s).	SMM
BE5.4	Processes change transactions to update Buy-In Beneficiary information. Identify and track errors or discrepancies between State and Federal Buy-In Beneficiary information.	SMM
BE5.7	Supports automated data exchange process(es), as specified by CMS, in order to identify and track Medicare Part D dual-eligible and Low Income Subsidy (LIS) eligible Beneficiaries for the purposes of cost-avoidance on prescription drug claims and calculating spend-down payments.	SMDL
CARE MANAGEMENT BUSINESS AREA: MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST		
MC1 – SUPPORT ASSESSMENT OF MEMBER ACCESS TO SERVICES		
MC1.2	Captures information identifying contracted providers within MCO network, including PCPs.	CFR

Req#	Requirement	Type
MC1.7	Provides information to support assessment of adequacy of provider network. This includes identifying and collecting data on the number and types of providers and provider locations.	CFR
MC1.8	Provides information to support review of new enrollments and to prohibit affiliations with individuals debarred by Federal Agencies.	CFR
MC2 – MAKE ACCURATE PAYMENTS TO MCOs		
MC2.9	Supports ANSI X12N 820 Premium Payment transaction as required by HIPAA.	HIPAA
MC3 – RECEIVE AND PROCESS ENCOUNTER RECORDS FROM MCOs		
MC3.1	Collects and stores encounter data on a periodic basis.	CFR
MC3.7	Accepts and processes encounter claims in formats as mandated by HIPAA, e.g., X12N837.	HIPAA
MC4 – PROCESS MCO DATA FOR USE IN ASSESSING QUALITY AND COST OF CARE		
MC4.1	Accesses and reports on encounter data for the purpose of monitoring appropriateness of care.	CFR
MC4.6	Processes encounter data to detect under-utilization of services by enrollees of the MCO.	CFR
MC5 – IDENTIFY MCO-COVERED SERVICES AND BLOCK DUPLICATE PAYMENTS		
MC5.1	Blocks payment to fee-for-service (FFS) providers for services included in the MCO benefit package, with the exceptions stated per the State Plan.	CFR
MC5.4	Allows payment for treatment obtained by an enrollee for an emergency medical condition without prior authorization.	CFR
OPERATIONS MANAGEMENT BUSINESS AREA: CLAIMS ADJUDICATION (CA) CHECKLIST		
CA1 – ROUTE CLAIMS FOR PROCESSING AND TRACK CLAIM PROGRESS, STATUS, AND LOCATION		
CA1.1	Tracks all claims within the processing period – paid, suspended, pending or denied.	SMM
CA1.2	Suspends claims with exceptions/errors and routes for correction to the organizational entity that will resolve the exception/error, unless automatically resolved. The organizational entity will resolve the claim based upon the State's criteria.	SMM
CA1.3	Verifies that suspended transactions have valid error/exception codes.	HIPAA
CA1.4	Tracks claims flagged for investigative follow-up because of third party discrepancies.	SMM
CA1.5	Generates audit trails for all claims, maintains audit trail history.	SMM
CA1.6	Verifies that all claims for services approved or disallowed are properly flagged as paid or denied.	SMM

Req#	Requirement	Type
CA1.7	Documents and reports on the time lapse of claims payment, flagging or otherwise noting clean claims (error free) that are delayed over 30 days. (See 447.45 CFR for timely claims payment requirements).	SMM
CA1.8	Provides prompt response to inquiries regarding the status of any claim through a variety of appropriate technologies, and tracks and monitors responses to the inquiries. Processes electronic claim status request and response transactions (ASC X12N 276/277) required by 45 CFR Part162.	SMM HIPAA
CA1.9	Provides claims history for use by Program Management and Program Integrity.	SMM
CA1.10	Assigns claim status (i.e., approved, denied, pended, rejected) based on the State's criteria.	IBP
CA1.13	Identifies and tracks all edits and audits posted to the claim in a processing period.	IBP
CA1.14	Provides and maintains, for each error code, a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied.	IBP
CA2 – PROCESS CLAIM DATA AGAINST DEFINED SERVICE, POLICY, AND PAYMENT PARAMETERS		
CA2.1	Verifies that all fields defined as numeric contain only numeric data.	SMM
CA2.2	Verifies that all fields defined as alphabetic contain only alphabetic data.	SMM
CA2.3	Verifies that all dates are valid and reasonable.	SMM
CA2.4	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.	SMM
CA2.5	Verifies that all coded data items consist of valid codes, e.g., procedure codes, diagnosis codes, service codes, etc. are within the valid code set HIPAA Transactions and Code Sets (TCS) and are covered by the State Plan.	SMM HIPAA
CA2.6	Verifies that any data item that contains self-checking digits (e.g., Beneficiary I.D. Number) passes the specified check-digit test.	SMM
CA2.7	Verifies that numeric items with definitive upper and/or lower bounds are within the proper range.	SMM
CA2.8	Verifies that required data items are present and retained) including all data needed for State or Federal reporting requirements (see SMM 11375).	SMM
CA2.9	Verifies that the date of service is within the allowable time frame for payment.	IBP
CA2.10	Verifies that the procedure is consistent with the diagnosis.	SMM
CA2.11	Verifies that the procedure is consistent with the Beneficiary's age.	SMM
CA2.12	Verifies that the procedure is consistent with the Beneficiary's sex.	SMM
CA2.13	Verifies that the procedure is consistent with the place of service.	SMM
CA2.14	Verifies that the procedure is consistent with the category of service.	SMM

Req#	Requirement	Type
CA2.16	Verifies that the billed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage (either above or below), then the claim is flagged and routed for manual review for: • Possible incorrect procedure; and, • Possible incorrect billed amount when too high, possible need for individual consideration.	SMM
CA2.17	Verifies that the claim is not a duplicate of a previously adjudicated claim (including a prior one in the current processing period).	SMM
CA2.18	Verifies that the dates of service of an institutional claim do not overlap with the dates of service of an institutional claim from a different institution for the same Beneficiary.	SMM
CA2.19	Verifies that the dates of service for a practitioner claim do not overlap with the dates of service for another claim from the same practitioner for a single Beneficiary unless the additional services are appropriate for the same date of service.	SMM
CA2.20	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.	SMM
CA2.21	Flags for review claims from a single provider for multiple visits on the same day to a single Beneficiary.	IBP
CA2.22	Verifies that the provider type is consistent with the procedure(s).	IBP
CA2.25	Has the capability to pay claims per capita, from encounter data or fee-for-service.	IBP
CA2.26	Prices out-of-State claims according to state policy (i.e., at the local rate, at the other State's rate or flags and routes for manual pricing).	IBP
CA2.28	Prices claims according to pricing data and reimbursement methodologies applicable on the date(s) of service on the claim.	IBP
CA2.29	Deducts Third Party Liability (TPL) paid amounts and Medicare paid amounts, as defined in the State Plan, when pricing claims.	IBP
CA2.30	Deducts Beneficiary co-payment amounts, as appropriate, when pricing claims.	IBP
CA2.32	Prices services billed with procedure codes with multiple modifiers.	IBP
CA2.33	Edits claims for consistency and payment limitations using the Medicare Correct Coding Initiative or similar editing criteria, based upon the State Plan.	IBP
CA2.35	Provides and maintains test claim processing capabilities including testing with providers.	IBP
CA3 – VALIDATES THAT CLAIMS ARE FROM PROPERLY ENROLLED AND ELIGIBLE PROVIDERS		
CA3.1	Verifies that the provider is eligible to render service(s) during the period covered by the claim.	SMM

Req#	Requirement	Type
CA3.2	Verifies that the provider is eligible to render the specific service covered by the claim.	IBP
CA3.3	Verifies that the provider is eligible to provide the specific service covered by the plan to the specific Beneficiary.	IBP
CA4 – VERIFY THAT CLAIMS ARE FOR ELIGIBLE BENEFICIARIES		
CA4.1	Verifies that the Beneficiary was eligible for the particular category of service at the time it was rendered.	SMM
CA4.3	Identifies, by Beneficiary, the screening and related diagnosis and treatment services the Beneficiary receives for Early and Periodic Screening Diagnosis, and Treatment, (EPSDT).	SMM
CA4.4	Routes and reports on claims that are processed that indicate the Beneficiary's date of death for follow-up by the Beneficiary eligibility or Third Party Liability (TPL) personnel.	IBP
CA4.5	Provides and maintains the capability to monitor services for suspected abusers using a "pay and report", lock-in, or some equivalent system function that will provide reports of the claim activity for these Beneficiaries as scheduled or requested.	IBP
CA4.6	Provides and maintains the capability to pend or deny claims for Beneficiaries assigned to the Beneficiary lock-in program based on state guidelines.	SMM
CA4.7	Provides and maintains the capability to edit claims for Beneficiaries in long term care (LTC) facilities to ensure that services included in the LTC payment rate are not billed separately by individual practitioners or other providers.	SMM
CA4.8	Provides and maintains the capability to process Beneficiary cost sharing (e.g., co-payments, LTC patient liability) on any service specified by the state using a fixed amount or percent of charges.	IBP
CA4.9	Edits claims for newborns' eligibility based upon State-defined newborn enrollment policies and procedures.	IBP
CA4.10	Edits for Beneficiary participation in special programs (i.e. waivers) against program services and restrictions.	IBP
CA5 – PROVIDE FOR THE TIMELY DISPOSITION OF PRIOR AUTHORIZATION REQUESTS		
CA5.1	Processes and retains all prior authorization request data.	SMM
CA5.3	Supports receiving, processing and sending electronic health care service review, request for review, and response transactions required by 45 CFR Part 162,as follows: • Retail pharmacy drug referral certification and authorization. • Dental, professional and institutional referral certification and authorization (ASC X12N 278). Optionally, supports Web or Internet submissions or prior authorization requests.	HIPAA

Req#	Requirement	Type
CA5.5	Supports searching for prior authorizations based on: • Provider name • Provider ID • Beneficiary name • Beneficiary Medicaid ID Number • Date of submission range • Dates of service requested range • Service requested • Status of the request	IBP
CA5.6	Supports retroactive entry of prior authorization requests.	IBP
CA5.7	Assigns a unique prior authorization number as an identifier to each prior authorization request.	SMM
CA5.8	Edits prior authorization requests with edits that mirror the applicable claims processing edits.	IBP
CA5.10	Edits to ensure that only valid data is entered on the prior authorization record, and denies duplicate requests or requests that contain invalid data.	SMM
CA5.12	Provides and maintains the capability to change the services authorized and to extend or limit the effective dates of the authorization. Maintains the original and the change data in the prior authorization record.	IBP
CA5.13	Accepts updates from claims processing that “draw down” or decrement authorized services.	IBP
OPERATIONS MANAGEMENT BUSINESS AREA: CLAIMS RECEIPT (CR) CHECKLIST		
CR1 – ACCEPT CLAIMS AND OTHER TRANSACTIONS ELECTRONICALLY AND VIA HARD COPY		
CR1.1	Captures accurately all input into the system at the earliest possible time.	SMM
CR1.2	Assigns each claim a unique identifier upon its entering the system.	SMM
CR1.3	Accepts and uses the common hospital paper billing form developed by the National Uniform Billing Committee (NUBC), for non-electronic claims.	SMM
CR1.4	Accepts and uses the common non- institutional paper claim form developed by the National Uniform Claim Committee (NUCC), for non-electronic claims.	SMM
CR1.6	Controls, tracks, and reconciles captured claims to validate that all claims received are processed.	IBP
CR1.7	Provides the ability to identify claims input for control and balancing (hardcopy and electronic media).	IBP

Req#	Requirement	Type
CR1.8	Provides and maintains a data entry system that includes, but is not limited to, hardcopy claims and claimadjustment/voids which provides for field validity edits and pre-editing for: • Provider number • Beneficiary ID number • Procedure codes • Diagnosis codes	SMM
CR1.9	Produces an electronic image of hardcopy claims and claims-related documents, and performs quality control procedures to verify that the electronic image is legible and meets quality standards.	IBP
CR1.10	Screens and captures electronic images, date-stamps, assigns unique control numbers and batches hardcopy claim forms and attachments, adjustment/void forms, and updated turnaround documents.	IBP
CR1.11	Logs each batch into an automated batch control system.	IBP
CR1.12	Provides the ability to identify claim entry statistics to assess performance compliance.	IBP
CR1.13	Provides a unique submitter number for each billing service or submitter that transmits electronic or paper claims to the MMIS for a single provider or multiple providers.	IBP
CR1.14	Provides an attachment indicator field on all electronic media claims to be used by the submitter to identify claims for which attachments are being submitted separately.	IBP
CR1.15	Provides and maintains a Web portal for providers to directly and efficiently enter claims.	IBP
CR1.16	Supports testing of new provider claims submission systems by allowing providers to submit electronic claims test files that are processed through the adjudication cycle without impact on system data.	IBP
CR1.17	Identifies any incomplete claim batches that fail to balance to control counts.	IBP
CR2 – ACCEPT ATTACHMENTS AND OTHER ASSOCIATED MATERIALS RELATED TO CLAIMS AND OTHER TRANSACTIONS REQUIRED FOR REVIEW AND APPROVAL		
CR2.2	Receives claim attachments associated with electronic media or paper claims and auto-archives or forwards to appropriate operational area for processing.	IBP
CR2.4	Accepts prior authorization attachments such as: • Surgical/anesthesia reports • Medical records • X-rays/images • Orthodontic study models • LTC prior Authorization • Certain prescription drugs as required • Other items required by State or Federal rules	IBP

Req#	Requirement	Type
CR2.5	Accepts other claim related inputs to the MMIS, including but not limited to: • Sterilization, abortion, and hysterectomy consent forms • Manual or automated medical expenditure transactions which have been processed outside of the MMIS (e.g., spend-down) • Non claim-specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts • Electronic cost reports • Disproportionate share reports • Drug rebate • Any other inputs required for services under the State's approved plan	IBP
CR3 – COMPLY WITH HIPAA REQUIREMENTS		
CR3.1	Provides system support for the sending and receiving of electronic claims transactions, containing valid codes, required by 45 CFR Parts 160 and 162, as follows: • Retail pharmacy drug claims (NCPDP) • Dental health care claims (X12N 837D) • Professional health care claims (X12N 837P) • Institutional health care claims (X12N 837I) • Coordination of benefits data, when applicable • Future claims attachments required under HIPAA	HIPAA
CR3.2	Provides secure, HIPAA compliant software and documentation for use by providers to submit electronic claims.	IBP
PROGRAM MANAGEMENT BUSINESS AREA: FEDERAL REPORTING (FR) CHECKLIST		
FR1 – CREATE AND SUBMIT THE FEDERALLY REQUIRED MSIS REPORTS		
FR1.1	Maintains data sets for MSIS reporting as required.	SMM
FR1.2	Merges into MSIS data from outside sources if required: • Capitation payment records from enrollment process • Eligibility characteristic data from eligibility intake process • Medicaid services processed by non-MMIS State departments, such as mental health services • Utilization based on Managed Care encounters	SMM 2700.2
FR1.3	Provides and maintains MSIS data for the following adjudicated claims: • Inpatient hospital • Long term institutional care • Prescription drugs • Other, not included in the above categories	SMM 2700.2
FR1.4	Provides and maintains encounter data in appropriate claim(s) file.	SMM 2700.2
FR1.5	Follows the eligibility reporting guidelines from Attachment A *MSIS Tape Specifications and Data Dictionary* document.	SMM 2700.2
FR1.6	Meets MSIS reporting timelines, providing MSIS tapes for submission in accordance with the tape delivery schedules.	SMM 2700.2

Req#	Requirement	Type
FR2 – CREATE AND SUBMIT THE FEDERALLY REQUIRED EPSDT REPORTS		
FR2.1	Produces the CMS-416 report in accordance with CMS requirements. The report must include: • The number of children provided child health screening services, • The number of children referred for corrective treatment, • The number of children receiving dental services, and • The State's results in attaining goals set for the state under section 1905(r) of the Act provided according to a State's screening periodicity schedule.	SMM 2700.4
FR3 – CREATE AND SUBMIT TO CMS THE FEDERALLY REQUIRED HCBS WAIVER REPORTS		
FR3.1	Produces the CMS-372 and CMS-372S Annual reports on Home and Community Based Waiver Reports, for any HCBS Waivers that exist in accordance with CMS requirements.	SMM 2700.6
FR4 – MEET ALL OTHER FEDERAL REPORTING REQUIREMENTS		
FR4.1	Provides data to support the production of CMS-37 and CMS-64 quarterly estimates and expenditure reports.	SMM
PROGRAM MANAGEMENT BUSINESS AREA: FINANCIAL MANAGEMENT (FI) CHECKLIST		
FI1 – PRODUCE INDIVIDUAL EXPLANATION OF BENEFITS (EOB)		
FI1.1	Provides individual EOB notices, within 45 days of the payment of claims, to all or a sample group of the Beneficiaries who received services under the plan as described in §11210.	SMM
FI2 – ENSURE THAT ACCOUNTS PAYABLE AND RECEIVABLE TRANSACTIONS ARE RECOGNIZED AND POSTED IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS		
FI2.1	Updates claims history and on-line financial files with the payment identification (check number, EFT number, warrant number, or other), date of payment, and amount paid after the claims payment cycle.	IBP
FI2.3	Maintains financial transactions in sufficient detail to support 1099 and, if the State has elected to do so W-2 and FICA reporting requirements for personal service care providers and providers of services under self-directed care initiatives.	CFR
FI2.4	Accounts for recovery payment adjustments received from third parties that do not affect the provider's 1099/W2.	CFR
FI2.5	Provides a full audit trail to the source of general ledger transactions generated by the MMIS or other supporting financial packages.	SMM
FI2.7	Maintains a history of claim recovery payments in excess of expenditures and allows distribution to the appropriate parties, including providers, Beneficiaries, or insurers.	SMM
FI2.8	Maintains a history of refunds.	SMM
FI2.9	Withholds the Federal share of payments to Medicaid providers to recover Medicare overpayments.	SMM CFR

Req#	Requirement	Type
FI3 – ENSURE THAT ALL FINANCIAL TRANSACTIONS RELATED TO PROGRAM DELIVERY ARE PROCESSED AS DEFINED BY STATE AND FEDERAL REGULATIONS		
FI3.1	Tracks Medicare deductibles and coinsurance paid by Medicaid for all crossover claims, by Beneficiary and program type.	SMM
FI3.2	Processes and retains all data from provider credit and adjustment transactions.	SMM
FI3.4	Issues a Remittance Advice detailing claims processing activity it the same time as the payment or payment information transfer.	SMM
FI3.5	Ensures that the system supports sending electronic claim payment/advice transactions (ASC X12N 835) meeting the standards required by 45 CFR Part 162.	HIPAA
FI3.6	Provides payment via electronic funds transfer (EFT) as an option.	SMM
FI3.7	Nets provider payments against credit balances or accounts receivable amounts due in the payment cycle in determining the payment due the provider.	SMM
FI3.8	Processes voids and replacements for incorrect payments or returned warrants, crediting fund source accounts and creating accounts receivable or credit balances where appropriate.	SMM
FI3.10	Allows on-line access to accounts receivable or provider credit balances to authorized individuals.	IBP
FI3.11	Allows on-line access to Remittance Advice through a Web-based browser.	IBP
FI3.13	Identifies providers with credit balances and no claim activity during a state-specified number of months.	IBP
FI3.16	Allows for withholding of payments in cases of fraud or willful misrepresentation without first notifying the provider of its intention to withhold such payments.	CFR
FI3.17	Supports refunding of Federal share of provider overpayments within 60 days from discovery of an overpayment for Medicaid services.	CFR
FI4 – SUPPORT MANAGEMENT OF PROGRAM FUNDS		
FI4.3	Updates records to reflect the processing of uncashed or cancelled (voided) Medicaid checks. Process replacements for lost or stolen warrants and updated records with new warrant information.	CFR
FI4.4	Processes payments from providers for refunds and updates records as needed. Adjusts 1099/W2 reporting.	CFR
FI4.5	Allows for history adjustments to claims processing to reflect changes in funding sources and other accounting actions that do not impact provider payment amounts or 1099/W2 reporting.	CFR

Req#	Requirement	Type
CARE MANAGEMENT BUSINESS AREA: HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST		
WA1 – CONTROL ENROLLMENT IN WAIVER PROGRAMS		
WA1.1	Identifies unduplicated participants enrolled in 1915 (c) waiver program.	HCBS
WA1.2	Tracks and reports the number of unduplicated participants in the 1915 (c) waiver program.	HCBS
WA1.3	Generates notices or alerts to agency if number of unduplicated participants enrolled in the wavier program exceeds the number of participants approved in the waiver application.	HCBS
WA1.4	Identifies the date a participant is assessed to meet the waiver level of care (LOC) and the date of the LOC reevaluation.	HCBS
WA2 – ENROLL TRADITIONAL AND ATYPICAL WAIVER PROVIDERS		
WA2.1	Captures enrollment information, including National Provider Identifier (NPI) if required, on entity or individual meeting the qualifications contained in the provider agreement including geographic locations and capitation or Fee-for Service (FFS) rates.	HCBS CFR
WA2.2	Prevents enrollment of entities and individuals who do not meet the provider qualifications contained in the provider agreement.	HCBS CFR
WA2.5	Prohibits enrollment of providers affiliated with individuals debarred by State or Federal Agencies, listed in Abuse Registries, or otherwise unqualified to provide service.	HCBS
WA3 – PROVIDE SERVICES AS DESCRIBED IN THE PLAN OF CARE		
WA3.1	Stores the plan of care and makes it available for viewing.	HCBS
WA3.2	Produces monitoring reports to determine if services approved in the plan of care are provided.	HCBS
WA3.3	Identifies the date a participant's plan of care (POC) assessment is completed and the date of the next POC re-evaluation, if applicable.	HCBS
WA4 – PROCESS WAIVER CLAIMS AND MAKE TIMELY AND ACCURATE PAYMENTS		
WA4.1	Processes claims for medical services	HCBS
WA4.2	Applies edits to prevent payments for services covered under a waiver program to a Medicaid provider who does not have a provider agreement.	HCBS
WA4.3	Prevents or suspends payments for Beneficiaries who have become ineligible for Medicaid.	HCBS
WA4.4	Suspends payments for waiver services furnished to individuals who are inpatients of a hospital, nursing facility or ICF/MR and sends notice to the provider of the admission. (If the State has approved personal care retainer, or respite services provided in an ICF/MR building but not covered under the ICF/MR benefit, an exception may be made.)	HCBS

Req#	Requirement	Type
WA4.5	Limits payment for services to those described within the Beneficiary's approved plan of care. Deny claims exceeding dollar or utilization limits approved in waiver or exceeding the approved individual waiver budget cap.	HCBS
WA4.6	Edits waiver services claims for prior authorization, if applicable.	HCBS
WA4.7	Edits waiver services claims for Third Party Liability (TPL) coverage prior to payment to ensure Medicaid is the payer of last resort.	HCBS
WA4.8	Edits waiver services claims for Beneficiary cost share of premium or enrollment fees prior to payment.	HCBS
WA5 – SATISFY FEDERAL REPORTING REQUIREMENTS, MONITOR UTILIZATION, AND ASSESS QUALITY OF CARE		
WA5.1	Gathers data and produces a variety of financial reports to facilitate cost reporting and financial monitoring of waiver programs.	HCBS SMM
*WA5.*2	Gathers data and produces utilization reports for monitoring cost neutrality of waiver services to a target population. The average cost of waiver services cannot be more than the cost of alternative institutional care. State may define average either in aggregate or for each participant.	HCBS
WA5.3	Accesses individual Beneficiary claims and/or encounter histories to extract data needed to produce annual report to CMS on cost neutrality and amount of services.	HCBS SMM
WA5.4	Collects and stores data needed to produce reports consistent with data collection plan to assess quality and appropriateness of care furnished to participants of the waiver program.	HCBS
WA5.5	Monitors provider capacity and capabilities to provide waiver services to enrolled participants.	HCBS
CARE MANAGEMENT BUSINESS AREA: IMMUNIZATION REGISTRY (RI) CHECKLIST - MMIS INTERFACED		
RI1 – ENSURE STANDARDIZED DATA IS AVAILABLE		
RI1.1	Collects and maintains claims history for vaccinations at the Beneficiary-specific level until the Beneficiary is 18 years of age.	AT
RI1.2	Interfaces with a statewide automated immunization registry and allows regularly scheduled data exchanges. • Populates the statewide automated registry to fully populate the registry with Medicaid children. • Populates the statewide automated registry with Medicaid claims for children receiving immunizations.	AT
RI1.3	Sends, at a minimum, the following information to a statewide immunization registry through the interface: • Medicaid identifier • Demographic information • CPT/billing procedure code • Identify rendering service provider • Reminder/recall notice dates	AT

Req#	Requirement	Type
CARE MANAGEMENT BUSINESS AREA: MANAGED CARE ENROLLMENT (ME) CHECKLIST		
ME1 – PROCESS ENROLLMENT AND DISENROLLMENT INTO/ OUT OF MCO OR PCP		
ME1.1	Captures enrollee choice of MCO or PCP and enters into Beneficiary record.	CFR
ME1.3	Assigns enrollee to MCO based on factors such as client age, sex, geographic location; and MCO capitation rate, location.	CFR
ME1.5	Displays enrollees associated with MCO.	IBP
ME1.6	Disenrolls member from MCO.	CFR
ME1.7	Disenrolls member without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.	CFR
ME1.8	Automatically disenrolls and re-enrolls members in new plans during periods of open enrollment or when an MCO leaves the program.	CFR
ME1.9	Automatically disenrolls member from a terminated MCO and places in regular fee-for-service status.	CFR
ME1.11	Identifies Beneficiaries excluded from enrollment, subject to mandatory enrollment, or free to voluntarily enroll in MCO.	CFR
ME1.12	Prioritizes enrollment for Beneficiaries to continue enrollment if the MCO does not have the capacity to accept all those seeking enrollment under the program.	CFR
ME1.13	Provides a default enrollment process for those Beneficiaries who do not choose a MCO.	CFR
ME1.14	Automatically re-enrolls a Beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less (optional if State Plan so specifies).	CFR
ME1.15	Supports ANSI X12N 834 transaction as required by the Health Insurance Portability and Accountability Act (HIPAA).	HIPAA
ME2 – SUPPORT DATA EXCHANGE WITH STAKEHOLDERS		
ME2.1	Receives and processes eligibility data from State's Eligibility source system.	SMM
ME2.3	Receives and processes provider eligibility data from MMIS or data repository for PCP program.	CFR
ME2.6	Supports ANSI X12N 820 transaction for PMPM premium payment as required by HIPAA.	HIPAA
ME2.7	Transmits enrollment and PMPM payment data to MMIS or data repository.	CFR
ME2.8	Transmits enrollment records and PMPM payments to MCOs.	CFR

Req#	Requirement	Type
ME4 – MAINTAIN PRIVACY AND SECURITY OF ENROLLMENT RECORDS		
ME4.1	Complies with provisions for Administrative Simplification under the HIPAA of 1996 to ensure the confidentiality, integrity, and availability of ePHI: • Provides safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies; • Performs regular audits; and • Supports incident reporting.	HIPAA
CARE MANAGEMENT BUSINESS AREA: PCCM AND GATEKEEPER MANAGED CARE (MG) CHECKLIST		
MG1 – SUPPORT ENROLLMENT INTO PCCM PROGRAM		
MG1.1	Captures enrollee choice of PCCM on Beneficiary record.	CFR
MG1.2	Auto-assigns enrollees to a PCCM who fail to choose a PCCM, and completes provider lock-in process.	CFR
MG1.4	Disenrolls member from PCCM.	CFR
MG1.5	Allows enrollee to disenroll from a PCCM without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.	CFR
MG1.6	Automatically disenrolls enrollees from a terminated PCCM provider and places the Beneficiary in regular fee-for-service status.	CFR
MG1.7	Performs mass reassignment of enrollees if contract with PCCM is terminated or Beneficiary disenrolls for any reason other than ineligibility for Medicaid.	CFR
MG1.8	Generates notices to Beneficiary of enrollment or disenrollment from PCCM.	CFR
MG1.10	Identifies Beneficiaries excluded from enrollment, subject to mandatory enrollment, or free to voluntarily enroll in PCCM.	CFR
MG1.11	Prioritizes enrollment for Beneficiaries to continue enrollment if the PCCM does not have the capacity to accept all those seeking enrollment under the program.	CFR
MG1.12	Provides a default enrollment process for those Beneficiaries who do not choose a PCCM.	CFR
MG1.13	Automatically re-enrolls a Beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less (optional if State Plan so specifies).	CFR
MG1.14	Supports ANSI X12N 834 transaction as required by HIPAA.	HIPAA
MG2 – IMPROVE BENEFICIARY ACCESS TO QUALIFIED PROVIDERS		
MG2.1	Identifies physicians who have agreed to provide gatekeeper services, geographic location(s), number of assigned Beneficiaries, and capacity to accept additional patients.	CFR

Req#	Requirement	Type
MG2.5	Generates reports to monitor enrolled providers to prohibit affiliations with individuals debarred by Federal agencies.	CFR
MG3 – MAKE ACCURATE AND TIMELY PAYMENT TO PCCM		
MG3.2	Supports ANSI X12N 837 transaction as required by HIPAA.	HIPAA
MG3.3	Supports ANSI X12N 835 transaction as required by HIPAA	HIPAA
MG4 – MAKE ACCURATE AND TIMELY PAYMENTS TO PROVIDERS		
MG4.2	Allows payment to providers for services carved out of the PCCM benefit package (e.g., family planning, women health specialist).	CFR
MG4.3	Allows payment for emergency medical condition without authorization from PCCM.	CFR
OPERATIONS MANAGEMENT BUSINESS AREA: PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST		
POS1 – MAINTAIN INTERFACES BETWEEN THE POS SYSTEM AND DATA SOURCES		
POS1.4	Provides real-time access to benefit business rules.	SMM
POS1.5	Provides real-time access to drug file and pharmacy claims history.	SMM CFR
POS1.6	Ensures that all claims are assigned a unique identification number upon entering the system.	SMM
POS1.7	Interfaces with the MMIS or other payment systems to maintain records of time of claims payment in order for the payment systems to pay claims within 30days after receipt by the POS system of an error free claim.	SMM CFR
POS2 – ENSURE TIMELY AND ACCURATE ADJUDICATION OF PROVIDER CLAIMS		
POS2.1	Performs online real-time capture and adjudication of pharmacy claims submitted by providers via POS devices, a switch, or through the Internet. Accepts ASC X12N NCPDP claims required by 45CFR Part 162.	SMM HIPAA CFR
POS2.2	Returns to the pharmacy provider the status of the claim and any errors or alerts associated with the processing, such as: • Edit failures • ProDUR alerts • Member (Beneficiary) or coverage restrictions • Prior authorization missing • Required coordination of benefits. • Refill to soon• Requires generic substitution • Deny experimental drugs • Requires unit dose (or not) • Package size not approved • Drug Efficacy Study Implementation (DESI) are not covered	CFR
POS2.3	Verifies that the Beneficiary is eligible on the date of service and not otherwise restricted, e.g., enrolled in MCO or a Lockin program; or receiving medication through a Waiver program, a carve-out mental health program, or a disease management program.	SMM CFR

Req#	Requirement	Type
POS2.4	Verifies that the pharmacy provider is eligible on the date of service.	SMM CFR
POS2.5	Verifies that all fields defined as numeric contain only numeric data.	SMM
POS2.6	Verifies that all fields defined as alphabetic contain only alphabetic data.	SMM
POS2.7	Verifies that all dates are valid and reasonable.	SMM
POS2.8	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.	SMM
POS2.9	Verifies that all coded data items consist of valid codes, including NDC for drug codes.	SMM HIPAA
POS2.10	Verifies that any data item that contains self-checking digits (e.g., Beneficiary I.D. Number) pass the specified check-digit test.	SMM
POS2.11	Verifies that required data items are present and retained (See SMM 11375) including all data needed for State or Federal reporting requirements.	SMM
POS2.12	Verifies that the date of service is within the allowable time frame for payment.	IBP
POS2.14	Verifies that the claim is not a duplicate of a previously adjudicated claim.	SMM
POS2.15	Pays according to the State plan at the lesser of approved pharmacy reimbursement methods, e.g., • AWP minus % + Dispensing Fee • Federal MAC (CMS Upper Limit + Dispensing Fee) • Usual and Customary Charges to the General Public • State MAC (State MAC + Dispensing Fee)	SMM
POS2.17	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.	SMM
POS2.18	Checks claims against state-defined service limitations.	CFR
POS2.19	Edits claims to ensure that all required attachments, per the reference records or edits, have been received and maintained for audit purposes or have been submitted prior to the claim and a prior authorization has been established.	CFR
POS2.20	Deducts Beneficiary co-payment amounts, as appropriate, when pricing claims.	IBP
POS2.21	Deducts TPL amounts, as appropriate, when pricing claims.	IBP
POS2.22	Verifies that the claim is for services covered by the State Plan.	CFR
POS2.23	Verifies that all data necessary for legal requirements are retained.	SMM
POS3 – VERIFY AUTHORIZATION FOR SERVICES THAT REQUIRE PRIOR APPROVAL		
POS3.1	Interfaces with the pharmacy prior authorization database.	SMM CFR

Req#	Requirement	Type
POS3.3	Interfaces with electronic authorization of health care service transactions required by 45 CFR Part 162, as follows: Retail pharmacy drug referral certification and authorization.	HIPAA
POS3.4	Performs edits to ensure that a prior authorization is present when required.	IBP
POS3.5	Notifies submitter when required prior authorization is missing.	CFR
POS4 – VERIFY THAT SERVICES ARE MEDICALLY APPROPRIATE, CONFORM WITH FEDERAL AND STATE POLICIES, AND RESULT IN THE MAINTENANCE OR IMPROVEMENT OF PATIENT HEALTH		
POS4.1	Provides an automated, integrated online real-time ProDUR system or provides assistance to the pharmacist to do a prospective drug utilization review.	CFR
POS4.3	Compares the claim against member history and benefit rules to determine if the new claim complies with State standards for: • Therapeutic appropriateness • Over Utilization • Underutilization • Appropriate use of generic products • Therapeutic duplication • Drug-disease contraindications • Drug-pregnancy contraindications • Drug-drug interactions • Incorrect drug dosage or duration of drug treatment • Clinical abuse or misuse • Consistent with patient age • Consistent with patient sex • Consistent with refill policy	SMM CFR
POS4.4	Generates alerts (messages) to pharmacy providers as required by State policy.	CFR
POS4.5	Allows the pharmacy the ability to override an alert.	IBP
POS5 – MANAGE CLAIMS FOR MEMBERS WITH THIRD PARTY COVERAGE		
POS5.1	Denies claims for members with appropriate third party coverage, enrollment in MCO, or Medicare Part D assignment. In this case, provides insurance information in the POS message along with notice of denial of payment.	SMM
POS5.2	Identifies claims appropriate for pay and chase function. If the drug is designated as “pay and chase”, processes and pays the claim (if it meets all other criteria), and reports the claim for follow up activities.	CFR
POS5.3	Identifies claims requiring third party payment.	CFR
POS6 - SUPPORT OTHER BUSINESS PROCESSES THAT REQUIRE PHARMACY CLAIMS DATA, e.g., REBATE INVOICING, RETROSPECTIVE DUR, AND DECISION SUPPORT		
POS6.1	Flags claims for Drug Rebate processing.	CFR

Req#	Requirement	Type
POS6.2	Prepares extracts of pharmacy claims history required by the drug manufacturer rebate process. Claims must include all NDC and other data needed to support the rebate process, as follows: • Period of time covered • NDC number • Total units paid • Product names • Number of prescriptions paid • Rebate amount per unit based on the CMS approved formula	CFR
POS6.3	Prepares extracts of pharmacy claims history (or access to the claims history) for purposes of retrospective DUR, prescriber and pharmacy provider profiling, management reporting, and other decision support functions.	SMM
POS6.4	Provides data to support the State in case of a drug manufacturer dispute over the rebate invoice.	CFR
PROGRAM MANAGEMENT BUSINESS AREA: SECURITY AND PRIVACY (SP) CHECKLIST		
SP1 – CONTROL ACCESS TO SYSTEM AND DATA		
SP1.1	Verifies identity of all users, denies access to invalid users. For example: • Requires unique sign-on (ID and password) • Requires authentication of the receiving entity prior to a system-initiated session, such as transmitting responses to eligibility inquiries	CFR
SP1.2	Enforces password policies for length, character requirements, and updates.	CFR
SP1.3	Supports a user security profile that controls user access rights to data categories and system functions.	CFR
SP1.4	Permits supervisors or other designated officials to set and modify user security access profile.	CFR
SP1.5	Includes procedures for accessing necessary electronic Protected Health Information (ePHI) in the event of an emergency; continue protection of ePHI during emergency operations.	CFR
SP1.6	Supports workforce security awareness through such methods as security reminders (at log on or screen access), training reminders, online training capabilities, and/or training tracking.	CFR
SP1.8	Alerts appropriate staff authorities of potential violations of privacy safeguards, such as inappropriate access to confidential information.	CFR
SP1.9	Contains a data definition for the Designated Record Set (DRS) that allows it to be included in responses to inquires and report requests.	CFR
SP1.10	Supports data integrity through system controls for software program changes and promotion to production.	IBP

Req#	Requirement	Type
SP2– PROTECT THE CONFIDENTIALITY AND INTEGRITY OF ePHI		
SP2.1	Contains verification mechanisms that are capable of authenticating authority (as well as identify) for the use or disclosure requested. For example: • Denies general practitioner inquiry for recipient eligibility for mental health services • Permits inquiries on claim status only for claims submitted by the inquiring provider	CFR
SP2.2	Supports encryption and decryption of stored ePHI or an equivalent alternative protection mechanism.	CFR
SP2.3	Supports encryption of ePHI that is being transmitted, as appropriate.	CFR
SP2.4	Supports integrity controls to guarantee that transmitted ePHI is not improperly modified without detection (e.g., provide secure claims transmission).	CFR
SP2.5	Provides data integrity of ePHI by preventing and detecting improper alteration or destruction (e.g., double keying, message authentication, digital signature, check sums etc).	CFR
SP3 – MONITOR SYSTEM ACTIVITY AND ACT ON SECURITY INCIDENTS		
SP3.1	Provides the capability that all system activity can be traced to a specific user.	IBP
SP3.2	Generates alerts for conditions that violate security rules, for example: • Attempts to access unauthorized data and system functions • Logon attempts that exceed the maximum allowed • Termination of authorized sessions after a specified time of no activity	CFR
SP3.3	Logs and examines system activity in accordance with audit policies and procedures adopted by the Medicaid agency.	CFR
SP3.4	Provides security incident reporting and mitigation mechanisms, such as: • Generate warning or report on system activity based on security parameters • Terminate access and/or generate report when potential security violation detected • Preserve and report specified audit data when potential security violation detected	CFR
SP3.5	Supports procedures for guarding, monitoring, and detecting malicious software (e.g., viruses, worms, malicious code, etc.).	CFR
SP4 – SUPPORT INDIVIDUAL RIGHTS		
SP4.1	Has the capability to respond to an authorized request to provide a report containing the DRS for a given individual.	CFR
SP4.2	Contains indicators that can be set to restrict distribution of ePHI in situations where it would normally be distributed.	CFR

Req#	Requirement	Type
SP4.3	Tracks disclosures of ePHI; provides authorized users access to and reports on the disclosures.	CFR
SP4.4	Has the capability to identify and note amendments to the DRS for a given individual.	CFR
PROVIDER MANAGEMENT BUSINESS AREA: PROVIDER MANAGEMENT (PR) CHECKLIST		
PR1 – ENROLL AND MAINTAIN ADEQUATE PROVIDER NETWORK		
PR1.4	Assigns and maintains provider numbers for all providers if the system is not natively NPI-compliant internally. Maps NPI identifiers to internal assigned numbers. Assigns and maintains provider numbers for providers not eligible for an NPI number.	SMM
PR1.7	Supports a provider appeals process in compliance with Federal guidelines contained in 42 CFR 431.105.	CFR
PR1.8	Maintains date-specific provider enrollment and demographic data.	SMM
PR2 – ENSURE QUALITY OF PROVIDER NETWORK AND ACCURACY OF RATES		
PR2.1	Tracks and supports the screening of applications (and ongoing provider updates) for (National Provider Identifier (NPIs),State licenses, Specialty Board certification as appropriate, review team visits when necessary, and any other State and/or Federal Requirement.	SMM
PR2.2	Tracks and supports any established provider review schedule to ensure providers continue to meet program eligibility requirements.	SMM
PR2.3	Verifies provider eligibility in support of other system processes, i.e., payment of claims.	SMM
PR2.4	Captures Clinical Laboratory Improvement Amendments (CLIA) certification information and the specific procedures each laboratory is authorized to cover. Links the information for use in claims adjudication.	SMM
PR2.7	Maintains multiple provider specific reimbursement rates with begin and end dates, consistent with State policy. Examples include: per diems, level-of-care per diems, case mix, percentage-of-charge rates, rates based on level of care, preferred provider agreements, managed care agreements, volume purchase contracts, or other cost-containment initiatives with begin and end effective dates.	SMM
PR3 – MAINTAIN PROVIDER INFORMATION		
PR3.1	Accepts, validates, and processes transactions or user entries to update and maintain provider information.	SMM
PR3.3	Tracks and controls the process of reconciliation of errors in transactions that are intended to update provider information.	SMM
PR3.4	Maintains current and historical multiple address capabilities for providers.	SMM
PR3.5	Maintains an audit trail of all updates to the provider data, for a time period specified by the State.	SMM
PR3.6	Maintains providers' Drug Enforcement Administration (DEA) numbers.	SMM

Req#	Requirement	Type
PR3.7	Updates and maintains financial data including current and prior year 1099 reported amounts.	SMM
PR3.8	Maintains links from providers to other entities, such as Groups, Managed Care Organizations (MCO), Chains, Networks, Ownerships, and Partnerships.	SMM
PR3.9	Provides capability to do mass updates to provider information, based on flexible selection criteria.	SMM
PR3.10	Maintains indicators to identify providers that are Fee-for-Service (FFS), Managed Care Organization (MCO) network only, and other State health care program participants.	SMM
PR3.11	Maintains a flag for providers who are eligible to use Electronic Funds Transfer (EFT) and Electronic Claims Submission.	SMM
PR4 – COMPLY WITH HIPAA REQUIREMENTS		
PR4.1	Requires (when appropriate), captures, and maintains the 10-digit National Provider Identifier.	HIPAA
PR4.2	Accepts the National Provider Identifier in all standard electronic transactions mandated under HIPAA.	HIPAA
PR4.3	Interfaces with the National Plan and Provider Enumerator System (NPPES) to verify the National Provider Identifier of provider applicants once the Enumerator data base is available.	HIPAA
PR4.4	Does not allow atypical providers to be assigned numbers that duplicate any number assigned by the NPPES.	HIPAA
PR4.5	Provides ability to link and de-link to other Medicaid provider IDs for the same provider, e.g., numbers used before the NPI was established, erroneously issued prior numbers, multiple NPIs for different subparts, etc. Captures/crosswalks subpart NPIs used by Medicare (but not Medicaid) to facilitate COB claims processing.	HIPAA
OPERATIONS MANAGEMENT BUSINESS AREA: REFERENCE DATA MANAGEMENT (RF) CHECKLIST		
RF1 – MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING		
RF1.1	Maintains reasonable and customary charge information for Medicaid and Medicare to support claims processing: • Reimbursement under the Medicaid program for other than outpatient drugs, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Indian Health Services (IHS) and hospital inpatient and outpatient reimbursement is to be the lower of the provider's "usual and customary" charge, the rate established by the State, or the amount, which is allowed under the Medicaid program. "Usual and customary" charges are calculated from the actual charges submitted on provider claims for Medicaid payment. • Reimbursement for prescription drugs are usually processed by either a) Federal Upper Limit (FUL) or Maximum Allowable Cost (MAC) with some drugs; the State defined Estimated Acquisition Cost (EAC), which is defined by the Average Wholesale Price (AWP) less 15 to 20 % plus a	SMM

Req#	Requirement	Type
	dispensing fee (ranging anywhere from 0.50 to several dollars); and/or plus a provider specific dispensing fee; or b) the provider's usual and customary charge, paying the lesser of these fees.	
RF1.2	Supports Payment for Services by providing reference data, including procedure, diagnostic, and formulary codes (42 CFR447).	SMM
RF1.3	Processes change transactions to procedure, diagnosis, and formulary codes and other data and responds to queries and report requests.	SMM
RF1.4	Archives all versions of reference information and update transactions.	IBP
RF1.5	Processes update transactions to the reasonable and customary charge data and responds to queries and report requests.	SMM
RF1.6	Retrieves, as needed, archived reference data for processing of outdated claims or for duplicate claims detection.	SMM
RF1.8	Maintains current and historical reference data used in claims processing.	IBP
RF1.9	Maintains online access to all reference tables with inquiry by the appropriate code.	IBP
RF1.11	Maintains revenue codes; provides online update and inquiry access, including:(a) Coverage information(b) Restrictions(c) Service limitations(d) Automatic error codes(e) Pricing data(f) Effective dates for all items	IBP
RF1.12	Maintains date sensitive parameters for all Reference Data Management data.	IBP
RF1.14	Supports code sets for the payment of Medicaid-covered non-health care services, e.g. waiver services.	HIPAA
RF1.15	Maintains the drug-pricing file, updating it at scheduled cycle.	IBP
RF1.16	Maintains the trauma indicators to identify potential Third Party Liability (TPL) cases.	SMM
RF1.17	Maintains diagnosis and procedure code narrative descriptions of each code contained in the files.	IBP
RF1.18	Updates all procedure, diagnosis and drug files if required prior to each payment cycle.	SMM
RF2 – COMPLY WITH HIPAA REQUIREMENTS		
RF2.1	Manages HIPAA-required external data sets (e.g., ICD-9; NDC).	HIPAA
RF2.2	Maintains all data sets defined by the HIPAA Implementation Guides to support all transactions required under HIPAA Administrative Simplification Rule (e.g., Gender, Reason Code).	HIPAA
OPERATIONS MANAGEMENT BUSINESS AREA: THIRD PARTY LIABILITY (TPL) CHECKLIST		
TP1 – PROVIDE EFFICIENT AND TIMELY IDENTIFICATION AND MAINTENANCE OF TPL RESOURCES		
TP1.1	Provides the storage and retrieval of TPL information including: • Name of insurance company. • Address of insurance company.	SMM

Req#	Requirement	Type
	• Policy number • Group number • Name of policyholder • Relationship to Medicaid Beneficiary • Services covered • Policy period • Multiple resources under one Beneficiary • Group health plan participants • Health Insurance Premium Payment (HIPP) participant	
TP1.2	Provides the storage and retrieval of casualty-related information (e.g., motor vehicle accident and workers' compensation information).	SMM
TP1.3	Identifies and follows up on third party information from all sources.	SMM
TP1.4	Identifies claims with trauma diagnosis codes, accident codes and indicators and routes them for follow-up to see if there is TPL	SMM
TP1.8	Maintains all third party resource information at the Beneficiary–specific level.	SMM
TP1.9	Maintains multiple third party coverage information for individual Beneficiaries for all of their periods of eligibility.	SMM
TP1.17	Identifies claims designated as “mandatory pay and chase”, makes appropriate payments and flags such claims for future recovery (i.e. identifies services provided to children who are under a medical child support order, and flags diagnosis information to identify prenatal care services provided to pregnant women and preventive pediatric services provided to children.	SMM
TP2 – OBTAIN THE MAXIMUM COST AVOIDANCE AND REIMBURSEMENT FOR MEDICAID BENEFICIARIES COVERED BY OTHER INSURANCE		
TP2.1	Screens claims to determine if claims are for Beneficiaries with TPL coverage, if service is covered and if date of service is within coverage period. Denies or suspends, as provided in State rules, claims that are for products or services that are covered. Notifies the provider of claims denied because of TPL coverage.	SMM
TP2.2	Generates automated TPL billing information to providers for beneficiaries with third party coverage.	SMM
TP2.3	Accounts for TPL payments to providers in determining the appropriate Medicaid payment.	SMM
TP2.4	Tracks and reports cost avoidance dollars.	SMM
TP2.5	Allows for payment of claims that would have been rejected due to TPL coverage if provider includes override codes that indicates that benefits are not available.	SMM
TP2.9	Seek recovery of claims previously paid when TPL coverage is identified by billing the third parties using the X12N 837 Coordination of Benefits transaction or a proprietary format.	SMM **CFR** **HIPAA**

Req#	Requirement	Type
TP2.11	Associates third party recoveries to individual claims.	SMM
TP2.13	Designates portions of claim amounts collected to reimburse CMS and the State with any remainder paid to the recipient.	SMM
TP2.15	Identifies Beneficiaries for referral to the Lock-in program.	SSA

APPENDIX E
Business and Technical Requirements

Table of Contents

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.1	**1. Determine Eligibility**			
ME.2	Ability to provide role-based (inquiry vs. update) access to the Member eligibility information using a variety of secure methods, including:			
ME.3	Web portal			
ME.4	By telephone to the Provider Help Desk			
ME.5	Automated Voice Response System (AVRS)			
ME.6	Electronic inquiry through a 270 transaction			
ME.7	Other as identified by BMS during DDI and accepted via formal change control			
ME.8	The Vendor is expected to accept eligibility information from a state-maintained sponsor system. Currently, this system receives eligibility information from Recipient Automated Payment and Information Data System (RAPIDS), and Families and Children Tracking System (FACTS).			
ME.9	The Vendor is required to on a daily basis, process Member eligibility, including Pharmacy, update information received from eligibility sponsor systems (in the sequence in which they were created) for use in claims processing, and generate all applicable update reports according to an agreed-upon processing schedule.			
ME.10	The Vendor is expected to verify that Medical/Dental and Pharmacy POS Member eligibility data match on, at a minimum, a monthly basis. If the two eligibility sources are not in the same database they should be synchronized and reconciled on a schedule that ensures that eligibility data used for all claims adjudication matches between both systems.			
ME.11	The Vendor is expected to transmit an interface file to RAPIDS and FACTS so that required Mountain Health Trust (HMO and PAAS), LTC rates, MHC (Mountain Health Choices), other insurance or Third Party Liability (TPL) and lock in information so that some of this information can be printed on the Medicaid ID cards.			
ME.12	Ability to support flexible rules-based logic (as specified by BMS and Federal guidelines) to determine Member benefit plans.			
ME.13	Ability to identify potential or actual overlaps in program eligibility periods (such as when a client switches from/to Medicaid, State-funded, or any other programs).			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.14	The system is expected to accept conflicting or overlapping eligibility segments, and should apply a hierarchy of business rules to determine which one takes precedence.			
ME.15	The MMIS is expected to accept the Medicaid ID assigned by the eligibility source or through the Master Data Management (MDM) solution.			
ME.16	Ability to accept and maintain eligibility to pay for services provided for Members who are not Title XIX or Title XXI Members.			
ME.17	The system should allow authorized users to manually enter Member eligibility information.			
ME.18	Ability to automatically apply data validation edits during manual entry of Member eligibility information.			
ME.19	**2. Enroll/Disenroll Member**			
ME.20	Capture, retain and report in a roster enrollee choice of provider. It can be either the MCO or the PAAS PCP.			
ME.21	Enrollment broker is to have direct (role-based) user-access to the MMIS. (The enrollment broker enters PCP information for the Health Maintenance Organization (HMO) and the Primary Care Case Management (PCCM) program).			
ME.22	The Vendor is to maintain appropriate benefits package for services for enrolled Member.			
ME.23	Ability to support flexible administration of benefits from multiple programs so that a Member may receive a customized set of services.			
ME.24	Ability to report on duplicate Member records using multiple criteria (e.g., name, SSN) in order to reconcile duplicate enrollment records.			
ME.25	Ability to capture and display from eligibility source head-of-household name. (These pieces of information are currently stored in the member record and do not vary by benefit plan or payor).			
ME.26	Capture and display case number in each individual Member record.			
ME.27	Ability to track and display on one screen: all Members in the case, including individual Members name under that case number; Medicaid ID number; date of birth; PCP/HMO name; and benefit program.			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.28	Ability to store, track and display eligibility source data including but not limited to eligibility codes, termination reason codes, termination dates, etc.			
ME.29	Generate monthly PAAS rosters to be submitted to the PAAS providers monthly.			
ME.30	**3. Manage Member Information**			
ME.31	Capture the Health Improvement Plan (HIP) from the enrollment broker. Generate monthly file to all parties as necessary (e.g., MCO Admin Vendor and MCOs). (The Health Improvement Plan (HIP) is a plan the member must complete with their physician and agree to complete specific health related activities in order to earn healthy rewards. This information is currently sent on a file to the MMIS vendor and loaded into the system).			
ME.32	Ability to accept electronic updates of the Member eligibility data (including updates to existing Member data and creation of new Member records) on a daily basis via batch file from the following or equivalent external systems:			
ME.33	RAPIDS (Recipient Automated Payment and Information Data System).			
ME.34	FACTS (Families and Children Tracking System).			
ME.35	TPL vendor/s as specified by BMS (the Bureau currently only receives TPL information from one vendor).			
ME.36	Enrollment broker/s as specified by BMS.			
ME.37	Other systems as specified by the BMS during DDI.			
ME.38	Ability to support the following functionality in regards to processing updates to the Member data set:			
ME.39	Automatically edit fields for reasonableness, validity, format and consistency with other data present in update transaction.			
ME.40	Transaction reconciliation reporting for file/data reconciliation with external data sources (e.g., totals and detail information, difference reports, change reports). (This requirement applies to reporting only).			
ME.41	Maintains record/audit trail of updates (including time/date, source, type, status of request). Reject files with fatal errors should be returned to source.			
ME.42	Online display of audit trail should include Member add and termination dates, PCP add and termination dates, and user who made the change.			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
ME.43	Error correction/synchronization error reporting – report all failed synchronization.			
ME.44	Ability to perform the following functions:			
ME.45	Maintain identification of all applicants eligible for Medicaid benefits.			
ME.46	Allow for timely updating of the database to include new Members and all changes to existing Member records.			
ME.47	Maintain positive (active, as opposed to passive) control over all data pertaining to Medicaid Member eligibility. (Maintain the data in a safe and secure environment including, but not limited to, appropriate access controls, change management, auditing functionality, and security).			
ME.48	Build and maintain a computer file of Member data to be used for claims processing, administrative reporting, and surveillance and utilization review.			
ME.49	Able to distribute eligibility data to other processing agencies. (This currently includes the three Medicaid Eligibility Verification Systems (MEVS) vendors and the State's eligibility vendors, which are RAPIDS and FACTS. For State eligibility vendors, we provide a monthly reconciliation file).			
ME.50	Provide file space for, and record whenever available, the Social Security Number of each eligible Member.			
ME.51	Contain and use the data necessary to support Third Party Liability recovery activities.			
ME.52	Role-based security providing confidential access for individuals or groups.			
ME.53	Ability to provide external eligibility sources daily access to approved Member eligibility data. (The vendor should propose their preferred method of accommodating this access. This could be through the MEVS vendor, online/portal access by other agency personnel, etc.).			
ME.54	Ability to support online data presence, validity, format, and relationship edits for manually entered updates.			
ME.55	Ability to maintain an audit trail of changes to Member data at the field or line level rather than at a higher tracking level of last change to screen or file.			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
ME.56	Ability to identify recipients with multiple ID numbers for cross referencing, and for unduplicated counts of recipients for reporting purposes.			
ME.57	Ability to automatically or manually populate, maintain and display multiple (at a minimum 15) indicators at the Member level (e.g., disease state management, TBI, MRDD).			
ME.58	Enrollment broker can automate or be able to directly enter information that would be maintained in the Member record.			
ME.59	Ability to allow enrollment brokers to enter Member choice (PCP or HMO) directly into the MMIS.			
ME.60	Ability to allow enrollment brokers to enter notes, comments, etc., into MMIS.			
ME.61	The Vendor is expected to provide RAPIDS an interface containing HMO/PAAS assignments, TPL, and lock-in information 2-3 days prior to the cut-off date to print on the Medicaid ID cards.			
ME.62	Ability to automatically update and edit eligibility information based on information received in Vital Statistics file.			
ME.63	Ability to interface with the Department of Corrections to receive incarceration file.			
ME.64	Send data to RAPIDS for review of Member termination.			
ME.65	Provide an automated link to claims for the Member under current and historical names and ID numbers and display the data.			
ME.66	Ability to track and display all Member current and historical names and ID numbers.			
ME.67	Provide update capability for all Member data for designated BMS staff and make update separate from inquiry.			
ME.68	Allow the user to inquire on Member benefit availability, service limitations, monetary limits, service utilization, and out-of-pocket contributions such as co-pay, deductible, and coinsurance.			
ME.69	Allow direct navigation access to a Member's historical claims, PAs, referrals, and case histories.			
ME.70	Ability to maintain current and historical eligibility data to support the following:			
ME.71	Basic program eligibility verification			
ME.72	Special program eligibility verification			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.73	ID card production (currently the Fiscal Agent provides an interface file that goes to RAPIDS and FACTS which contains Mountain Health Trust, Mountain Health Choices, TPL, and LTC information).			
ME.74	Claims processing			
ME.75	Premium processing			
ME.76	Prior authorization processing			
ME.77	Reporting			
ME.78	Other activities as specified by the BMS during the DDI phase			
ME.79	Ability to maintain a Member data set that contains all data elements, including (but not limited to): (FACTS currently sends different ID numbers for Foster Children vs. State Covered Entities. These numbers are different from the Medicaid ID numbers. Some member IDs are manually entered and are different from RAPIDS and FACTS ID numbers. In the future, the Master Data Management Solution may use different numbering schemes that the MMIS would need to be able to accommodate).			
ME.80	Name			
ME.81	Residence and mailing address(es)			
ME.82	Phone numbers (home, cell, etc.)			
ME.83	E-mail address			
ME.84	Gender			
ME.85	Date of Birth (DOB)			
ME.86	DHHR County Office ID			
ME.87	Member ID number			
ME.88	Unique and/or universal Member identifiers from the eligibility systems			
ME.89	Social Security Number (SSN)			
ME.90	Medical Health Insurance Claim (HIC) Number (Medicare Number)			
ME.91	Race			
ME.92	Ethnicity			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.93	Head of household detail (including but not limited to name, Member ID, SSN)			
ME.94	Rate code or MAS/BOE ("aid category")			
ME.95	Long Term Care			
ME.96	Nursing Home name and Provider ID the Member resides in			
ME.97	Effective/Term dates for stay			
ME.98	Resource amounts (patient responsibility amount)			
ME.99	Resource amounts effective and term dates (patient responsibility amount)			
ME.100	Other as identified by BMS during DDI and accepted via formal change control			
ME.101	Ability to establish unique, date-specific benefit packages for each program applicable to a Member to ensure correct benefit application.			
ME.102	Ability to maintain periods of Medicare eligibility with flexible segments. (Maintaining separate segments for Part A, Part B, and Part D).			
ME.103	Ability to maintain client (member) identification numbers to twelve (12) or more digits.			
ME.104	Ability to cross-reference current and historical Member identification numbers for all eligibility sources.			
ME.105	Maintain and cross-reference Member name changes, including name change date and effective date (the date at which the name change becomes effective).			
ME.106	Ability to maintain accurate, date-sensitive SSN information for foster and adopted children whose SSNs are changed by SSA while protecting confidential client information. (This is date-sensitive SSN information regarding Foster and Adopted Children. Fiscal Agent should be able to maintain all claim history for a member even if his SSN is changed).			
ME.107	Ability to capture and restrict user access to the actual residential address information, including Zip Codes, for protected populations, in addition to publicly disclosed residential addresses.			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.108	Ability to maintain and report Member and other data in order to respond to a request from a Member for an accounting of disclosures of his/her Protected Health Information (PHI), in accordance with HIPAA guidelines.			
ME.109	**4. Inquire Member Eligibility**			
ME.110	The Vendor is expected to maintain a Medicaid Eligibility Verification System (MEVS).			
ME.111	The Vendor is expected to provide each Medicaid Eligibility Verification System (MEVS) vendor daily access to approved Member eligibility data.			
ME.112	The Vendor is expected to provide an Automated Voice Response System (AVRS) which accesses the MEVS information.			
ME.113	The system is expected to provide web portal eligibility verification with at least the same functionality as that which is available via AVRS.			
ME.114	Ability to electronically generate eligibility verification reports based on supplied list (there may be an associated cost to the provider).			
ME.115	The system should maintain a log of all telephone and electronic inquiries to eligibility inquiry systems.			
ME.116	**5. Perform Population & Member Outreach**			
ME.117	Ability to track Member outreach communications detail, including:			
ME.118	Target population			
ME.119	Quality measure/s addressed			
ME.120	Purpose (e.g., implement programs like enrollment campaigns for waiver programs or other plan/benefits change, privacy notice)			
ME.121	Date/s of distribution			
ME.122	Method/s of distribution			
ME.123	Other as identified by BMS during DDI and accepted via formal change control			
ME.124	**6. Manage Applicant & Member Communication**			
ME.125	Ability to generate and distribute Member-related correspondence, reports and associated documents.			

1. Member Management (ME)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
ME.126	Ability to attach Member-related correspondence documents to the Member record.			
ME.127	Periodically generates Member satisfaction surveys.			
ME.128	The system is expected to receive and track summary level mailing data from the enrollment broker for reporting purposes.			
ME.129	**7. Manage Member Grievance & Appeal**			
ME.130	Ability to track PA denials in MMIS.			
ME.131	Provide the ability for BMS to manually flag denied prior authorizations under appeal.			
ME.132	Provide the ability for BMS to run a report of all denied prior authorizations flagged as under appeal.			
ME.133	Provide the ability for BMS to display a report of all denied prior authorizations flagged as under appeal.			
ME.134	The system should support workflow for the appeals and grievances processes.			
ME.135	The system should employ the use of a control mechanism which automatically assigns unique control numbers to monitor, track, and maintain control over all consumer review cases.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.1	**1. Enroll Provider**			
PM.2	Ability to enroll Providers eligible to provide Medicaid services.			
PM.3	Ability to enroll non-traditional Medicaid Providers to support payment of services in the MMIS. For example, taxi/transportation and respite.			
PM.4	Ability to enroll non-Medicaid Providers on behalf of different program or different agency or others as defined by BMS and accepted via formal change control. (No other entities identified at this time, but the Vendor's system is expected to be flexible, scalable, and capable of supporting others).			
PM.5	The Vendor is expected to maintain control over all data pertaining to Provider enrollment (including paper batches and electronic data).			
PM.6	Ability to generate unique tracking numbers for Provider enrollment applications and updates.			
PM.7	Ability to give Providers secure temporary access to the enrollment process and once approved for enrollment, permanent access to the online system.			
PM.8	The system should allow Providers the ability to complete and submit enrollment applications and updates in a secure online environment.			
PM.9	Ability to automatically assign Providers a temporary username/password for the online enrollment process.			
PM.10	Ability to automatically generate to the submitter a receipt notification with a tracking number when an online application and/or update are submitted for review.			
PM.11	Ability to notify Provider that an online update has been received, but requires validation before it becomes effective. (Any update provider would submit. Addition of Medicare number, new address, new certification, etc.).			
PM.12	Ability to allow Providers to access their own information and group owners to access information for all Providers in the group.			
PM.13	Ability to allow Providers access (with appropriate level of security) to retrieve the status of online applications and updates using their application tracking number.			
PM.14	Online screens should provide alternative contact information (e.g., telephone access number, help desk number) for use in case of questions or technical issues.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.15	Ability to allow Providers to view online alerts and notifications generated by BMS or Vendor staff.			
PM.16	The Vendor is to notify Providers of acceptance/rejection as a West Virginia Medicaid Provider (per BMS specifications regarding notification medium and content).			
PM.17	Ability to route online applications and updates to the appropriate staff to work. Configuration of workflow to be defined by BMS during DDI.			
PM.18	Ability to alert appropriate staff that a Provider enrollment application has pended for a certain amount of days as defined by BMS.			
PM.19	Ability to provide forms online and in downloadable format. Specific forms to be defined by BMS during DDI (e.g., applications, addendums, Provider agreements, W-9 form, EFT, change of address, CLIA forms).			
PM.20	Ability to maintain hard and soft (electronic) copies of required Provider enrollment documentation, as defined by the BMS.			
PM.21	The Vendor is to maintain a file of all electronic enrollments, including approved and denied Providers. The specifications of the file (including contents and medium) are to be defined by the BMS.			
PM.22	Ability to purge enrollment tracking data based on parameters defined by the BMS.			
PM.23	Ability to enroll only those Providers who agree to abide by the rules and regulations of the State Medicaid program.			
PM.24	Ability to identify and assign Provider applications and updates by Provider types, as defined by BMS.			
PM.25	Ability to identify and assign Provider enrollment application status, as defined by BMS (e.g., Initial/New, Resubmitted with Modifications, Cancellation).			
PM.26	Ability to identify and display the applicant type, as defined by BMS (e.g., Rendering Provider, Billing Agent, Pay to Affiliations).			
PM.27	Ability to track the date enrollment forms are received for each Provider application.			
PM.28	Ability to automatically identify and terminate a duplicate enrollment request or update, and give the Provider a meaningful error message.			
PM.29	Ability to save partially completed Provider enrollments for a given number of days (to be defined by BMS).			
PM.30	Ability to notify applicants of partially submitted applications.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PM.31	Ability to conduct re-verification of currently enrolled Provider, based on BMS-specified conditions. (Specified conditions will be determined during DDI).			
PM.32	Ability to use a single online Provider enrollment application with required fields or forms that are dynamically driven by Provider or application characteristic/s (as defined by BMS), including:			
PM.33	Applicant type			
PM.34	Provider type			
PM.35	Other as identified by BMS during DDI and accepted via formal change control			
PM.36	Ability to incorporate edits into the dynamic (online) application process to ensure that required fields (as defined by BMS) are completed properly before the application may be submitted.			
PM.37	Ability to verify required licenses and certifications at the time of Provider enrollment, and thereafter, at the time of renewal, and maintain all related information.			
PM.38	Ability to hold application in pending status until pre-approving entity gives authorization to proceed.			
PM.39	Ability to cross-reference license and sanction information with other State and/or Federal agencies. (BMS currently received a monthly file from OIG. A State equivalent is being developed for national use).			
PM.40	Ability to verify certification in other states for participating out-of-state Providers.			
PM.41	Ability to track, display, and maintain verification of enrollment application/record information, including:			
PM.42	Provider Identifiers (e.g., NPI, SSN, EIN)			
PM.43	Sanction status (e.g., HIPDB, NPDB, boards, criminal background checks)			
PM.44	Credentials (e.g., licensure specialty boards, school, affiliations)			
PM.45	Other as identified by BMS during DDI and accepted via formal change control			
PM.46	Ability to use an expedited enrollment process to enroll Out of Network Providers for a limited period of time.			
PM.47	Ability to allow approved users to manually reactivate inactive Providers.			
PM.48	Ability to automatically reactivate inactive Providers, according to criteria defined by BMS.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.49	Ability to track and report a Provider's enrollment activity from receipt of application to final disposition.			
PM.50	Ability to assign unique Provider number when enrollment is approved.			
PM.51	Ability to track and support BMS-established review schedule to ensure Providers continue to meet program eligibility requirements.			
PM.52	Ability to maintain and display history and audit trails for online changes and updates.			
PM.53	Ability to report and maintain enrollment and update activity statistics (as defined by the BMS). For example: number of enrollment applications/updates received hourly, daily, etc.; number of applications/updates pending.			
PM.54	**2. Provider Contracts**			
PM.55	Ability to define procedures and diagnoses a Provider is allowed to render under a Provider's license.			
PM.56	Ability to define types of Provider contracts.			
PM.57	Ability to support flexible rules-based logic (as specified by BMS and Federal guidelines) to define Provider contracting parameters.			
PM.58	Ability to define and easily update (per BMS) the procedures or services a Provider is allowed to provide under a contract.			
PM.59	Ability to define and easily update (per BMS) the procedures or services a Provider is allowed to provide based on a Provider grouping.			
PM.60	Ability to 'model' or create a new contract from an existing contract.			
PM.61	Ability to track and support BMS-established review schedule to ensure Providers continue to meet program eligibility requirements.			
PM.62	Ability to maintain and display history and audit trails for online changes and updates.			
PM.63	Ability to report and maintain enrollment and update activity statistics (as defined by the BMS). For example: number of enrollment applications/updates received hourly, daily, etc.; number of applications/updates pending.			
PM.64	**3. Disenroll Provider**			
PM.65	Ability to allow Providers to submit online request for termination of their Provider agreement.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.66	Ability to identify Provider disenrollment request status, as defined by BMS (e.g., initial, duplicate, resubmitted with modifications).			
PM.67	Ability to validate that disenrollment meets State rules, as defined by the BMS.			
PM.68	Ability to allow users with appropriate authorization to terminate providers.			
PM.69	Ability to process disenrollment requests for the full range of Provider types, organizations, specialties, types of applicants (e.g., primary Provider, billing agent, pay-to entity).			
PM.70	Ability to process disenrollment requests for all application status types (e.g., Initial/New, Modification, Cancellation, Update).			
PM.71	Ability to disenroll Providers after a certain period of inactivity (to be defined by BMS).			
PM.72	Ability to distribute notifications of disenrollment due to sanctions or disciplinary actions to the WV Office of the Inspector General (OIG) and other states.			
PM.73	**4. Inquire Provider Information**			
PM.74	The Vendor is expected to accommodate Provider enrollment verification requests via phone, fax, portal, and other methods (as specified by BMS during DDI and accepted via formal change control).			
PM.75	Ability to log and track all Provider information requests, including:			
PM.76	Name of requesting party			
PM.77	Date of inquiry			
PM.78	Parameters used in system query			
PM.79	User name (of user querying system)			
PM.80	Validation of Authorization detail			
PM.81	Date/time information queried in system			
PM.82	Date/time information sent to requester			
PM.83	Other as identified by BMS during DDI and accepted via formal change control			
PM.84	Ability to support entry of free-form text field that allows narratives (of a length defined by the BMS) for each Provider information inquiry. Each entry is expected to include identification of user and date/time entered.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.85	Ability to display free-form narrative in chronological or reverse chronological sequence.			
PM.86	**5. Manage Provider Communication**			
PM.87	Ability to generate and distribute Provider-related correspondence, information requests, and notifications, including:			
PM.88	Enrollment applications			
PM.89	Enrollment rejection notifications			
PM.90	Billing instructions			
PM.91	Relevant State policy information			
PM.92	Request for information to support enrollment/contracting process			
PM.93	Mailing labels			
PM.94	Program memorandum			
PM.95	Notifications of pending expired Provider eligibility			
PM.96	Other as identified by BMS during DDI and accepted via formal change control			
PM.97	Ability to maintain a record (including an audit trail) of all communication sent to Providers.			
PM.98	Ability to maintain a record (including an audit trail) of all communication received from Providers.			
PM.99	Ability to maintain an Inquiry Log which identifies each Provider inquiry (electronic, written or telephone) by name, date, nature of the inquiry, and outcome.			
PM.100	Ability to track and maintain working files of historical Provider inquiries. Common inquiries (e.g., eligibility, payment status, and billing questions) are to be logged and documented in these files.			
PM.101	The BMS is to have the ability to view and update the Provider Inquiry Log.			
PM.102	Ability to track and report Provider inquiries regarding billing and submission practices.			
PM.103	Ability to allow Provider correspondence to be generated or suppressed according to BMS defined parameters.			
PM.104	Ability to allow users to choose between standard/routine Provider correspondence, or to develop customized correspondence.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.105	Ability to track and notify Providers of date-dependent events, as defined by BMS (e.g., review dates).			
PM.106	Ability to refer Providers to appropriate licensing board (according to criteria defined by BMS).			
PM.107	Ability to allow users to view Provider labels, letters, and listings online or on paper.			
PM.108	Ability to suppress Provider's ID number from labels, envelopes and other correspondence, as required.			
PM.109	Ability to suppress Member's ID number from labels, envelopes and other correspondence, as required.			
PM.110	Provider notifications should be linked to related documentation in the system.			
PM.111	**6. Manage Provider Appeal**			
PM.112	Ability to support appeals for prospective and current Providers.			
PM.113	Ability to track Provider appeal detail, including:			
PM.114	Issue detail			
PM.115	Filing party			
PM.116	Reviewer/s			
PM.117	Process status (initial, second, expedited, withdrawn, disposed)			
PM.118	Review/hearing date/time			
PM.119	Hearing ruling			
PM.120	Disposition			
PM.121	Other as identified by BMS during DDI and accepted via formal change control			
PM.122	Ability to support entry of free-form text field that allows narratives (length to be defined by BMS) for each Provider grievance/appeal that identifies user and date/time entered.			
PM.123	Ability to display free-form narrative in chronological or reverse chronological sequence.			
PM.124	Vendor should filter Provider correspondence to verify that it meets the criteria (as defined by BMS) to qualify as a grievance prior to submitting to the BMS.			
PM.125	Ability to support grievance/appeals process work flow, including automatic notification to appropriate parties (as defined by the BMS).			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PM.126	**7. Manage Provider Information**			
PM.127	Ability to perform data exchanges to obtain Provider data from licensing boards, CMS, DEA, the NPI enumeration contractor, and other BMS specified sources.			
PM.128	Ability to identify and display the source of any data that is obtained from an external source.			
PM.129	Ability to generate automatic notification to the Provider when information is received from external sources to update Provider records (as defined by BMS).			
PM.130	Ability to provide role-based access to authorized users to perform mass updates to Provider data, based on flexible selection criteria.			
PM.131	Ability to provide role-based access to authorized users, allowing online update and inquiry capabilities of the Provider information files.			
PM.132	Ability to provide online, real-time, role-based access to the Provider information using a variety of secure methods, including:			
PM.133	Web			
PM.134	WAN/LAN			
PM.135	Point-of-service devices			
PM.136	Other as identified by BMS during DDI and accepted via formal change control			
PM.137	Ability to integrate with the following systems to allow users to access and/or enter/edit Provider data:			
PM.138	Medicaid Provider Web Portal			
PM.139	Automated Voice Response System (AVRS)			
PM.140	Electronic Document Management System (EDMS)			
PM.141	Other systems as specified by the BMS during DDI			
PM.142	Ability to maintain and display an audit trail of all changes to Provider attributes, including date/time and username/source of change (for an amount of time to be defined by BMS).			
PM.143	Ability to identify the NPIs of prescribers for Pharmacy purposes.			
PM.144	Ability to identify crossover-only Providers.			
PM.145	The Vendor should update Provider information as follows:			
PM.146	Perform authorized updates on a daily (or otherwise specified) basis with online updates.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.147	Perform updates using full transaction files received.			
PM.148	Perform mass Provider updates as directed by BMS.			
PM.149	Ability to provide authorized users access to current Provider information (e.g., PAs and referrals, Claims, correspondence).			
PM.150	Ability to provide online inquiry or look-up of historical Provider information (including enrollment records of terminated Providers), searchable by entering complete or partial identifying information, including:			
PM.151	Medicaid Provider ID			
PM.152	Provider name			
PM.153	National Provider Identifier (NPI)			
PM.154	Medicare number			
PM.155	Social Security Number (SSN)			
PM.156	Phone number			
PM.157	Employer Identification Number (EIN)/Taxpayer Identification Number (TIN)			
PM.158	Federal Drug Enforcement Agency (DEA) number			
PM.159	Previous Identifier(s) (so that all data is historically maintained)			
PM.160	Phonetic search			
PM.161	Other identifiers used by the BMS			
PM.162	Ability to provide authorized users limited role-based access to archived Provider data.			
PM.163	Ability to uniquely identify each Provider, allowing for the association of multiple standardized and user-defined identifiers and qualifiers, including:			
PM.164	National Provider Identifier (NPI)			
PM.165	Former Medicaid ID number			
PM.166	Federal Drug Enforcement Agency (DEA) number			
PM.167	National Council of Prescription Drug Programs (NCPDP) number			
PM.168	Other as identified and/or defined by BMS during DDI and accepted via formal change control			
PM.169	Ability to maintain an online cross-reference of BMS-assigned identifier to all other identifiers maintained for a Provider.			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.170	Ability to maintain an online cross-reference of a Provider's Tax ID number(s) in the event that a new ID is issued to an existing Provider.			
PM.171	Ability to identify when multiple BMS-assigned Provider numbers are assigned to a single Provider.			
PM.172	Ability to maintain CLIA information.			
PM.173	The system should have an automated process that verifies CLIA numbers (e.g., interface with CMS, Health and Human Services (HHS) and Centers for Disease Control (CDC) that monitors CLIA).			
PM.174	Ability to use consistent Provider naming conventions to differentiate between first names, last names, and business or corporate names or DBA (Doing Business As) names and to allow flexible searches based on Provider name.			
PM.175	Ability to display claims summary information by Provider, including total number of claims submitted, pended, denied, paid and the total dollar amounts (billed and paid amounts) of each category. Reporting periods to be determined by BMS (e.g., calendar month-to-date, Medicaid processing month-to-date, calendar year, Provider fiscal year, Federal/State fiscal year).			
PM.176	Ability to identify the Provider Program(s) the Provider is participating in, including but not limited to:			
PM.177	State Plan Medicaid			
PM.178	Ryan White Program			
PM.179	Juvenile Services Benefit Plan			
PM.180	Tiger Morton Benefit Plan			
PM.181	Mental Retardation/Developmentally Disabled (MRDD) waiver			
PM.182	Aged Disabled waiver			
PM.183	Children's Health Insurance Plan (CHIP)			
PM.184	Breast and Cervical Cancer Program			
PM.185	Birth to Three Benefit			
PM.186	Other as identified by BMS and accepted via formal change control			
PM.187	Ability to associate multiple service locations to the same Provider base identifier. (Service locations are not currently used in claims billing or claims processing and are not captured in the service location claim field).			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.188	Ability to identify multiple practice locations for a single Provider and associate all relevant data items with the location, such as address and CLIA certification.			
PM.189	Ability to maintain group affiliations and managed care enrollment.			
PM.190	Ability to affiliate individual Providers to their group(s) (i.e., program(s)).			
PM.191	Ability to associate a group with all individual Providers.			
PM.192	Ability to associate an unlimited number of Providers with a single group.			
PM.193	Ability to define Providers and Provider groups that share common ownership.			
PM.194	Ability to identify the type of Provider ownership arrangement.			
PM.195	Ability to transfer Provider ownership without re-entry of duplicate information.			
PM.196	Ability to identify, cross reference, and link one Provider owner to many rendering Providers and one rendering Provider to many owners.			
PM.197	Ability to process changes in Provider ownership in which a new owner assumes liability for all activity performed by the Provider prior to the ownership change.			
PM.198	Ability to establish Provider pay-to affiliations in a way that accommodates actual practicing locations and Federal and State tax requirements (one 1099 per taxable entity).			
PM.199	Ability to identify the affiliation a physician may have with a hospital or multiple hospitals and indicates what types of privileges they have.			
PM.200	Ability to maintain corporate names with a naming structure for corporations that do not have first and last names.			
PM.201	Ability to track and maintain licensing, credentialing, sanction and certification information that includes:			
PM.202	Type, specialty, and sub-specialty			
PM.203	Taxonomy			
PM.204	Certification begin and end dates			
PM.205	Certification type code			
PM.206	Certifying agency			
PM.207	Certifying state			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PM.208	Verification type			
PM.209	Verification date			
PM.210	Verification due date			
PM.211	License ID			
PM.212	Sanctioning agency			
PM.213	Sanctioning state			
PM.214	Sanction begin and end dates			
PM.215	Other as identified by BMS during DDI and accepted via formal change control			
PM.216	The system should support automatic re-verification of credentials on a periodic basis by program and Provider type, by identifying and notifying when Provider credentials are expiring (notification may include e-mail and/or letters).			
PM.217	Provider enrollment/screening should be conducted in compliance with PPACA rules and regulations (e.g., ownership and ownership exclusions are to be screened as directed under PPACA).			
PM.218	Ability to enter, store, display and access Provider data, including:			
PM.219	Provider Number			
PM.220	Provider name			
PM.221	Facility name			
PM.222	Billing name			
PM.223	Provider license number			
PM.224	IRS name			
PM.225	Provider type - with the flexibility to accommodate and maintain non-medical Providers on the Provider master and affiliates.			
PM.226	Provider title			
PM.227	Multiple mailing addresses			
PM.228	Multiple practice addresses			
PM.229	Ownership information			
PM.230	Change in ownership information			
PM.231	Long-term care facility data, including:			
PM.232	Number of beds by licensed level of care			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.233	WV DHHR Office of Health Facility Licensure and Certification (OHFLAC) certification/re-certification			
PM.234	Physical address and contact information of the facility			
PM.235	Other as identified by BMS during DDI and accepted via formal change control			
PM.236	Payment address			
PM.237	County number			
PM.238	Multiple phone numbers			
PM.239	Fax number			
PM.240	Multiple e-mail addresses			
PM.241	Web site url			
PM.242	Drug Enforcement Agency (DEA) number - including historic data with effective and end dates			
PM.243	National Council for Prescription Drug Programs (NCPDP) number - including historic data with effective and end dates			
PM.244	Employer Identification Number (EIN)/Taxpayer Identification Number (TIN) and effective and term dates			
PM.245	Social Security Number (SSN)			
PM.246	Provider CLIA (Clinical Laboratory Improvement Amendments) number and related address			
PM.247	Medicare numbers			
PM.248	Managed Care Organization (MCO) affiliations			
PM.249	Group number			
PM.250	Specialty/sub-specialty data			
PM.251	License and certification data			
PM.252	Date of birth			
PM.253	Date of death			
PM.254	Gender			
PM.255	Language			
PM.256	Additional training or certification indicator			
PM.257	Restrictions on dispensing of specific drugs			
PM.258	Provider enrollment status codes with associated effective and end dates			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.259	Provider program eligibility with associated effective and end dates			
PM.260	Contractual terms, including:			
PM.261	Services contracted to provide			
PM.262	Performance measures (service level agreements and KPIs)			
PM.263	Reimbursement rates			
PM.264	Summary level payment data which is automatically updated after each claims processing payment cycle by the following:			
PM.265	Calendar week-to-date			
PM.266	Calendar month-to-date			
PM.267	Calendar year-to-date			
PM.268	State fiscal year-to-date			
PM.269	Federal fiscal year-to-date			
PM.270	1099 reported amount (current and prior year)			
PM.271	Ownership date			
PM.272	Physician Assured Access System (PAAS) indicator			
PM.273	Fee-for-service (FFS) indicator			
PM.274	Crossover indicator			
PM.275	Suspended/Suspension indicator			
PM.276	Suspended/Suspension effective and terminated dates			
PM.277	Primary Care Case Management (PCCM) indicator			
PM.278	Out-of-state Provider indicator			
PM.279	Rural, urban, or teaching hospital indicator			
PM.280	Electronic Funds Transfer (EFT) information			
PM.281	Electronic Claims Management (ECM) data			
PM.282	Billing restriction data, with applicable begin and end dates			
PM.283	Medical degree information.			
PM.284	Providers PCP panel information including:			
PM.285	Accepting new patient indicator			
PM.286	Age range			
PM.287	Gender			

2. Provider Management (PM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PM.288	Authorized enrollment			
PM.289	Current enrollment/maximum enrollment and number left			
PM.290	Other as identified by BMS during DDI and accepted via formal change control			
PM.291	Ability to identify Provider 'on call' information to capture 'covering for' and 'covered by' Providers.			
PM.292	Ability to provide an free-form text narrative (length to be determined by BMS) at the base-Provider level that:			
PM.293	Identifies the user, date, and time entered.			
PM.294	Provides the capability to display free form narrative in chronological or reverse chronological sequence.			
PM.295	Includes an associated user-defined special condition code/flag (for classification/reporting purposes).			
PM.296	Ability to report on the special condition code/flag.			
PM.297	Ability to define the relationship between a Provider and an EDI submitter as well as billing agent.			
PM.298	**8. Perform Provider Outreach**			
PM.299	Ability to track Provider outreach communications detail, including:			
PM.300	Target population			
PM.301	Issues or measure/s addressed (e.g., new immigrant population in need of language compatible Providers)			
PM.302	Purpose (e.g., corrections to billing practice, public health alerts, public service announcement)			
PM.303	Date/s of distribution			
PM.304	Method/s of distribution			
PM.305	Other as identified by BMS during DDI and accepted via formal change control			
PM.306	Ability to perform Provider outreach to both prospective and current Providers.			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM1.1	**1. Authorize Referral**			
OM1.2	Ability to adjudicate claims for PAAS Member service referrals from the Member's PCP to another Provider, using the standard fee-for-service claims processing rules.			
OM1.3	Ability to verify Member eligibility and PAAS participation during referral claim processing.			
OM1.4	Ability to verify PAAS referral during claim processing.			
OM1.5	Ability to conduct claims edits/audits for referral claims according to BMS business rules.			
OM1.6	**2. Authorize Services**			
OM1.7	The Prior Authorization component of the system should integrate with the Claims component.			
OM1.8	Claim processing performs Prior Authorization validation.			
OM1.9	The Prior Authorization component should be integrated with the web portal, AVRS, EDI and EDMS components.			
OM1.10	Ability to access (or extract) data in other BMS system files to obtain reference information, including service limitations, to update PA records. The prior authorization file should interface with, as a minimum, Claim Processing, Provider Management Data Store, Member Management Data Store, and reference systems.			
OM1.11	Ability to interface with MMIS to identify procedure codes that require PA (medical utilization requirements).			
OM1.12	Ability to accommodate additions and updates of prior authorizations by interface.			
OM1.13	The Vendor is expected to support on-line entry and interface entry of prior authorization data with other prior authorization vendors.			
OM1.14	The system is expected to provide real-time access via various methods (e.g., Web, AVRS, WAN/LAN workstations) for PA status inquiries.			
OM1.15	Ability to support submission of prior authorizations by other State agencies, other vendors, and BMS. (The Vendor is expected to be responsible for providing the prior authorization part of the MMIS system. In some cases the vendor will be expected to key PAs into the system. Prior Authorization review is to be performed by BMS or by the prior authorization vendor).			
OM1.16	Ability to allow users to submit a PA request on the Provider's behalf.			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM1.17	Ability to accept and create PAs from MDS data for nursing facilities. (MDS is the Minimum Data Set which is a federally mandated assessment to be completed for all nursing home residents that reside in Medicare and Medicaid certified beds).			
OM1.18	Ability to accommodate future versions of the HIPAA electronic PA transactions.			
OM1.19	Ability to ensure all known and emerging BMS and Federal policy changes are reflected in the maintenance of the PA data repository.			
OM1.20	Ability to maintain and easily retrieve Provider-specific and Member-specific PA history.			
OM1.21	Ability to accept on-line, real-time inquiry, entry and update of PA requests, including initial entry of PA requests pending determination.			
OM1.22	Ability to allow Providers to submit PA requests electronically or through the web portal.			
OM1.23	Ability to provide an on-line tutorial for PA application to guide users through the screens necessary to complete to request a PA.			
OM1.24	Ability to allow for electronic submission of PA request attachments (e.g., EDI 275, HL7).			
OM1.25	Ability to allow PA request forms to be available online for download by users.			
OM1.26	Ability to automatically generate and distribute the necessary (i.e., specific to the situation / PA requirements) BMS-approved PA request forms and attachments to Providers.			
OM1.27	Ability to integrate prior authorization-related correspondence, reports and associated documents with the EDMS component.			
OM1.28	Ability to support PA entries for medical services such as (but not limited to) the following:			
OM1.29	Vision			
OM1.30	Dental			
OM1.31	Durable Medical Equipment (DME)			
OM1.32	Surgical procedures			
OM1.33	Other as identified by BMS during DDI and accepted via formal change control			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM1.34	Ability to process PA requests for covered services excluded from the long-term care all-inclusive rate (e.g., Physician services, Hospital, etc.) or an indicator that serves to deny their services for purposes of reporting.			
OM1.35	Ability to automatically provide PA staff (during PA process) with information when Member is a LTC facility resident/inpatient. Information should include:			
OM1.36	Level of Care (LOC)			
OM1.37	LOC effective dates			
OM1.38	Name of facility			
OM1.39	Medicaid Provider Number			
OM1.40	LTC facility date spans			
OM1.41	Spend-down amount			
OM1.42	Patient Liability Amount (PLA)			
OM1.43	PLA effective dates			
OM1.44	Ability to submit and approve retrospective authorizations.			
OM1.45	Ability to interface with MMIS and populate PA screens with PA information to be determined during design.			
OM1.46	Ability to generate a unique tracking number for PA requests.			
OM1.47	Ability to automatically notify submitter of successful submission and display the tracking number.			
OM1.48	Ability to assign a unique PA number as soon as the submitted request is approved.			
OM1.49	Ability to accept and retain the PA number submitted by the PA vendor.			
OM1.50	Ability to use tracking number to link attachments submitted by mail to electronic PA request.			
OM1.51	Ability to use tracking number to link attachments submitted electronically to electronic PA request.			
OM1.52	Ability to recognize both the NPI and former Medicaid ID number.			
OM1.53	The system should have the ability to capture and display PA data which includes, at minimum, the following:			
OM1.54	PA number			
OM1.55	Member ID			
OM1.56	Service code/s			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM1.57	Procedure/NDC code			
OM1.58	Modifier codes			
OM1.59	Billing, rendering, and referring Provider information, including name, and Provider ID/NPI			
OM1.60	Dates of service			
OM1.61	Effective and term date of PA			
OM1.62	Requested effective date of PA			
OM1.63	Units of service expressed as days, quantity per day, number of services, dollars, tooth number/letter, tooth surface			
OM1.64	Quantity used			
OM1.65	Miscellaneous codes w/ notes field (for contractors)			
OM1.66	Rates			
OM1.67	Member Rate code			
OM1.68	Dollar cap			
OM1.69	Local Provider information			
OM1.70	Limits (including calendar month limits)			
OM1.71	Room and board			
OM1.72	Waiver start date			
OM1.73	Manufacturer product number			
OM1.74	Status of the PA request (including pending, denied, approved, and modified)			
OM1.75	Date approved			
OM1.76	History of all actions taken on PA request, including amendments			
OM1.77	Date of last change, ID of person changing, and information changed for each PA record			
OM1.78	ID of authorizing person			
OM1.79	Other as identified by BMS during DDI and accepted via formal change control			
OM1.80	Ability to allow the identification of the principal procedure and date, and the inclusion of five additional procedures and dates.			
OM1.81	Ability to include descriptions of codes in the PA request.			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM1.82	Ability to allow for expansion and addition of fields to the on-line PA request form.			
OM1.83	Ability to provide a free-form text narrative (length to be approved by BMS) at the base PA level and at functional levels that:			
OM1.84	Identifies and displays the user, date, and time entered			
OM1.85	Provides the capability to display free form narrative in chronological or reverse chronological sequence			
OM1.86	Ability to accommodate flexible time span dates for PA (by calendar month, calendar year, rolling month, and other as defined by BMS).			
OM1.87	Ability to apply the method and hierarchy of PA processing criteria as defined by BMS.			
OM1.88	Ability to automatically approve certain PA requests based on information entered (as identified by BMS).			
OM1.89	Ability to perform comprehensive on-line and batch edits to ensure the integrity of prior authorization data.			
OM1.90	Ability to run edits on submitted PA requests, such as the following:			
OM1.91	Relationship edits			
OM1.92	Field length/type			
OM1.93	Character type			
OM1.94	Ability to edit PAs on-line for the presence of required data to include:			
OM1.95	Valid Provider ID and eligibility			
OM1.96	Valid procedure and diagnosis codes			
OM1.97	Presence of required claim type-specific data on the PA			
OM1.98	Covered service			
OM1.99	Allowed dollar amounts/unit			
OM1.100	Other as identified by BMS during DDI and accepted via formal change control			
OM1.101	Ability to automatically alert Providers of the need for additional information (e.g., HIPAA 278 transaction, pdfs), providing return messages that clearly describe necessary action.			
OM1.102	Ability to reject PA request if it does not pass all edits.			
OM1.103	Ability to automatically notify the submitter of failed PA submission and identify which field(s) did not pass edits.			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM1.104	Ability to automatically generate Provider alerts and notifications, to include:			
OM1.105	The need for additional information on an already submitted PA request			
OM1.106	Reminders of missing information			
OM1.107	System updates/policy changes			
OM1.108	Duplicate or possible duplicate requests			
OM1.109	Ability to automatically notify users of duplicate or possible duplicate PA requests for on-line PAs as well as PAs submitted via the interface files.			
OM1.110	Ability to identify and reject duplicate PAs across all PA types based on user configurable criteria including:			
OM1.111	Client identifier			
OM1.112	Rendering Provider identifier			
OM1.113	Service from and through dates			
OM1.114	Diagnosis code(s)			
OM1.115	Procedure code(s), revenue code(s)			
OM1.116	Other as identified by BMS during DDI and accepted via formal change control			
OM1.117	Ability to allow Providers access to pended PAs for near real-time corrections, but only have access to certain data fields (those fields that need to be corrected).			
OM1.118	Ability to alert/notify specified staff when an on-line PA request pends. Notification should identify and briefly describe the edit that caused the PA request to pend/suspend.			
OM1.119	Ability to retain incomplete PA request submissions for a minimum number of days, to be defined by BMS, before deleting the record.			
OM1.120	When a Member record is not on file, an electronic PA should be re-cycled (i.e., resubmitted for processing) for 30 days before being included in the PA rejection file.			
OM1.121	Ability to notify the Provider following the approval or denial of a PA.			
OM1.122	Ability to automatically generate approval or denial notices as soon as the determination has been made.			
OM1.123	Ability to support role-based override capabilities for individual edits by authorized user.			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM1.124	Ability to identify those individuals who authorized and performed an override.			
OM1.125	Ability to accept PAs for a terminated Member for eligible dates of services.			
OM1.126	Ability to maintain PA active status when Member loses eligibility.			
OM1.127	Ability to allow staff to suspend PA requests, based on BMS rules, and identify the PA suspense status. Notify Provider electronically or in a written format (e.g., mail) with results of PA clerical and/or clinical reviews and request additional information that is required from the Provider.			
OM1.128	Ability to allow staff to select the reason codes explaining the disposition of the request when a PA denies/approves.			
OM1.129	Ability to allow staff to query PA history on-line, and filter and sort results based on select criteria defined by BMS (e.g., Member, Provider, procedure code).			
OM1.130	Ability to link to eligibility data when reviewing the PA request.			
OM1.131	Provide authorized PA staff information about the Member's participation or enrollment in other programs that would affect the disposition of the PA without having to move to another application or environment.			
OM1.132	Ability to auto-populate the PA number at the claim line level regardless of Provider submission.			
OM1.133	The system should allow Providers to view remaining/unused units authorized.			
OM1.134	Ability to make authorization data available to BMS staff, if other vendors or organizations perform authorizations, to the same extent the information would be available if BMS performed the PA function.			
OM1.135	Ability to provide PA search options, including search by PA number.			
OM1.136	Ability to return multiple PAs if more than one match is found.			
OM1.137	Ability to provide multiple users with simultaneous, on-line, role-based access to a PA request, but build in features that would preclude simultaneous edits by multiple users.			
OM1.138	Ability to allow users to amend a PA record multiple times and display the history on-line.			
OM1.139	Ability to provide PA audit trail capability to:			
OM1.140	Track and report all PA related changes			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM1.141	Identify the individual who modified the system data			
OM1.142	Record the date that the modification occurred			
OM1.143	Display an audit trail of all PA processing steps			
OM1.144	View on-line all PA audit trail information			
OM1.145	Other as identified by BMS during DDI and accepted via formal change control			
OM1.146	Ability to process the PA and limit the price for a service to the amount authorized on the PA.			
OM1.147	Ability to maintain the authorized PA price.			
OM1.148	Ability to develop business rules which dictate whether the rate established under the PA approval takes precedence over other payment rules (e.g., lesser of billed charges cannot exceed the maximum fee scheduled) or vice versa. Assure that, if non-PA pricing rules take precedence, pre-determined override procedures and business rules are followed to make special pricing exceptions requiring that special documentation be completed for the override to work.			
OM1.149	Ability to provide flexibility to allow waiver PAs to be capped at a dollar amount at the consumer level, at the service level, at the Provider level or any combination that can be controlled and/or measured through available claim/PA file data (as determined by business rules approved by BMS).			
OM1.150	Ability to approve service authorization requests for waiver services up to a specific dollar amount.			
OM1.151	Ability to prohibit PA approval from occurring (i.e., PA should not force the claim to pay) if BMS business rules prohibit coverage of the service.			
OM1.152	Ability to assure that, when an overall service requiring PA results in the submission of multiple claim types from a variety of Provider types, the disposition of all PA requests are consistent with one another (if the methodology requires a separate PA request for each claim to be submitted). The system should link or bundle all related PAs so that the disposition is the same across all Providers. (For example, if gastric-bypass surgery requires PA, the disposition for the hospital facility payment, the surgeon's payment, and the anesthesiologist's payment should be consistent (e.g., approved, denied, deferred, etc.).			
OM1.153	The system should allow users to call up PA requests with a linked or bundled relationship as a complete service package.			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM1.154	Ability to handle HCPCS codes with a minimum of four (4) modifiers. When processing prior authorized claims, the system should match the PA-required procedure codes submitted on the claim against the approved PA request at the modifier, or if applicable, at the multiple modifier level.			
OM1.155	Ability to automatically link the paid claim record with the PA record.			
OM1.156	Ability to update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars, during each PA request period. This information should be captured and displayed with PA history.			
OM1.157	Ability to provide dual limitation (e.g., total units/year with a monthly limit) controlling the dispensing of services over a long period of time.			
OM1.158	Ability to identify service categories that are subject to the same limitation and accumulate the same combination of services. Use combined services to compare to service authorization limit.			
OM1.159	Ability to allow for modification to the scope of services authorized and extend or limit the effective dates of authorization.			
OM1.160	Ability to update PA records based on claims processing to restore reversed units to the PA, during each PA request period.			
OM1.161	Ability to amend authorizations past the end date.			
OM1.162	Ability to identify and review PA requests for which an appeal has been submitted (including those that are approved and on appeal), indicate the outcome of such reviews, and identify PAs for which an appeal has been filed.			
OM1.163	Ability to automatically identify active or pended PA records when a reference file has been updated (e.g., procedure code, Provider ID), generate a report and request an update as necessary.			
OM1.164	The system should provide statistical and operational reporting capabilities.			
OM1.165	Ability to report and maintain web portal PA activity statistics.			
OM1.166	Ability to automatically generate a letter to the Provider for BMS entered authorizations. The letter is to include the PA number.			
OM1.167	Ability to provide PA-related correspondence functions to include the following:			
OM1.168	Template development and the ability for users to select desired correspondence from a list of available templates			

3. Operations Management (OM) OM1. Service Authorization				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM1.169	Display, print, and save PA-related correspondence via the EDMS component of the MMIS			
OM1.170	Regenerate correspondence			
OM1.171	Allow users to suppress or allow auto generation of correspondence based on user configurable event-driven criteria			
OM1.172	Allow users to insert and override address information on correspondence			
OM1.173	Allow users to add free form text to individual or groups of PA correspondence			
OM1.174	Other as identified by BMS during DDI and accepted via formal change control			
OM1.175	Ability to automatically alert staff via email that letters/notifications have been generated.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.1	**1. Claims Processing**			
OM2.2	Ability to provide and maintain a claims processing component with the capability to process electronic and paper transactions.			
OM2.3	Ability to perform real-time adjudication of claims.			
OM2.4	Ability to process all standard claim types, including:			
OM2.5	Institutional (UB-04, 837-I)			
OM2.6	Professional (CMS-1500, 837-P)			
OM2.7	Dental (ADA, 837-D)			
OM2.8	Pharmacy (NCPDP current and future versions (electronic) or Universal claim form (paper))			
OM2.9	Ability to provide a Claims Processing component that offers the following functionality:			
OM2.10	Claim Entry and Editing			
OM2.11	Claim Auditing			
OM2.12	Claims Inquiry			
OM2.13	Claims Tracking			
OM2.14	Batch Control (Batch Control is used for paper claims. Currently these are batches of 50 claims. A report is also produced as these claims are sent to a keying organization. The Batch Control report verifies that all claims in a batch are accounted for).			
OM2.15	Quality Control			
OM2.16	Pricing			
OM2.17	Claim Output (Claim Output would be used in interface files or in reporting. The formats of Claim Output would be discussed in DDI).			
OM2.18	Suspense (pend) Correction			
OM2.19	Interface with POS system			
OM2.20	Third Party Liability			
OM2.21	Month-End Processing			
OM2.22	1099 Adjustments			
OM2.23	Claims History File			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.24	Attachments			
OM2.25	Claim Forms			
OM2.26	Automated procedure code editing which allows acceptance of nationally recognized modifiers			
OM2.27	Claim Disposition (for all claim types, according to BMS and Federal processing rules)			
OM2.28	Electronic Media Claims			
OM2.29	Claim Payment			
OM2.30	Accounts Payable Management			
OM2.31	Accounts Receivable Management			
OM2.32	Provider Credits and Adjustments Processing			
OM2.33	Explanation of Medical Benefits (EOMB) Processing			
OM2.34	Diagnosis Related Group (DRG) Processing			
OM2.35	Resource Based Relative Value Scale (RBRVS) Processing			
OM2.36	APC (Ambulatory Patient Classification) Processing (OPPS, out-patient prospective processing system)			
OM2.37	Prior Authorization (PA) Processing			
OM2.38	Refund Function at Header and Line Level (for all medical, dental and pharmacy claims)			
OM2.39	Gross payment for Med/Dent and Pharmacy POS			
OM2.40	Adpay for Med/Dent and Pharmacy POS (an adpay is a financial, non-member specific transaction/claim created to issue certain types of payments such as DSH to providers).			
OM2.41	Manage Member Incentive Programs			
OM2.42	Produce Check Files			
OM2.43	Produce Remittance Advice			
OM2.44	Other as identified by BMS during DDI and accepted via formal change control			
OM2.45	Ability to accept all HIPAA formatted electronic claims submissions.			
OM2.46	The system should not accept non-HIPAA compliant codes or characters into the system.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.47	Ability to identify Members with other insurance (including, but not limited to, Medicare Part A, B, and D).			
OM2.48	Ability to collaborate with Medicare intermediaries, Part A, B and D, on an ongoing basis to receive and process cross-over claims through the Medicare electronic data submission system.			
OM2.49	Ability to identify and process pay-and-chase claims (including subrogation). Capture other insurance allowed and payable amounts.			
OM2.50	Ability to identify TPL and assure that the Title XIX program is the payer of last resort in accordance with the State plan.			
OM2.51	Ability to process claims for populations that are not Title XIX.			
OM2.52	The claims processing component is expected to integrate with all other functional areas of the MMIS, including Member, Provider, Benefit Plans, Prior Authorizations, Contracts, Pharmacy, Referrals, Reference (including Correct Coding Initiative, editing), enhanced claim editing, other insurance, and Financial.			
OM2.53	Adjudicated claims cannot be changed outside an approved adjustment process. Once a claim is adjudicated and in a final status, the information is to remain static while it is displayed (e.g., users may not cut claim information from claim lines/data).			
OM2.54	Ability to provide a free-form text narrative (length/number of characters to be approved by BMS) on the claim record that:			
OM2.55	Identifies the user, date, and time entered			
OM2.56	Provides the capability to display free form narrative in chronological or reverse chronological sequence			
OM2.57	Includes an associated user-defined special condition code/flag			
OM2.58	Ability to report on the special condition code/flag.			
OM2.59	Other as identified by BMS during DDI and accepted via formal change control			
OM2.60	**2. Claims History File**			
OM2.61	Ability to maintain a full historical record, which includes edit, audit, and resolution information, from initial receipt to paid status.			
OM2.62	Ability to capture and store adjudication details to include payments, contracts, discount adjustments, and patient liability.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.63	Ability to capture and store the data that is derived during claims processing functions.			
OM2.64	Ability to use historical records of client eligibility for claims processing functions.			
OM2.65	**3. Claims Management / Claims Capture and Controls**			
OM2.66	The system is expected to capture and control claims data from the time of initial receipt through the final disposition, payment and archiving on claims history files.			
OM2.67	Ability to employ the use of a claims control mechanism which automatically assigns unique control numbers to monitor, track, and maintain control over claims, adjustments and financial transactions.			
OM2.68	Ability to maintain accurate and complete registers and audit trails of all processing.			
OM2.69	Ability to provide claims audit trail capability to:			
OM2.70	Track and report all claim related changes			
OM2.71	Identify the individual who modified the claim data			
OM2.72	Record the date that the modification occurred			
OM2.73	Display an audit trail of all processing steps			
OM2.74	View on-line all claims audit trail information			
OM2.75	Other as identified by BMS during DDI and accepted via formal change control			
OM2.76	Records and edits that all required attachments, per the reference records or edits, have been received and maintained for audit purposes.			
OM2.77	Ability to retain and display as part of the claim record the billing agent submitter/ID number.			
OM2.78	**4. Claims Inquiry**			
OM2.79	Ability to respond to queries concerning Member eligibility and benefit status.			
OM2.80	Ability to verify that Member is eligible for the type of service at the time the service was rendered, plus a hierarchy algorithm for dual eligibles.			
OM2.81	Ability to provide online, real-time claims inquiry by search criteria including:			
OM2.82	Member ID and/or name			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.83	Rendering Provider ID and/or name, including NPI			
OM2.84	Billing Provider ID and/or name			
OM2.85	PA or referral			
OM2.86	Dates of service, paid, denied, pended			
OM2.87	HCPCs, CPT, DRG, revenue, and/or NDC codes			
OM2.88	Combination of any of the above			
OM2.89	Other inquiry criteria as determined by the BMS during DDI			
OM2.90	**5. Prior Authorization**			
OM2.91	Ability to automatically identify and link the correct PA based on matching data between the claim and the PA, driven by BMS-defined user configurable criteria such as Client ID, Rendering Physician ID, Date of Service, diagnosis code, and procedure code, and payment amount.			
OM2.92	Ability to provide a selection screen when multiple PAs match the auto assignment criteria.			
OM2.93	Ability to link PAs to claims based on PA identifiers submitted with the claim.			
OM2.94	Ability to allow multiple PAs to be linked to a specific claim.			
OM2.95	Ability to provide a claims screen that displays all PAs linked to a specific claim.			
OM2.96	Ability to update PA data during the adjudication process to reflect utilization of services including:			
OM2.97	Authorized unit, visit, and dollar amounts used			
OM2.98	Authorized unit, visit, and dollar amounts remaining			
OM2.99	Accumulators reset for claims reversals			
OM2.100	Other as identified by BMS during DDI and accepted via formal change control			
OM2.101	**6. Business Rules**			
OM2.102	Ability to maintain information that allows procedures to be automatically priced according to BMS–defined business rules, rates and effective dates.			
OM2.103	Ability to manage audits/edits to avoid hard-coding that is not accessible to the user.			
OM2.104	Ability for the user to define and update business rules real-time.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM2.105	Ability to maintain and view business rule change history on-line.			
OM2.106	Ability to maintain status of business rules (development, testing, production).			
OM2.107	Ability to retain in and display as part of the claim record all business rules that were applied to the claim for adjudication and pricing.			
OM2.108	Ability to execute impact analysis testing of any proposed business rule change.			
OM2.109	**7. Edits/Audits**			
OM2.110	Ability to process claims according to a Member's program benefits.			
OM2.111	Ability to provide claim editing processes necessary to detect and correct (when possible and appropriate) erroneous data. The system should include:			
OM2.112	Real-time integration to MMIS claims adjudication processes			
OM2.113	User configurable functions			
OM2.114	Report generation features			
OM2.115	Up-to-date code sets and edit criteria			
OM2.116	Other as identified by BMS during DDI and accepted via formal change control			
OM2.117	The system is expected to incorporate the BMS's existing edits and audits.			
OM2.118	Ability to apply any defined audit/edit specific to any procedure code when billed on any claim form type, as defined by the user.			
OM2.119	Ability to apply Medicare Correct Coding Initiative (CCI) edits to defined claim line items.			
OM2.120	Ability to edit Third Party Liability (TPL) claims to adhere to the cost avoidance adjudication rules specified in the Federal Regulations.			
OM2.121	Ability to establish edits specific to a TPL insurance policy.			
OM2.122	Ability to allow authorized users (per BMS approval) to set criteria allowing claims to bypass the enhanced claim editing component based on a variety of factors to include:			
OM2.123	Dollar thresholds			
OM2.124	Member or Provider specific criteria			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.125	Medical coding			
OM2.126	Other as identified by BMS during DDI and accepted via formal change control			
OM2.127	Ability to apply any claims processing function based on characteristics of the Provider (e.g., type, specialty, and individual or group enrollment).			
OM2.128	Ability to perform pre-payment claims audits using criteria that includes:			
OM2.129	Comparison of diagnosis codes against billed services			
OM2.130	Unbundling of procedure codes, when bundling is more appropriate and vice versa			
OM2.131	Mutually exclusive procedures			
OM2.132	Duplicate or near duplicate payments			
OM2.133	Duplicate services			
OM2.134	Service limits			
OM2.135	Age and gender appropriate services			
OM2.136	Duplicate Medicare cross-over claims			
OM2.137	Consistent payment across various Provider types for the same services			
OM2.138	Breakdowns of savings based on changes to clinical rules			
OM2.139	Trends in historical data			
OM2.140	Rules review			
OM2.141	New visit frequency			
OM2.142	Incidental surgical procedures			
OM2.143	Pricing of multiple surgeries and multiple modifiers			
OM2.144	Add-on codes from multiple surgery editing			
OM2.145	Application of AMA guidelines as defined in the CPT for asterisked procedures			
OM2.146	Appropriate use of modifiers			
OM2.147	An automated clinical review process			
OM2.148	Other as identified by BMS during DDI and accepted via formal change control			
OM2.149	Ability to use data in any field on a claim to apply an audit.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.150	Ability to verify that all Providers submitting input are properly enrolled.			
OM2.151	Ability to pay for services, Members or Providers who are normally not paid through the MMIS (where applicable), when required for exception claim processing. (Note - Provider is to be enrolled to receive payment.)			
OM2.152	Ability to process mathematical calculations on the current claim and associated claims in history to limit payments to global (i.e., bundled, controlling) procedures.			
OM2.153	Ability to define date parameters to support adjudication of services.			
OM2.154	**8. Suspensions (Pends) and Exceptions**			
OM2.155	The Vendor is expected to perform online pended claims resolution.			
OM2.156	Ability to automatically suspend all transactions in error until corrections are made.			
OM2.157	Ability to perform exception control (desktop procedures).			
OM2.158	Ability to allow authorized users to override any edits/audits to manually adjudicate a claim when required for exception claim processing.			
OM2.159	Ability to capture the identity of the user who authorizes the exception payment.			
OM2.160	Ability to reprocess claims that have not been finalized for payment.			
OM2.161	Ability to reprocess claims automatically when that claim was denied as a result of an unapproved PA and that PA is later approved.			
OM2.162	Ability to systematically reprocess claims that have not reached final disposition without requiring the user to intervene on a claim-by-claim basis.			
OM2.163	Ability to define criteria for systematic claims reprocessing, with the ability to review and modify that selection of claims prior to reprocessing.			
OM2.164	Ability to flag and reprocess previously paid claims within the designated service date span if a rate change happened to be a retroactive rate change, and implement into production only upon authorized staff approval.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM2.165	Ability to capture and report on reprocessed claims detail, including (but not limited to) retroactive rate changes, identify of the user authorizing, dates of original processing and reprocessing.			
OM2.166	Ability to override established pricing calculations if the claim or the Provider billing the claim meets the requirements defined by BMS for pricing exceptions.			
OM2.167	Able to capture, display and report on encounter data.			
OM2.168	**9. Price Claim/Value Encounter**			
OM2.169	The system is expected to price all claims in accordance with West Virginia Medicaid program policy, benefits and limitations.			
OM2.170	The Vendor is expected to allow for manual pricing of claims.			
OM2.171	Ability to price each claim line item according to the applicable pricing rules.			
OM2.172	Ability to display all service lines of a single claim.			
OM2.173	Ability to determine and display the number of units paid on a claim line.			
OM2.174	Ability to define Member co-payments at the claim line level.			
OM2.175	Ability to define Member co-payments at the claim header level.			
OM2.176	Ability to process claims including Member liability in the final payment amount.			
OM2.177	Ability to provide an automated process, approved by BMS, to acquire Medicare Rates, and ensure conformance with Federal requirements regarding Medicare pricing.			
OM2.178	Calculate Medicare and TPL coinsurance and deductible charges for specified crossover and TPL claims using BMS "lesser than" calculation described in common chapters of the Provider manuals.			
OM2.179	Ability to accommodate Provider custom fees which override other pricing considerations.			
OM2.180	Ability to accommodate pricing for payments that may exceed billed charges, including payment of encounter fees to:			
OM2.181	Rural Health Clinics (RHCs)			
OM2.182	Federally Qualified Health Clinics (FQHCs)			
OM2.183	DRGs			
OM2.184	Critical Access Hospitals (CAHs)			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.185	Ability to calculate spend down and reimbursement amount after capturing and applying information captured in the patient pay field.			
OM2.186	Ability to limit claim payments based on Member-specific expenditure histories (i.e., to limit payments to budgeted amounts at the Member level).			
OM2.187	Ability to view Benefit utilization information through the user interface (UI) for Benefit Plan accumulations.			
OM2.188	Ability to maintain a DRG file as determined by BMS. The DRG file should contain, at a minimum, elements such as:			
OM2.189	DRG code			
OM2.190	DRG description			
OM2.191	Add date			
OM2.192	Begin date			
OM2.193	End date			
OM2.194	DRG weight (relative value)			
OM2.195	Audit trail			
OM2.196	Average length of stay			
OM2.197	Other as identified by BMS during DDI and accepted via formal change control			
OM2.198	Ability to provide on-line role-based access to pricing formulas and their associated parameters/variables, including the ability to view and modify (for authorized staff only) pricing formulas. Parameters should include:			
OM2.199	Anesthesia conversion factors (with the ability to accept and process by units and/or minutes based on BMS's choice)			
OM2.200	Anesthesia base rates			
OM2.201	Vaccine for Children (VFC) rates			
OM2.202	Multiple RBRVS Conversion Factors for the same period of time			
OM2.203	All other conversion factors as defined by BMS during DDI			
OM2.204	Ability to define date parameters to support pricing of services.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.205	Ability to capture and display rate codes defined by BMS. (The term "Rate Code" is a combination of RAPIDS program codes plus the old CMS Aid Category codes, or in the case of a non-Medicaid program, the aid category plus the first two numbers assigned to the MAID#).			
OM2.206	Ability to allow for consistent calculation of payment amounts according to all reimbursement methodologies approved by BMS, including:			
OM2.207	Provider specific fee schedule			
OM2.208	Usual and Customary Rate (UCR)			
OM2.209	Per diems			
OM2.210	LTC facility room and board charges			
OM2.211	LTC coinsurance amount (uses "lesser than" calculation)			
OM2.212	Diagnosis Related Groups (DRGs)			
OM2.213	Medicare coinsurance/deductible and pricing methodology			
OM2.214	TPL pricing methodology			
OM2.215	Formulas			
OM2.216	Percentages			
OM2.217	Pricing by PA			
OM2.218	Other payment methods (as defined by BMS during DDI)			
OM2.219	Ability to maintain pricing history per BMS specifications.			
OM2.220	Ability to establish edits for production or test region adjudication and notify BMS staff of any services that are not priced under the current fee schedules.			
OM2.221	Ability to generate pricing data for all Provider programs using selection parameters specified by the State.			
OM2.222	**10. Apply Claim Attachment**			
OM2.223	Ability to accurately accept, store, track, and process claim attachments submitted via both hard-copy and electronic transmission.			
OM2.224	Ability to integrate with the EDMS component, for inbound imaging of claims and attachments, claims reporting, and correspondence.			
OM2.225	Ability to electronically match attachments to their associated claims.			

3. Operations Management (OM) OM2. Payment Management, Claims/Encounter Adjudication				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM2.226	Ability to allow authorized users to manually modify the link between a claim and its associated attachments, PAs and image files.			
OM2.227	Ability to process related claims based on the presence of specific attachments, as defined by the user.			
OM2.228	Ability to accept unlimited number and types of attachments per claim.			
OM2.229	Ability to allow users to navigate to and view claims attachments from within the claim screens.			
OM2.230	Accepts Medicare crossover claims with Medicare Explanation of Benefits (EOB) claims attachments.			
OM2.231	Employs an electronic tracking mechanism to locate archived source documents or to purge source documents in accordance with HIPAA security provisions.			
OM2.232	**11. Apply Mass Adjustment**			
OM2.233	Ability to provide mass update capability for claims, including paid and denied claims determined eligible for adjustment.			
OM2.234	Ability to link together claims reversal and replacement claim (for mass updates only) so claims go through budget relief at the same time.			

3. Operations Management (OM) OM3. Payment Management, Payment & Reporting				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM3.1	**1. Prepare Remittance Advice/Encounter Report**			
OM3.2	Ability to generate paper and electronic Remittance Advice (RA) that captures all data necessary to meet BMS, State, and Federal reporting requirements (HIPAA 835 transaction).			
OM3.3	Ability to print and distribute paper Remittance Advice (printed in black and white) in accordance with BMS approved schedule.			
OM3.4	Ability to produce the paper Remittance Advice copies on demand.			
OM3.5	Ability to generate additional remittance voucher pages (X number of pages free, fee thereafter -- per Fiscal Agent pricing structure).			
OM3.6	Ability to allow Remittance Advice for zero pay and zero balance items.			
OM3.7	Ability to suppress Remittance Advice relating to adjustments performed for the purpose of correcting internal account or category codes.			
OM3.8	Ability to associate the warrant/ACH number with the claim.			
OM3.9	Ability to include warrant/ACH number in 835 Remittance Advice transaction.			
OM3.10	Ability to print warrant/ACH number on the Remittance Advice.			
OM3.11	Ability to include all claims and financial transactions (such as recoupments) on the paper Remittance Advice.			
OM3.12	Ability to distribute the Remittance Advice to multiple locations.			
OM3.13	Ability to report any withholdings to a Provider's payment on the Remittance Advice.			
OM3.14	Ability to generate reports summarizing payment and status transactions (HIPAA 820, 277).			
OM3.15	**2. Prepare Coordination of Benefits (COB)**			
OM3.16	Ability to capture and provide COB information online and in batch format.			
OM3.17	Ability to comply with the following Federal Third Party Liability (TPL) processing and HIPAA requirements, including:			
OM3.18	Ability to store a unique identifier for individual health plans			
OM3.19	Other as identified by BMS during DDI and accepted via formal change control			

3. Operations Management (OM) OM3. Payment Management, Payment & Reporting				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM3.20	Ability to maintain a process to identify projected allowed amount for previously denied claims in order to estimate savings due to TPL.			
OM3.21	Ability to identify all payment costs avoided due to established TPL.			
OM3.22	Ability to use the HIPAA 837 transaction to facilitate TPL billing functions (i.e., using the 837 COB functionality).			
OM3.23	**3. Prepare Home and Community-Based Services (HCBS) Payment**			
OM3.24	Ability to support processing for HCBSs as it is conducted for any other claim/transaction type. WV has no unique processing requirements for HCBS.			
OM3.25	**4. Prepare EOMB**			
OM3.26	Ability to increase or decrease sample sizes (in regards to CMS checklist item CMS FI1.1, "Provides individual EOMB notices, within 45 days of the payment of claims, to all or a sample group of the Beneficiaries who received services under the plan as described in §11210.").			
OM3.27	**5. Prepare Provider EFT/Check**			
OM3.28	The Vendor is to generate a check file in accordance with BMS process and schedule. The process is as follows: Pass check file to MIS, MIS passes to State Auditor and State Treasurer offices (where warrant #, EFT conf #, payment date added), passed back to MIS and then back to Vendor to load into the MMIS.			
OM3.29	Ability to generate an electronic check file that segregates types of payment based on check, Electronic Fund Transfer (EFT), and Inter-Governmental Transfer (IGT) payment data (Medicare A, B, D).			
OM3.30	Payment processing should be independent of other system activity.			
OM3.31	Ability to support a fixed payment schedule (as defined by BMS).			
OM3.32	Ability to support unscheduled payment generation (per BMS request).			
OM3.33	Ability to calculate payment amounts for claims, including:			
OM3.34	FFS Claims			
OM3.35	Pharmacy POS			
OM3.36	HCBS Provider claims			
OM3.37	MCO/Capitation			
OM3.38	Performance incentives (per BMS)			

3. Operations Management (OM) OM3. Payment Management, Payment & Reporting				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM3.39	Withholdings			
OM3.40	Other as identified by BMS during DDI and accepted via formal change control			
OM3.41	Ability to base payment calculations on inputs that include:			
OM3.42	Patient Resource Amounts			
OM3.43	Spend-down amounts			
OM3.44	TPL payment adjustments			
OM3.45	Crossover payment adjustments			
OM3.46	Member payment Adjustments			
OM3.47	Ability to determine net payment amount			
OM3.48	Other as identified by BMS during DDI and accepted via formal change control			
OM3.49	Ability to support payroll processing (e.g., HCBS Providers), including withholding payments for payroll, and State and Federal taxes.			
OM3.50	The Vendor is expected to support WV BMS budget relief (Accounts Payable) process. Processes include: reconciliation process for managing A/P inventory, release of payments per BMS criteria, withhold amounts per defined repayment schedules, and suspension of Provider payment, creation of check file, updating of claim with payment data			
OM3.51	**6. Prepare Premium EFT/Check**			
OM3.52	Ability to calculate payment amounts for premium payments, including:			
OM3.53	MCO premium payments based on MCO contract data (reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package)			
OM3.54	PCCM premium payments based on BMS rules			
OM3.55	Other as identified by BMS during DDI and accepted via formal change control			
OM3.56	Ability to associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA.			

3. Operations Management (OM) OM4. Payment Management, Capitation & Premium Preparation				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM4.1	**1. Prepare Health Insurance Premium Payment**			
OM4.2	Ability to support HIPP invoicing and payment processing.			
OM4.3	Ability to update Member records to reflect capitation payments made on his/her behalf.			
OM4.4	Ability to calculate premium assistance cost effectiveness based on historical claims payment information compared to insurance premiums for a Member.			
OM4.5	Ability to employ a user-configurable process to identify potential high cost Members.			
OM4.6	Ability to identify Members for whom insurance premiums are to be paid and automatically generate prospective premium payments to insurance companies, employers, Members, or other entities.			
OM4.7	Ability to allow payment of premiums to multiple payees for a single Member.			
OM4.8	Ability to accommodate prospective and retrospective premium payments.			
OM4.9	Ability to generate and transmit to Providers the content of HIPAA compliant automated premium payment reports (ASC-X12N 820), on a scheduled specified by the BMS.			
OM4.10	Ability to store premium assistance payment tracking details such as warrant numbers.			
OM4.11	Ability to make adjustments to premium payments.			
OM4.12	Ability to integrate all premium assistance reporting and correspondence with the EDMS component.			
OM4.13	**2. Prepare Medicare Premium Payment**			
OM4.14	Ability to support the payment of the Part A and Part B premiums.			
OM4.15	Ability to receive appropriate Medicaid Member eligibility data from all sources of eligibility determination.			
OM4.16	Ability to receive State Data Exchange (SDX), Enrollment Data Base (EDB) file, and/or Beneficiary Data Exchange (BENDEX) eligibility files. (The Bureau currently accesses the EDB file and downloads it directly from CMS. The file is then sent to the FA vendor. RAPIDS currently uses the Bendex and SDX files).			
OM4.17	Ability to perform a matching process against Member data.			
OM4.18	Ability to generate a two-part buy-in file, one for Medicare Part A and one for Medicare Part B.			

3. Operations Management (OM) OM4. Payment Management, Capitation & Premium Preparation				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM4.19	Ability to receive Medicare buy-in records and load on a monthly basis.			
OM4.20	Ability to send/receive buy-in files to/from CMS.			
OM4.21	Ability to automatically update eligibility information based on information received in the Medicare Enrollment Database (EDB) file.			
OM4.22	Ability to post buy-in changes to the appropriate Member record.			
OM4.23	Ability to produce buy-in reports as specified by BMS.			
OM4.24	Provides Buy-In Beneficiary information for program or management use, including:			
OM4.25	Transaction processed			
OM4.26	Errors identified			
OM4.27	Errors correction status			
OM4.28	Tracks Buy-In exceptions for those Beneficiaries who are identified as eligible, but whose premiums have not been paid.			
OM4.30	**3. Prepare Capitation Premium Payment**			
OM4.31	Ability to process adjustments to capitation (health plan premium) payments.			
OM4.32	Ability to process per-Member per-month (PMPM) capitation payment based on BMS-defined rate factors such as age, sex, category of eligibility, health status, geographic location, and other.			
OM4.33	Ability to establish capitation rates based on multiple risk criteria (gender, geography, etc.) and PCCM.			
OM4.34	Selects premium payment amount and generates PMPM payment (capitation, premium, case management fee).			
OM4.35	Ability to query Member-specific history of capitation payments for each applicable managed care program to which that Member belongs.			
OM4.36	Identifies individuals/enrollees who have terminated enrollment, disenrolled, or are deceased, and excludes those individuals from the monthly MCO capitation payment.			
OM4.37	Generates regular capitation payments to MCOs or PCPs, at least on a monthly basis in compliance with HIPAA-standard X12 820 Premium Payment transaction where applicable.			

3. Operations Management (OM) OM4. Payment Management, Capitation & Premium Preparation				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM4.38	Adjusts capitation payment based on reconciliation of errors or corrections or approved retroactive rates (e.g., retroactive adjustments to a particular capitation payment based on more accurate data that the MMIS obtains retroactively on Member enrollments, disenrollments, and terminations).			
OM4.39	Performs reconciliations of payments to MCO, PCP roster.			
OM4.40	Verifies correct transfer of capitation payment when Member disenrolls from one MCO and enrolls in another plan.			
OM4.41	Ability to generate capitation recoupments automatically, based on user-defined criteria.			
OM4.42	Ability to maintain Member-specific history of capitation payment activity for each applicable managed care program to which that client belongs.			
OM4.43	Ability to maintain edit logic to prevent duplication of capitation and fee-for-service payments for services covered under the managed care program.			
OM4.44	Process per-Member per-month (PMPM) for primary care gatekeeper services.			

3. Operations Management (OM) OM5. Payment Information Management				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM5.1	**1. Manage Payment Information**			
OM5.2	Ability to provide a Payment Data Repository to track and maintain all payment detail, including:			
OM5.3	Claims and adjudication history (including payment)			
OM5.4	Premium and capitation payment history			
OM5.5	HCBS claims and payment history			
OM5.6	Other as identified by BMS during DDI and accepted via formal change control			
OM5.7	**2. Inquire Payment Status**			
OM5.8	Ability to receive claim status inquiries in a variety of mediums, including:			
OM5.9	X12 276 and 277 Transactions through portal and in batch file process			
OM5.10	Mail			
OM5.11	Phone (Agent)			
OM5.12	Fax			
OM5.13	Phone (AVRS)			
OM5.14	Provider Enrollment Tracking System (PETS)			
OM5.15	Other as identified by BMS during DDI and accepted via formal change control			
OM5.16	Ability to automatically assign a unique control (or identification or tracking) number to each Payment Status Request to track requests, from time of receipt to disposition.			
OM5.17	Ability to respond to claim status inquiries in a variety of medium, including:			
OM5.18	X12 276 and 277 Transactions through portal and in batch file process			
OM5.19	Mail			
OM5.20	Phone (Agent)			
OM5.21	Fax			
OM5.22	Phone (AVRS)			
OM5.23	Other as identified by BMS during DDI and accepted via formal change control			

3. Operations Management (OM) OM5. Payment Information Management				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM5.24	Ability to provide payment inquiry response in conformance with BMS, State, and Federal policies.			
OM5.25	Ability to deny requests not in compliance with BMS's information access/privacy policies and HIPAA guidelines.			

3. Operations Management (OM) OM6. Member Payment Information				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM6.1	**1. Calculate Spend-Down Amount**			
OM6.2	Ability to accept and display a spend-down indicator from RAPIDS showing that the spend-down amount has yet to be met.			
OM6.3	Ability to automatically generate a spend-down report identifying the Members whose spend-down indicator is "Yes."			
OM6.4	Ability to edit against the spend-down indicator and pend for "Yes."			
OM6.5	Ability to provide a screen for BMS staff to enter the spend-down amount to be applied to the claim, and capture and maintain this information so that it is available for reporting.			
OM6.6	**2. Prepare Member Premium Invoice**			
OM6.7	Calculates and generates enrollment and premium notices to policy holders.			
OM6.8	Processes premium receipts from policy holders.			
OM6.9	Supports inquiries regarding premium collections.			
OM6.10	Produces premium collection reports.			
OM6.11	Ability to provide an Accounts Receivable function to create entries from the premium billing cycle and to post premium payment against (i.e., to bill and collect premiums).			
OM6.12	Ability to generate an invoice to the Member for program premiums.			
OM6.13	Ability to define premium rates and associate to specific benefit offerings.			
OM6.14	Ability to identify through Member eligibility the applicable premium rate determination in order to generate invoices for premium payment.			
OM6.15	Ability to prepare member premium invoices on a set schedule (as specified by the BMS).			

3. Operations Management (OM) OM6. Member Payment Information				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM6.16	Ability to capture all data necessary to meet BMS, State, and Federal premium reporting requirements. (The Bureau currently collects premiums and enrollment fees for eligible MWIN participants. A description of this program is found in 2.3.2.1.6. At a minimum, the data would need to identify member detail such as Member Medicaid ID, member name and related demographics, program type, eligibility effective dates, eligibility rate code, premium amount, premium notification mail date, date of premium receipt date, past due mail dates, program termination date, reason codes for termination. This is not meant to be an all-inclusive list. The system functionality should be flexible to accommodate additional expansion populations beyond the current MWIN program if the Bureau chooses to pursue).			
OM6.17	Ability to integrate premium billing invoices and associated reporting with the Electronic Document Management System (EDMS) component.			
OM6.18	Ability to maintain an audit trail of all transactions.			

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM7.1	**1. Manage Recoupment**			
OM7.2	Ability to support multiple recoupment options, rules and terms for recovery of all overpayments.			
OM7.3	Ability to net against current or future payments to recover overpayments using a lump sum, percentage or repayment plan.			
OM7.4	Ability to assess and collect interest per business rules (as defined by BMS).			
OM7.5	Ability to post checks to outstanding receivable balances.			
OM7.6	The system is expected to include an integrated (with other system components), fully functional accounts receivable component, including all required reporting (to be defined by BMS).			
OM7.7	Ability to track the status of recoupment by Provider through all stages of the collection and appeals processes.			
OM7.8	Ability to create bank deposit. (The system should provide functionality to post Accounts Receivable (A/R) for all check payments received in the Bureau. A daily report of all entries/postings is required to accompany the checks to be deposited for each date).			
OM7.9	**2. Manage Estate Recovery**			
OM7.10	Ability to identify Members subject to estate recovery.			
OM7.11	Ability to interface with TPL vendor files.			
OM7.12	Ability to automatically generate a unique case identifier upon referral for Estate Recovery Case Management. Identifier methodology to be specified by BMS.			
OM7.13	Ability to automatically create the Case Management record (from the initial case review data) upon referral to Case Management.			
OM7.14	Ability to track and maintain Case Management data at the individual case level, including:			
OM7.15	Case number			
OM7.16	Case status (e.g., open, suspended, closed)			
OM7.17	Actions taken			
OM7.18	Outcomes including monetary recoveries			
OM7.19	Listing of case contacts/affected parties			

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM7.20	Chronology of significant case activity (e.g., dates of phone calls to Providers, dates of records/information received from Provider/Member/attorney), including description.			
OM7.21	Significant case documentation/evidence (e.g., medical records, Member interview findings, Provider credential verification)			
OM7.22	Other as identified by BMS during DDI and accepted via formal change control			
OM7.23	Ability to integrate and analyze data from external sources (e.g., vendors) in multiple media types.			
OM7.24	**3. Manage TPL**			
OM7.25	Ability to track and maintain contractor activity related to Third Party Liability (TPL) requirements (e.g., cost avoidance, trauma, post-payment recoveries).			
OM7.26	Automatically generates casualty-related claims information that can be used for follow-up to Beneficiaries, attorneys, motor vehicle department, etc. according to BMS-specified criteria.			
OM7.27	Edits additions and updates to the Beneficiary insurance information to prevent the addition of duplicate policies.			
OM7.28	Provides a mechanism to identify outdated TPL information.			
OM7.29	Generates and maintains an audit trail of all updates to the Beneficiary insurance data, including those updates that were not applied due to errors, for a time period specified by the State.			
OM7.30	Allows only authorized staff members to do manual deletes and overrides of alerts/edits.			
OM7.31	Ability to report TPL resources against paid claims history retroactively for five (5) years to identify recoverable funds.			
OM7.32	Manages accounts receivable and claims adjustments as TPL related invoices are paid.			
OM7.33	Provides data storage and retrieval for Third Party Liability (TPL) information; supports TPL processing and update of the information.			
OM7.34	Ability to support entry of free-form text field that allows narratives for each recovery case that identifies user and date/time entered (length of this text field to be determined during DDI, per BMS approval).			
OM7.35	Ability to display date-specific free-form narrative in chronological or reverse chronological sequence.			

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
OM7.36	Ability to identify claims subject to recoupment, based on criteria defined by BMS, and generate letters to Providers instructing them to re-bill the primary carrier.			
OM7.37	Ability to track post-payment recovery and adjustment of paid claims, including account receivable entries.			
OM7.38	**4. Manage Drug Rebate**			
OM7.39	Ability to support non-traditional drug rebates (i.e., DME, other state drug rebate programs).			
OM7.40	Ability to generate CMS 64 reporting related to drug rebate.			
OM7.41	Ability to upload external drug rebate data into the system reference file (e.g., CMS labeler contact information and pricing file, supplemental rebate pricing file).			
OM7.42	Ability to maintain all fields provided by CMS quarterly drug rebate file including historical data as determined by BMS.			
OM7.43	Ability to generate statement of accounts.			
OM7.44	Ability to generate quarterly utilization file for transfer back to CMS.			
OM7.45	Ability to generate drug rebate invoices for different rebate programs.			
OM7.46	Ability to compare National Drug Code (NDC) unit rebate amounts supplied by the manufacturer directly with the same information supplied by CMS.			
OM7.47	Ability to exclude drug expenditures (e.g., claims from the 340B pharmacies) from rebate invoicing.			
OM7.48	Ability to generate invoices that reference changes made to claim information reported on previously produced invoices. Corrections are to reflect original invoice quarter.			
OM7.49	Ability to invoice for drugs dispensed in the physician office, drugs dispensed from a pharmacy, using the NDC identifier, and eligible drugs paid through MCO.			
OM7.50	Ability to flag, withhold and correct invalid claims data before it reaches invoice generation.			
OM7.51	Ability to assess interest according to Federal requirements.			
OM7.52	Ability to automatically set up Accounts Receivables at the NDC level for drug manufacturers invoiced for all rebate programs.			

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM7.53	Ability to generate user defined reports to monitor the status of invoice or NDC detail, including but not limited to: amount collected, amount invoiced, outstanding receivables, number of disputes received and resolved, and amount collected in disputed items and non-disputed items.			
OM7.54	Ability to selectively produce a periodic statement of accounts for outstanding debt, including interest calculated based on CMS rules.			
OM7.55	Ability to record and track manufacturer disputes of drug rebate invoices at the NDC detail level.			
OM7.56	Ability to associate the claims with NDC level detail related to a manufacturer's dispute.			
OM7.57	Ability to report on all drug rebate programs individually and collectively.			
OM7.58	Ability to provide drug manufacturers access through the Web Portal to upload data (as approved by BMS). (A secure portal for the Drug Rebate Program would allow access by the drug manufacturers to their invoices, claims level data, payment data and statements of account. While the intent is to provide data to the manufacturer, it is conceivable that payment data could be returned by the manufacturer).			
OM7.59	Ability to manage reversal/adjustment claims for invoicing purposes.			
OM7.60	Ability to import, maintain and modify historical rebate claims, pricing and payment data.			
OM7.61	Ability to support and apply conversion factors.			
OM7.62	Ability to post payment data at the deposit, check, invoice and line item levels.			
OM7.63	Ability to generate user defined and ad hoc reports that meet Federal and State requirements as well as supporting the functional and technical operation of the program.			
OM7.64	**5. Manage Settlement**			
OM7.65	Ability to process and distinguish settlement amounts owed and payments due Provider for reporting purposes.			
OM7.66	The system should allow Providers access to cost settlement information via the portal (similar to Medicare).			
OM7.67	The system is expected to generate all required cost settlement reporting.			
OM7.68	Ability to apply check payment to an open receivable.			

3. Operations Management (OM) OM7. Cost Recoveries				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
OM7.69	Ability to track the status of settlement by Provider through all stages of the collection and appeals processes.			
OM7.70	Ability to generate cost settlement information reports online via the Provider Portal. Specifics of the report to be agreed-upon during DDI.			
OM7.71	Ability to internally generate all required cost settlement reporting. Specifics of the report to be agreed-upon during DDI.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.1	**1. Manage Rate Setting**			
PG.2	Ability to compare encounter data claims and capitation fees vs. fee-for-service payment data to determine utilization and payment-analysis.			
PG.3	Ability to calculate rates utilizing the designated fee schedule, while providing the ability to manipulate factors in the calculation, as defined by the user.			
PG.4	Ability to maintain a history of any rate that includes effective and termination dates.			
PG.5	Ability to assign budget neutrality.			
PG.6	Ability to assess the fiscal impact of updating rates by testing against previously paid claims.			
PG.7	Ability to use the pricing files such as Medicare Physician Fee Database (MPFDB) File to update Reference data without manual intervention.			
PG.8	Ability to automatically update Provider rate tables through an electronic means (e.g., Excel, ODBC compliant database).			
PG.9	Ability to accept an electronic file from a third-party entity of pricing information to assist in rate setting (e.g., TPL allowed amount).			
PG.10	Ability to associate Provider-specific reimbursement contracts with the Providers. Ability to accommodate various pricing files, UCR, custom fee RBRVS, PPS. (The reference to PPS encompasses all Medicare Prospective Payment Systems that the Bureau currently utilizes or may wish to utilize in the future).			
PG.11	System can receive an electronic update of Medicare rates for Federally Qualified Health Centers (FQHC).			
PG.12	Ability to pend claims awaiting approval of fee, rate and code updates.			
PG.13	Ability to accommodate retroactive application of rates.			
PG.14	Upon any change in rates, the system can provide automatic notification to an appropriate distribution list.			
PG.15	Ability to accommodate multiple rate-setting schedules (i.e., hospitals, long-term care facilities, intermediate care facilities for the mentally retarded (ICF/MR)).			
PG.16	Ability to extract information that supports rate setting functions.			
PG.17	System should capture and apply Member resource amount or spend-down amount for claims adjudication.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.18	**2. Manage 1099s**			
PG.19	Ability to establish Provider affiliations in a way that accommodates actual practicing locations and Federal and State tax requirements (one 1099 per taxable entity).			
PG.20	Ability to produce and distribute 1099 files, documents and reports as required by the IRS. (The MMIS vendor is responsible for creating a check file that is transferred to the auditor and treasurer's office for processing payments. The file is returned to the MMIS vendor with the warrant and EFT information appended to the original file. The State agencies do not change the payment information received from the MMIS).			
PG.21	Ability to produce copies of 1099s.			
PG.22	Ability to generate corrected tax 1099s.			
PG.23	Ability to automatically adjust 1099 amounts from repayments of claims.			
PG.24	Ability to automatically adjust 1099 amounts from repayments of claims paid out and repaid in the same calendar year.			
PG.25	The system has the ability to produce test 1099 list and provide a reconciliation of reportable amounts for review before printing or transmitting final to IRS.			
PG.26	Ability to accommodate accurate 1099 processing for multiple tax IDs for the same Provider occurring in one reporting period.			
PG.27	**3. Perform Accounting Functions**			
PG.28	Ability to interface all claims payment and financial activities with the West Virginia Accounts Payable and Accounts Receivable system.			
PG.29	Ability to provide online access to accounting information based on the user's role.			
PG.30	Ability to provide access to financial transactions and specifically related claims or other related or source information.			
PG.31	Provide online inquiry of financial records based on a variety of criteria that may include:			
PG.32	Payee or payer identifiers and names			
PG.33	Payment, service, and processing dates			
PG.34	Claim identifiers to be defined by BMS			
PG.35	Remittance identifiers and dates			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PG.36	Ability to capture cost report information in a prescribed electronic format for financial analysis and settlement.			
PG.37	Ability to query the mapping from the data elements in MMIS to a State-defined reporting/financial account code.			
PG.38	Ability to maintain a date-effective map from the data elements in MMIS to a State-defined reporting/financial account code.			
PG.39	Ability to retain the State financial/reporting account code for each price (claim level, service line level, or for add-ons). Used for determining payment/adjudication decisions.			
PG.40	Ability to assign a valid State financial system account code prior to final payment (e.g., State fund, Medicaid, etc.).			
PG.41	Ability to calculate and apply interest on accounts receivable/payable account balances, as defined by the user.			
PG.42	Ability to maintain date-effective interest rates.			
PG.43	Ability to adjust interest payments when a claim that was originally paid with interest is adjusted.			
PG.44	Ability to apply different interest rates.			
PG.45	Ability to maintain all the data in the system that is necessary to generate the State financial system account code (e.g., claim information, Provider contracts, and Member characteristics).			
PG.46	Ability to reconcile account code balances between the system and the State financial system.			
PG.47	Provides method for lump-sum reimbursement, such as Disproportionate Share Hospital (DSH).			
PG.48	Ability to withhold A/R from current payments.			
PG.49	Ability to generate A/R aging.			
PG.50	Provides and maintains the capability to process standard financial transactions including recoupments and payouts which cover more than one claim/service.			
PG.51	**4. Perform Accounting Functions - Adjustments**			
PG.52	Ability to associate a transaction control number (TCN) with all claim credits and adjustments.			
PG.53	Ability to reverse a previously paid claim.			
PG.54	Ability to associate a reason code with all claim credits and adjustments.			
PG.55	Ability to maintain the record of the original claim when a claim credit is generated.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.56	Ability for reversal and replacement claims to retain same log date.			
PG.57	Ability to maintain a minimum of three years of on-line claim history to be used for adjustment processing upon implementation (e.g., MINIMUM of 3 years available on Day One of implementation), including encounter data.			
PG.58	Ability to link adjustments or replacement claims to immediate predecessor or original claims.			
PG.59	Ability to associate all supporting documentation for gross adjustments to the transaction control numbers (TCNs) assigned to the gross adjustment.			
PG.60	Ability to assign specified functions at line level (e.g., ignore, warn, pend, pay, deny).			
PG.61	Ability to access all incoming adjustment requests and claims regardless of input media and assign a unique tracking number and an adjustment type identifier.			
PG.62	Ability to image claim adjustments requests from Providers (including faxes).			
PG.63	Ability to process returned warrants or EFTs. Functionality should include:			
PG.64	Re-establishment of all claims into a to-be paid status			
PG.65	Reinstate units and dollars for prior authorized services			
PG.66	Ability to place Provider on hold until bank account information updated			
PG.67	Other as identified by BMS during DDI and accepted via formal change control			
PG.68	Ability to receive and maintain all managed care retroactive and current eligibility enrollment spans and trigger retroactive adjustment claims.			
PG.69	Ability to trigger take backs or payments and generate the content of 820 Remittance Advice for premium payments to Providers, at BMS-defined intervals.			
PG.70	Ability to allow adjustments payments for retroactive eligibility.			
PG.71	Ability to allow adjustments due to third-party prior payment and alert the cost avoidance unit.			
PG.72	Ability to display both contracted agreement amount and actual payment amount.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.73	Ability to establish weekly payment reductions or increases based on the following:			
PG.74	IRS levy/lien			
PG.75	Child Support			
PG.76	Other conditions as defined by BMS during DDI			
PG.77	Ability to process mass adjustments that may include multiple Providers.			
PG.78	Ability to provide easily customizable, parameter-driven mass adjustment selection and review process.			
PG.79	Ability to establish and provide a sandbox environment that provides the functionality to create, test, modify and store fiscal impact scenarios. At a minimum, the MMIS Integrated Test Environment (ITE) should include: - Development Test Environment - UAT Environment - Training Environment - Production Test Environment			
PG.80	Ability to provide internal communication capabilities (notification/explanation) tied to mass adjustments when necessary (e.g., policy initiated mass adjustments).			
PG.81	Ability to deny or hold payments for review or release for immediate payment.			
PG.82	Accept electronic reversal and replacement claims and/or adjustment claims.			
PG.83	Ability to track and maintain source of reversal submissions in the user interface (GUI). Reversals may be submitted via paper, electronically, or entered directly into the system.			
PG.84	**5. Perform Accounting Functions - Accounts Payable**			
PG.85	The Vendor is to support BMS's financial functions with the use of an accounts payable file of adjudicated claims which are paid at least weekly according to specific release criteria:			
PG.86	Payment release by Provider Type			
PG.87	Payment release by TCN			
PG.88	Payment release by Provider ID			
PG.89	Payment release by Claim Type (e.g., capitation, fee-for-service, POS)			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.90	Other as identified by BMS during DDI and accepted via formal change control			
PG.91	Ability to generate separate payment files for other payers using the WV MMIS (e.g., Juvenile Justice).			
PG.92	Ability to generate a user-defined gross payment to a Provider in lieu of a payment based on adjudicated claims.			
PG.93	Ability to generate multiple or expedited payments outside of the normal payment cycle.			
PG.94	Ability to maintain A/P payment processing aging file for managing claim-specific and Provider-specific information to disburse payments via check, Electronic Funds Transfer (EFT), Inter-Governmental Transfer (IGT) payment., Part A, Part B and Part D payments.			
PG.95	Ability to generate a paper remittance file, an electronic remittance voucher file and a print image form.			
PG.96	Ability to accommodate multiple or changing tax IDs within the payment and enrollment components of the MMIS.			
PG.97	Identifies Providers with credit balances resulting from claim reversal.			
PG.98	Ability to associate each paid claim with the corresponding warrant or ACH number, warrant amount and paid date that ties to a Remittance Advice.			
PG.99	Ability to net a Provider's payment against the balance in that Provider's accounts receivable account, as defined by the user.			
PG.100	Ability to maintain user approved repayment plans for Providers.			
PG.101	Ability to assign recoupments to a specific treating/servicing Provider to accommodate changes in employment.			
PG.102	Ability to distribute payments to a specified location regardless of the distribution location of the Remittance and Status Advice (RA).			
PG.103	Ability to cease a Provider's payment at the individual performing Provider or corporation level, as defined by the user.			
PG.104	Ability to associate the service rendered to the Provider who receives payment.			
PG.105	Ability to accept returned financial transactions and void the Provider payment by automatically reversing all transactions associated with the payment including claim payments, claim credits, and other financial transactions (e.g., cancelled, returned warrants).			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.106	**6. Perform Accounting Functions - Accounts Receivable**			
PG.107	Ability to establish a receivable and distinguish between principle and interest balances.			
PG.108	Ability to establish a receivable and net against any current disbursement.			
PG.109	Ability to update or modify an established A/R invoice.			
PG.110	Ability to query A/R invoices.			
PG.111	Ability to post checks to outstanding receivable balances.			
PG.112	Ability to define the types of entities (e.g., individual Provider, organization, corporation, etc.) responsible for an A/R account.			
PG.113	Ability to establish repayment plans that extend over multiple periods.			
PG.114	Ability to support multiple settlement options, rules and terms for recovery of all overpayments.			
PG.115	Ability to modify (add, delete, change, pend) any item in the A/R account.			
PG.116	Ability to maintain on-line inquiry to current and historical financial information with access by Member, Provider, manufacturer or other entity identification.			
PG.117	Ability to provide for a flexible, parameter-based, on-line query capability for financial information.			
PG.118	Ability to accept liens and/or orders to withhold from State and Federal entities.			
PG.119	Ability to apply user-defined criteria for facilitating lien and/or orders to withhold (e.g., percentage of payment, percentage of lien, flat rate).			
PG.120	Ability to assign a disposition on an A/R for suspending collection and interest activities (e.g., fair hearing, bankruptcy) and apply user-specified business rules.			
PG.121	Ability to create a bank deposit transmittal and/or summary.			
PG.122	Ability to maintain A/R aging Receivable file of all receivables regardless of current activity.			
PG.123	**7. Develop and Manage Performance Measures and Reporting**			
PG.124	The Vendor is expected to develop operations reports to demonstrate compliance with applicable performance measures, as detailed in Appendix G, Service Level Agreements, and Appendix H, Performance Measures.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PG.125	**8. Monitor Performance and Business Activity**			
PG.126	The Vendor is expected to monitor performance against BMS-established performance measures, as detailed in Appendix G, Service Level Agreements, and Appendix H, Performance Measures.			
PG.127	The Vendor is expected to implement corrective action plans to address performance issues (i.e., when performance falls below acceptable threshold).			
PG.128	**9. Manage Program Information**			
PG.129	Provides, maintains and updates a database to support MARS extract functions. Updates to the database should occur, at a minimum, monthly.			
PG.130	System automatically maintains data integrity and verifies/reconciles data against the source systems, including payment data, and accounts for discrepancies.			
PG.131	Vendor is to demonstrate process for ensuring that data is representative of all data elements used for claims processing and payment and reconciled to financial control totals.			
PG.132	Maintains appropriate controls and audit trails to ensure that the most current data is used in all processes relying on the data repository.			
PG.133	Ability to accommodate reporting across all Medicaid services and Social Service payments regardless of service delivery method and financing mechanism.			
PG.134	Ability to schedule any report to be run at varying levels of immediacy, frequency, or user-defined condition.			
PG.135	Ability to correct, rerun, verify, and distribute a report for which a problem occurred, for any period in which a problem occurred, or a specified point in time.			
PG.136	Ability to produce all reports as defined by the BMS Master Reports List (see Procurement Library).			
PG.137	Ability for up to 16 BMS authorized users to create ad-hoc reports.			
PG.138	Ability to report according to current and future HEDIS administrative reporting guidelines. (The FFS Program does not currently report on any HEDIS measures).			
PG.139	Provides the ability to report on unduplicated counts such as Members, Providers, and services.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.140	Provides the ability to report based on a Member enrollment hierarchy established by the BMS.			
PG.141	Ability to display to the user the number of pages that will be printed before the user proceeds with printing a report.			
PG.142	Monitor the progress of claims processing activity and provide summary reports which reflect the current status of claims.			
PG.143	Present claims processing and payment information that demonstrates compliance with Federal prompt payment rules.			
PG.144	Analyze areas of program expenditure to determine cost benefit.			
PG.145	Analyze the frequency, extent, and type of Provider and other claims processing errors.			
PG.146	For reporting purposes, assigns to all claim line details line, and subline categories that correspond to the CMS 64.			
PG.147	Analyze Provider claim filing for timeliness, fiscal controls and ranking. Assume this would include analysis and reporting such as Top 25 Late Filing Providers, Provider Participation Analysis, Provider Top 100 Report, Denied Claims Summary Report by Provider Type, etc.			
PG.148	Maintains comprehensive list of standard reports and their intended use (business area supported).			
PG.149	Maintains a list of users of each standard report.			
PG.150	Retains and maintains access to reports for the period of time specified by the BMS report owner.			
PG.151	Ability to provide staff with access to reports on changes and modifications made to benefit plans and/or related components by beginning and end dates.			
PG.152	Ability to generate reports on service limitations and exclusions for each benefit plan and/or related component.			
PG.153	Ability to generate expenditure, eligibility and utilization data by benefit plan(s) and/or any of its components to support budget forecasts, monitoring and health care program modeling.			
PG.154	Provide a means of obtaining various listings of the Procedure, Diagnosis, and Formulary File.			
PG.155	Generate various listings of the claims processing suspense file.			
PG.156	Provides the Statistical Report on Medical Care: Eligibles, Members, Payments and Services (Form CMS-2082).			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.157	**10. Maintain Benefit/Reference Information**			
PG.158	Provides the comprehensive source where all current and historical reference data is maintained and updated in support of the following processes:			
PG.159	Provider enrollment			
PG.160	Medical, Dental and Pharmacy Medicaid Claims processing to ensure that claims are paid in accordance with 42 CFR 447 - Payment for Services, and non-Medicaid claims in accordance with State and Federal Policy			
PG.161	Payment processing			
PG.162	Adjustments			
PG.163	Prior authorizations (PA)			
PG.164	Maintain Procedure, Revenue, Drug, Diagnosis, and DRG data			
PG.165	Maintain Modifier data			
PG.166	Maintain Medicare Action Code data (Medicare Action Code data are action codes that are used in Medicaid cross-over processing).			
PG.167	Maintain Resource Based Relative Value Scale (RBRVS) data			
PG.168	Maintain Provider Charge file data			
PG.169	Maintain free-form text memo information (Each entry is expected to include identification of user and date/time entered).			
PG.170	Maintain System Parameter data			
PG.171	Maintain Edit Code data			
PG.172	Identify service frequency limitations			
PG.173	Drug Rebate processing			
PG.174	Drug Rebate file data			
PG.175	Labeler file			
PG.176	Drug Rebate Claim file			
PG.177	NDC Summary file			
PG.178	Produce various reports			
PG.179	Other activities as specified by the BMS during the DDI phase			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PG.180	Provides user-friendly navigation among the various reference files.			
PG.181	Provides on-line inquiry capability to all current reference data.			
PG.182	Provides on-line inquiry capability and archive access to historical reference data as defined by the BMS Data Retention Policy.			
PG.183	Provides BMS-designated on-line role-based access for approval/update/edit of reference file data tracked through the Change Request process.			
PG.184	Ability to maintain a history of all code sets, including the source and date/time of change, version, and a history of replacements or changes in meaning.			
PG.185	Maintains an audit trail record that describes the change, the date of change, retroactive change, who requested the change, who authorized the change, and user id of who implemented the change.			
PG.186	Table design should be flexible to ensure that the MMIS is able to readily accommodate changes.			
PG.187	Inputs to the reference file should include (at a minimum): POS updates; CMS HCPCS updates; and online and batch updates requested by BMS.			
PG.188	Ability to accept on-line updates, additions, and deletions, with the ability to make changes to individual records or mass changes to groups or classes of records (e.g., across Provider type and specialty).			
PG.189	Ability to accept manual and automated updates, additions, and deletions by electronic transmission to all reference files, with the ability to make changes to individual records or mass changes to groups or classes of records (e.g., across Provider type and specialty).			
PG.190	Ability to implement automated load processes to apply code set updates when updates are made available by CMS or other data publishing sources.			
PG.191	Ability to support the transition to future versions of code sets (e.g., ICD-11).			
PG.192	All reference file updates are expected to be tested by Vendor and approved by BMS prior to moving data to production.			
PG.193	Ability to alert designated BMS staff upon completion of updates of reference file data. This alert should identify all changes and revisions, deletions, and replacements and provide a cross-reference.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.194	Ability to perform mass updates, from multiple sources determined by BMS, on the test region and upon approval migrate to production on a schedule defined by BMS.			
PG.195	Ability to assure updates do not overlay or otherwise make historical information inaccessible. Should maintain back-up features to assure changes in parameters are maintained.			
PG.196	Ability to allow the tracking of changes to the reference file using on-line notes capability.			
PG.197	Ability to maintain effective dates for all code sets.			
PG.198	Ability to add values or update any code set attributes.			
PG.199	Ability to maintain a map of procedure codes to diagnosis codes to define valid/invalid combinations.			
PG.200	Ability to maintain a map of 11-digit NDC codes to J-codes (i.e., Healthcare Common Procedure Coding System (HCPCS) Level II codes) through electronic updates.			
PG.201	Ability to associate National Drug Codes (NDCs) with their therapeutic indicators.			
PG.202	Ability to maintain an on-line cross-reference between HCPCS and International Classification of Diseases-10 (10th revision)-Clinical Modification (ICD-10-CM) procedure codes.			
PG.203	Maintain an on-line cross-reference between ICD-10-CM and DSM diagnosis codes and DSM diagnosis, including DSM age 0-3 diagnosis.			
PG.204	Ability to maintain a map of ICD-10 (International Classification of Diseases, version 10) surgical procedure codes to CPT (Current Procedural Terminology) procedure codes to apply claims processing functions based on the CPT code.			
PG.205	Ability to maintain a map of Revenue codes to CPT procedure codes to apply claims processing functions based on the CPT code.			
PG.206	**11. Maintain Benefit/Reference Information - Benefit Plans**			
PG.207	Ability to maintain the benefit plan data repository and ensure that data is captured, stored and maintained by program per BMS specifications.			
PG.208	Able to create and modify multiple benefit plans that define, identify and maintain separate service profiles under each program in accordance with policy.			
PG.209	Ability to maintain and update effective and end dates for all benefit plans.			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.210	Ability to provide standardized testing/modeling environment or tools to determine impact of modifications to the benefit plan(s) and/or any of its components.			
PG.211	Ability to easily add, delete, or modify benefit plan(s) and/or its related components.			
PG.212	Ability to automatically notify staff (as specified by BMS) of changes to health plans and/or related components (e.g., databases, modules, rules, etc.) and their effective dates.			
PG.213	Ability to allow an existing benefit plan and its associated components to be copied and renamed (to facilitate the creation of a new plan).			
PG.214	Ability to support a hierarchy of program rules to determine which program the claim will be paid.			
PG.215	**12. Maintain Benefit/Reference Information - Reference File Procedure Data Set**			
PG.216	Ability to maintain a Procedure Data Set which is expected to contain the following elements:			
PG.217	International Classification of Disease (ICD)-9/10-CM diagnosis and procedure codes			
PG.218	Approved versions of Health Common Procedure Coding System (HCPCS) procedure codes			
PG.219	Procedure code data status (active/inactive) code segments with effective begin and end dates for each segment			
PG.220	History of full descriptions for procedure codes			
PG.221	History of short descriptions for procedure codes			
PG.222	Effective and term dates for all items			
PG.223	Diagnostic Related Groups (DRG)			
PG.224	NDC drug codes			
PG.225	HIPAA mandated code sets			
PG.226	HL 7 LOINC code sets			
PG.227	Current Dental Terminology (CDT) procedure codes			
PG.228	Current Procedure Terminology (CPT) procedure codes			
PG.229	Indicators associated with selected parameters for use in claims processing (to determine include, exclude, disregard)			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PG.230	Multiple modifiers and the percentage of the allowed price applicable to each modifier			
PG.231	Revenue Center Codes (RCC)			
PG.232	Revenue Center Codes (RCC) should indicate if itemizations of HCPCS codes are required for claims processing and identify the list of valid/invalid HCPCS codes			
PG.233	Provider charge file legacy custom rates			
PG.234	Managed care program covered benefits exclusion plans			
PG.235	Relative value units			
PG.236	Edit/audit criteria and disposition tables			
PG.237	Business rules			
PG.238	Ambulatory Payment Classifications (APCs)			
PG.239	Base units for American Society of Anesthesiologists (ASA) codes			
PG.240	Coding values that indicate if a procedure is covered by Medicaid or other programs			
PG.241	Authorized specialty and taxonomy			
PG.242	Required Clinical Laboratories Improvement Amendments (CLIA) certification type			
PG.243	PA requirements (e.g., always required, sometimes required, never required)			
PG.244	Valid/invalid Place Of Service (POS) limitations			
PG.245	Recipient age/gender restrictions			
PG.246	Contraindicated edits			
PG.247	Pre and post-operative days			
PG.248	Once-in-a-lifetime indicator			
PG.249	Never events (TBD) HAC			
PG.250	Two digit place of service			
PG.251	Co-pay indicator, and associated data including the co-payment amount/per service unit and/or aggregate out-of-pocket co-payment thresholds for the service			
PG.252	Aid category, rate code, RAPIDS program code, or MAS/BOE code			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PG.253	Family planning indicator (method defined by BMS)			
PG.254	Emergency indicator			
PG.255	Claim type			
PG.256	Diagnosis code requirements including the list of valid/invalid diagnosis codes and if diagnosis is required (header/line) for claims adjudication			
PG.257	Units of service			
PG.258	Review indicator			
PG.259	Tooth number or letter			
PG.260	Tooth surfaces			
PG.261	EPSDT indicator			
PG.262	Anesthesia base values			
PG.263	Duplicate check			
PG.264	Indicator of TPL actions, such as cost avoidance, benefit recovery or pay, by procedure code.			
PG.265	Indication of MCO carve-outs			
PG.266	Procedures manually priced or manually reviewed			
PG.267	Limits of the procedure			
PG.268	Indication of non-coverage by third-party payers			
PG.269	Information such as accident-related diagnosis codes for possible TPL, Federal cost-sharing			
PG.270	Indicators for surgical, bi-lateral surgical, and endoscopy procedures			
PG.271	Indication of when or whether claims for the procedure can be archived from on-line history (such as once-in-a-lifetime procedures)			
PG.272	Payment Type (one-time, repetitive, invoiced)			
PG.273	Post-operative day(s) parameter used for determining bundling policy for surgical claims/visits			
PG.274	Indicate if referring Provider number is required for the procedure code			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.275	Indicate if multiple surgery pricing (based on the modifier) applies to the procedure code and the extent to which Multiple Surgery (MS) pricing is applicable (the MS rule followed by business rules, canned or customized to meet BMS needs)			
PG.276	Non-reportable indicator			
PG.277	**13. Maintain Benefit/Reference Information - Reference File Drug Data Set**			
PG.278	Ability to accommodate updates to the Drug Data Set from sources including: contracted drug data and pricing service; the CMS Drug Rebate file and future State rebate program updates; and updates from BMS staff as needed.			
PG.279	Vendor is expected to procure the Drug Reference database for use in claims processing.			
PG.280	Ability to import CMS drug rebate file and use it for claims processing as directed by BMS.			
PG.281	Provides a notification to BMS that drug code and pricing changes need manual review.			
PG.282	Automatically implements drug code and pricing changes upon approval of BMS.			
PG.283	Maintains current and historical coverage status and pricing information (including effective and termination dates) on legend drugs and Over The Counter (OTC) items.			
PG.284	Ability to maintain a Drug Data Set which is expected to contain the following:			
PG.285	Eleven digit NDC			
PG.286	Brand name			
PG.287	Generic name			
PG.288	Name of manufacturer and labeler codes			
PG.289	Add date			
PG.290	Begin date			
PG.291	Effective date			
PG.292	CMS termination date			
PG.293	Obsolete date			
PG.294	Specific therapeutic class codes and descriptions			
PG.295	Route of administration			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.296	Identification of strength, units, quantity, and dosage form (powder, vial, liquid, cream, capsule) on which price is based			
PG.297	Standard packaging indicators, size and description			
PG.298	Previous NDC			
PG.299	Minimum dosage units and days			
PG.300	Maximum dosage units and days			
PG.301	Generic indicator			
PG.302	Generic code number (GCN)			
PG.303	Generic sequence number (GSN)			
PG.304	DEA code			
PG.305	Unlimited date-specific pricing segments which include all prices needed to adjudicate drug claims records in accordance with BMS policy			
PG.306	Indicators for multiple dispensing fees			
PG.307	Identification of CMS Drug Rebate, Medical Assistance Program (MAP) Rebate program status and corresponding dates.			
PG.308	CMS unit of measure			
PG.309	Quantity field for pharmacy claims (allow for decimal units)			
PG.310	Indicators for controlled drug, over-the-counter (OTC)			
PG.311	DESI/LTE indicator (drug efficacy study index, less than effective)			
PG.312	Preferred drug list status			
PG.313	Indicators for schedule assigned to controlled drugs			
PG.314	Drug Utilization Review (DUR) functions (e.g., high dose, low dose, drug to drug interaction)			
PG.315	Date-specific, BMS-specific restrictions on conditions to be met for a claim to be paid including (but not limited) the following and any combinations thereof: maximum/minimum days supply; quantities; refill restrictions; preferred versus non-preferred indicators; recipient age/gender restrictions; prior authorization requirements; place of service for medical claims			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.316	Pricing indicators to accommodate the following reimbursement methodologies: Federal Upper Limit (FUL); State Maximum Allowable Cost (SMAC); Wholesale Acquisition Cost (WAC); Estimated Acquisition Cost (EAC); Average Wholesale Price (AWP); AWP-minus; WAC-plus; and other pricing methodologies as they become available			
PG.317	Other as identified by BMS during DDI and accepted via formal change control			
PG.318	**14. Maintain Benefit/Reference Information - Reference File Revenue Code File**			
PG.319	Ability to maintain a Revenue Code File with a code data set that contains at a minimum, the following elements:			
PG.320	Revenue code date-specific pricing segments, including, effective begin and end dates, and allowed amount for each segment			
PG.321	Revenue code status code segments with effective begin and end dates for each segment			
PG.322	Indicators associated with selected parameters to designate whether the code should be included, excluded, or disregarded in claims processing			
PG.323	Complete narrative descriptions of revenue codes.			
PG.324	Indication of TPL actions, such as cost avoidance, benefit recovery, or pay, by revenue code			
PG.325	Indication of non-coverage by third-party payers			
PG.326	Information such as accident-related indicators for possible TPL, Federal cost-sharing indicators, Medicare coverage, and allowed amounts			
PG.327	**15. Maintain Benefit/Reference Information - Reference File Pricing Data Set**			
PG.328	Ability to transmit and/or provide on-line inquiry access to pricing files for outside vendors and entities determined by the BMS.			
PG.329	Ability to configure the reference file to allow the same procedure code to be priced differently (e.g., based on age of consumer for the same date span).			
PG.330	Ability to adjust and maintain pricing data for all health plans and/or benefit packages and identify and calculate payment amounts according to rates and rules established by BMS for various categories of pricing methods, for claim types other than retail pharmacy claims, including:			
PG.331	Fee schedule			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.332	Maximum allowable fee per service (note: some situations require paying Federal portion of fees)			
PG.333	Percent of charge (billed amount) pricing			
PG.334	Multiple rates for all Providers and Provider types (as identified by BMS)			
PG.335	Interim and final rates, per Provider			
PG.336	Per diem rates for BMS-specified Provider types			
PG.337	Capitated rates for MCOs and PCCM services			
PG.338	Case-by-case pricing (by report, manually priced, etc.)			
PG.339	PA pricing fee schedule			
PG.340	PA pricing case-by-case			
PG.341	Enhanced or adjusted incentive payments as determined by BMS-defined pricing rules (e.g., dental pediatric incentive, HPSA pricing)			
PG.342	Per diem rates, assigned to each LTC Provider with a corresponding date span for pricing			
PG.343	Anesthesia pricing			
PG.344	LTC facility daily rate, room and board charges			
PG.345	LTC Prospective Payment System (PPS) rates			
PG.346	LTC nursing rate			
PG.347	Case mix adjusted rates for long term care facilities			
PG.348	Payment rates and effective dates for each rate, per facility			
PG.349	Consumer-specific pricing based on consumer location (i.e., hospice), monthly cost caps per consumer (i.e., for waiver programs)			
PG.350	Medicare pricing or payment rates			
PG.351	Procedure code modifier pricing			
PG.352	Drug cost plus dispensing fee per prescription			
PG.353	Different rates for transplants and organ acquisition costs			
PG.354	Assistant-at-Surgery pricing			
PG.355	Package size pricing			
PG.356	Individual consideration pricing (e.g., hospital outliers)			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
PG.357	Ambulatory Surgical Center (ASC) group pricing as determined by BMS			
PG.358	VFC (Vaccines for Children program) pricing and rates by procedure code			
PG.359	National Drug Code (NDC) (used for pricing hospital claims)			
PG.360	Transportation pricing			
PG.361	Non-specified formula pricing, where non-specified formula pricing would refer to having a PA price a claim			
PG.362	Other as identified by BMS during DDI and accepted via formal change control			
PG.363	Ability to maintain the following hospital-specific inpatient and outpatient rate data, by effective date(s) including:			
PG.364	Inpatient DRG rate components			
PG.365	Inpatient and outpatient cost to charge ratios			
PG.366	Other hospital specific payment components such as per diems, percentages			
PG.367	Ability to accommodate multiple outpatient hospital reimbursement methodologies based on business rules provided by BMS, including:			
PG.368	Outpatient prospective payment			
PG.369	Per discharge/visit			
PG.370	Percent of charge			
PG.371	Fee-For-Service (FFS) procedure code prices for outpatient hospital care			
PG.372	Line level and revenue center code pricing			
PG.373	Other as identified by BMS during DDI and accepted via formal change control			
PG.374	Ability to accommodate multiple inpatient hospital reimbursement methodologies based on business rules provided by BMS, including:			
PG.375	DRG			
PG.376	Per discharge/visit			
PG.377	Per diem			
PG.378	Percent of charge			

4. Program Management (PG)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
PG.379	Line level and revenue center code pricing			
PG.380	Other as identified by BMS during DDI and accepted via formal change control			
PG.381	**16. Maintain Benefit/Reference Information - Reference File ICD-CM Coding Set**			
PG.382	Ability to maintain a Diagnosis set that utilizes ICD-CM coding sets. The diagnosis data set is expected to contain, at a minimum:			
PG.383	Age			
PG.384	Gender			
PG.385	Family planning indicator			
PG.386	Prior authorization indicator			
PG.387	EPSDT indicator			
PG.388	TPL trauma and emergency trauma codes			
PG.389	Inpatient length of stay criteria			
PG.390	Accident/trauma indicator			
PG.391	Begin date			
PG.392	End date			
PG.393	Add date			
PG.394	Description of the diagnosis			
PG.395	Primary and secondary diagnosis code usage			
PG.396	Indicators associated with selected parameters to designate whether they should be: included, excluded, or disregarded in claims processing			
PG.397	Covered			
PG.398	Not covered			
PG.399	Effective dates for all items			
PG.400	Indication of non-coverage for certain eligibility groups			
PG.401	Indication of non-coverage by managed care organizations			
PG.402	Cross reference to procedure codes			
PG.403	Performance, utilization, and program integrity reviews			
PG.404	Participation in Member care management			
PG.405	Other as identified by BMS during DDI and accepted via formal change control			

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
CM.1	**1. Manage Medicaid Population Health**			
CM.2	Ability to query both clinical and claims data for Members in both MCO and FFS populations in order to analyze performance of current programs and to conduct "what-if" analyses.			
CM.3	Ability to access and query data from other governmental entities (outside of BMS, including but not limited to HIE, HIX, and CMS) in order to:			
CM.4	Design and improve programs for potential as well as existing Medicaid Members			
CM.5	Coordinate decision-making and program development across agencies and offices in support of common care management goals			
CM.6	Query data and extract reports to analyze effectiveness of Medicaid dollars granted to other agencies/programs in support of care management goals			
CM.7	Provide training - BMS expects the Vendor to provide training in the use of data analysis and toolset for purposes of care management			
CM.8	Ability to use MMIS data to support population health analyses.			
CM.9	Ability to receive population health data from various external entities. Data should include:			
CM.10	Census data			
CM.11	Vital statistics			
CM.12	Immigration data			
CM.13	Public health data			
CM.14	Statewide Health Information Exchange			
CM.15	National Health Information Network			
CM.16	Other as identified by BMS during DDI and accepted via formal change control			
CM.17	Ability to track and maintain detail for population health initiatives, including:			
CM.18	Originator/source of inquiry			
CM.19	Data source/s used			
CM.20	Strategy (or strategies) developed in response to data analysis			
CM.21	Changes to benefits			

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
CM.22	Changes to reference data			
CM.23	Record of communication materials			
CM.24	Time period/case schedule of review			
CM.25	Other as identified by BMS during DDI and accepted via formal change control			
CM.26	The system should support the entry of free-form text field (number of characters as approved by BMS during DDI) associated with each request/analysis, including identification of user and date/time entered.			
CM.27	Ability to display free-form narrative in chronological or reverse chronological sequence.			
CM.28	**2. Establish Case**			
CM.29	Ability to automatically or manually populate, maintain and display multiple indicators at the Member level (e.g., disease state management, TBI, MR/DD).			
CM.30	Ability to use claims history information to support care management program eligibility determination (e.g., Disease Management and Disability Determinations).			
CM.31	Ability to use historical data to identify potential participants for specific programs, including historical data from the following:			
CM.32	Medicaid Waiver program case management - Home and Community Based Services (HCBS) and other			
CM.33	Disease management			
CM.34	Catastrophic cases			
CM.35	Early Periodic Screening, Diagnosis, and Treatment (EPSDT)			
CM.36	Population management			
CM.37	Other as identified by BMS during DDI and accepted via formal change control			
CM.38	Ability to support flexible rules-based logic (as specified by BMS) to determine care management program eligibility criteria for:			
CM.39	Individual Member			
CM.40	Family			
CM.41	Target populations			
CM.42	Other as identified by BMS during DDI and accepted via formal change control			

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
CM.43	Ability to generate a high-cost Member report to determine potential participation in a care management program.			
CM.44	Ability to allow user to specify values/range of values when performing program participant data search. A user may limit values for any combination of the following:			
CM.45	Target population characteristics (e.g., Member age, location, specific medical conditions)			
CM.46	Data requirements (e.g., time period)			
CM.47	Data elements presented in reporting (e.g., procedure codes, diagnosis codes)			
CM.48	Other as identified by BMS during DDI and accepted via formal change control			
CM.49	Ability to identify clients of special or State-funded programs, such as waiver, case-management, Aging and Disability Services Administration (ADSA) programs, Health Resources and Services Administration (HRSA) programs, and other assistance programs, with effective dates and other data required by the State.			
CM.50	Ability to support flexible rules-based logic (as specified by BMS) to determine program/s appropriate for each Member.			
CM.51	Ability to track and maintain Member treatment (care) plans and Health Improvement Plans, including the following detail:			
CM.52	Member detail (name, ID, etc.)			
CM.53	Identifies care needs as specified in the Health Improvement Plan			
CM.54	Care Management Program (e.g., EPSDT, Disease Management)			
CM.55	Provider type/s			
CM.56	Provider detail of Provider/s associated with case (name PIN, contact info, etc.)			
CM.57	Patient-Centered Medical Home (PCMH)			
CM.58	Program starting and end dates			
CM.59	Care setting			
CM.60	Services to be delivered			
CM.61	Services delivered detail (including cost & date)			
CM.62	Frequency of service/s			

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
CM.63	Expected results			
CM.64	Review detail, including dates			
CM.65	Other as identified by BMS during DDI and accepted via formal change control			
CM.66	Ability to provide role-based access (defined by BMS) to Member treatment plans.			
CM.67	Ability to close the program case and automatically notify* appropriate parties (including Member and Provider) if the Member chooses not to enroll in the care management program. *(BMS to determine notification method; may include letter or e-mail.)			
CM.68	Ability to set a program maximum number of unduplicated participants (as specified by BMS) for care management programs.			
CM.69	Ability to create a waiting list when the maximum number of unduplicated participants has been reached for a program.			
CM.70	Ability to automatically generate a notice/alert (defined by BMS) when number of unduplicated participants enrolled in a program exceeds the specified maximum.			
CM.71	Ability to automatically generate a notice/alert (defined by BMS) when unduplicated enrollment reaches a BMS-specified percentage of maximum enrollment.			
CM.72	Ability to manually override program maximum enrollment.			
CM.73	**3. Manage Case**			
CM.74	Ability to track and report the number of unduplicated participants in all care management programs.			
CM.75	Ability to accept and update care management screening data fields from claim and encounter data at least weekly.			
CM.76	Ability to track and maintain program Provider qualification requirements for each care management program.			
CM.77	Ability to match the care management periodicity schedule with FFS billing, managed care encounter data, and Health Outcome Measures.			
CM.78	Ability to automatically deny participation for Providers not meeting care management program qualification requirements.			
CM.79	Ability to monitor program data to determine if the services approved in the plan of care are provided.			

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
CM.80	Ability to provide on-line role-based access (as assigned/decided by BMS) to case management data, including:			
CM.81	Program data and imaged documentation			
CM.82	Member information (e.g., hospitalizations, LTC facility, pharmacy, PA information, State Plan services)			
CM.83	Claims data			
CM.84	Historical case, claims and enrollment data			
CM.85	Eligibility information			
CM.86	Benefit packages			
CM.87	Provider information (e.g., outpatient services, waiver services by type, waiver services by Provider and by Member)			
CM.88	Case notes			
CM.89	Case activity codes			
CM.90	Other as identified by BMS during DDI and accepted via formal change control			
CM.91	Ability to search on-line care management data (according to role-based access defined by BMS) by any of the following: Member name, Member ID, and/or Provider ID.			
CM.92	Ability to provide Case Managers role-based access (as assigned/decided by BMS, roles to be determined) to case management data. Case Managers can be defined as any of the following:			
CM.93	BMS staff			
CM.94	Nurses			
CM.95	Other State agencies			
CM.96	Contractors			
CM.97	Social workers			
CM.98	Other entities as defined by BMS			
CM.99	Ability to maintain Member-level EPSDT records with functionality that:			
CM.100	Includes user configurable periodicity schedules			
CM.101	Maintains tracking data, by Member, including notification and screening dates, screening results, referral details			
CM.102	Stores summary and detail EPSDT activities and services			

5. Care Management (CM)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
CM.103	Generates initial and follow-up EPSDT notices (for Providers) based on periodicity schedules			
CM.104	Track immunization records and status for children from birth to age eighteen (18)			
CM.105	Track services provided as a result of EPSDT			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.1	**1. General/Technical**			
POS.2	Ability to provide a system capable of easy modifications and updates based on current technology to insure integrity and drug coverage within BMS guidelines.			
POS.3	The Pharmacy POS is expected to support all pharmacy functions, files and data elements necessary to meet the requirements in this RFP.			
POS.4	Ability to maintain an easy to read audit trail of all database changes/updates accessible through online inquiry, with a date, time, reason and user ID.			
POS.5	Ability to support the following inputs:			
POS.6	Claims history data			
POS.7	Member data			
POS.8	National Provider Identifier (NPI) validation			
POS.9	Provider data			
POS.10	Reference file data			
POS.11	Drug utilization review (DUR) reporting parameters			
POS.12	National Council on Prescription Drug Program (NCPDP) Version 5.1, and batch Version 1.1, or the most current HIPAA compliant version of electronic claims and hard copy submitted claim information			
POS.13	HIPAA compliant electronic Prior Authorization requests and hard copy Prior Authorization requests, to include an automated prior authorization process using NCPDP Standards (Version 5.1 and any future releases). Currently, BMS uses an automated prior authorization process through the services of a vendor using NCPDP P1-P4 transactions. Requests for drugs not included in the auto PA process could be submitted electronically via the Web Portal to the current drug prior authorization services vendor that receives them into its automated fax system.			
POS.14	Online prescription data from Providers for Prospective Drug Utilization Review (ProDUR)			
POS.15	Automated preferred drug data file updates			
POS.16	ProDUR criteria			
POS.17	Other as identified by BMS during DDI and accepted via formal change control			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
POS.18	The Vendor is expected to maintain and update the Pharmacy Provider file, including (at a minimum) the following fields: the pharmacy NPI; pharmacy Provider type and pharmacy specialty, pharmacy physical address, fax, and phone numbers; and others as defined by BMS during DDI.			
POS.19	Ability to perform print screen on all Pharmacy POS screens directly from the system.			
POS.20	Ability to link to specific information (e.g., Provider, Member, Drug, PA, etc.) within and across data fields as specified by BMS (for example, drill-down capability among Prescriber, Provider, Member, etc.).			
POS.21	Provide a free-form memo field (number of characters as approved by BMS during DDI) associated with drug reference file maintenance. Each entry is expected to include identification of user and date/time entered.			
POS.22	The system should support ad hoc reporting on the memo field based on criteria as defined by BMS (e.g., type of memo, user and date range).			
POS.23	The Pharmacy POS is expected to maintain batch controls and audit trails on all pharmacy claims processing activities.			
POS.24	The Pharmacy POS is expected to assign a unique control number to every claim at the time when the record is processed.			
POS.25	The Vendor should store electronic record of every claim and attachment at the Vendor site in accordance with the BMS Data Retention Policy.			
POS.26	The Pharmacy POS is expected to have the ability to identify those individuals who performed a force or override on an error code.			
POS.27	The Pharmacy POS is expected to provide audit trail capabilities for any changes to the system.			
POS.28	Ability to set minimum and maximum quantity limits on each drug with no additional charge.			
POS.29	At a minimum, ability to support paid, denied, duplicate pay, duplicate reverse, rejected, reversed and rejected reversed claims.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.30	**2. General/Technical - Help Desk & User Support**			
POS.31	The Vendor is to supply a POS Pharmacy Help Desk dedicated to the West Virginia account. (The current pharmacy POS clinical prior authorization services vendor is expected to continue to provide drug prior authorization services only, under a separate contract. The Vendor is expected to assume the POS Pharmacy Help Desk role and processes).			
POS.32	The system should support a notes functionality – in regard to help desk activity			
POS.33	Ability to provide secure online access to current, updated source documents, Vendor developed policy/procedure manuals, system documentation, Provider manuals and forms for contract and BMS staff, including document search capabilities.			
POS.34	Ability to store current, updated source documents, Vendor developed policy/procedure manuals, system documentation, Provider manuals and forms in electronic format accessible via PC workstation.			
POS.35	**3. General/Technical - Inputs/Interfaces**			
POS.36	All claims data from the Pharmacy POS system should be passed by an interface file to the MMIS (on a schedule determined by BMS) for reporting, payment and remittance voucher generation.			
POS.37	Ability to allow the Pharmacy POS real-time access to Pharmacy and Medical/Dental claims databases.			
POS.38	Ability to support interfaces with external systems, including (but not limited to):			
POS.39	Retro DUR vendor			
POS.40	DW/DSS (Data Warehouse/Decision Support System)			
POS.41	CMS and/or their agents			
POS.42	Commercial drug file vendor			
POS.43	Other as identified by BMS during DDI and accepted via formal change control (the Vendor is expected to exhibit a willingness to support BMS defined interfaces)			
POS.44	Ability to support the following online processing of pharmacy claims through networks provided by contracted switch vendors:			
POS.45	Transmission and online real-time processing of pharmacy claims			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.46	Real-time access to Member and Provider eligibility information			
POS.47	Prior Authorization processing			
POS.48	Third Party Liability (TPL) processing and response			
POS.49	Respond to Drug Utilization Review (DUR) alerts			
POS.50	Notification of co-payment requirements			
POS.51	Other as identified by BMS during DDI and accepted via formal change control			
POS.52	Pharmacy POS should support an eligibility transaction through network Providers to provide or support Provider queries on eligibility. (The POS should support NCPDP eligibility request transactions).			
POS.53	**4. Drug File**			
POS.54	The Pharmacy POS drug file is expected to have the capability to indicate preferred drug status.			
POS.55	The Pharmacy POS drug file is expected to have the capability to indicate prior authorization requirements.			
POS.56	Ability to develop, implement and maintain the BMS's customized drug database.			
POS.57	Ability to, at a minimum, support all data elements provided by a commercial drug file vendor for each drug. (BMS prefers the vendor use First DataBank (FDB) and the AWP pricing file from Medispan. Currently, all clinical and therapeutic policies are based on FDB nomenclature, while AWP pricing is supported by using Medispan file.			
POS.58	Ability to maintain a master drug data file, which contains an entire list of products available including legend and Over the Counter (OTC) drugs, as well as others as specified by the BMS.			
POS.59	Ability to maintain, at a minimum, all standard drug-specific data elements used by pharmacy claims processors and the BMS-specific data elements.			
POS.60	Ability to provide for electronic update of the drug database from a commercial drug file vendor on at least a weekly basis or as directed by the BMS. (BMS does not expect to be purchasing/leasing the commercial drug file. The Vendor is expected to be responsible for this contract. First DataBank is the current vendor and Medispan's AWP pricing file was added in September 2011).			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.61	Ability to overwrite data transferred from commercial drug file vendor.			
POS.62	The Pharmacy POS is expected to have the ability to protect manual changes from automatic updates from the drug database vendor.			
POS.63	Ability to allow user-defined Drug file data elements in addition to those provided by commercial drug file vendor.			
POS.64	Ability to provide online, real-time update capability for changes to specific drug codes on the database at the direction of the BMS.			
POS.65	Ability to manually update term dates of drugs.			
POS.66	Ability to provide the BMS online inquiry window access to the Master Drug Data files, and access to pending changes that are to be used to update the Master Drug Data files.			
POS.67	Ability to view all database elements that are found in the drug file records.			
POS.68	Ability to provide an automated audit trail system to document reference database changes approved by the BMS, as well as documentation of the change and the reason for change.			
POS.69	Ability to maintain history of the deleted NDCs from the drug reference file.			
POS.70	Ability to generate report of changes made on Drug Reference File (including date of change), including date, time, reason and user ID.			
POS.71	Ability to import the CMS drug file and reconcile with the drug database file according to BMS established criteria. (BMS expects that drug termination dates, DESI information, and rebate status published by CMS are used/considered when processing POS claims. BMS expects that CMS' data, when different from the drug file data, would overlay the drug file data, if approved by BMS. BMS expects there to be an automated process for applying this data).			
POS.72	**5. Claims Processing - General**			
POS.73	Ability to provide and maintain a pharmacy claims processing system with the capability to process electronic and paper transactions.			
POS.74	Ability to monitor and track all claims processing activities.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.75	Ability to process all claims in a real-time mode via POS technology.			
POS.76	Ability to allow system users to define which fields are displayed as part of a POS claim screen.			
POS.77	The Pharmacy POS is expected to support the universal claim form for paper submittals.			
POS.78	Ability to provide a system to process paper claims (including those with attachments if allowable by NCPDP) and maintain edits and audits identical to those in the POS system.			
POS.79	Ability to accept DEA on paper claim (either NPI or DEA is acceptable as a prescriber identifier on paper only).			
POS.80	Ability to support multiple transactions within 1 transmission from a Provider, based on current NCPDP standards.			
POS.81	On-line access to Member claim profile information that includes, but not be limited to:			
POS.82	Drugs with descriptions			
POS.83	Narrative denial reasons			
POS.84	Other as identified by BMS during DDI and accepted via formal change control			
POS.85	Ability to limit benefits on a Member-by-Member basis (i.e., individual member basis), per BMS approval, for limitations such as therapeutic categories, optional services and others defined as BMS.			
POS.86	The Pharmacy POS should respond with reject codes for each transaction within a transmission as defined by NCPDP standard.			
POS.87	Ability to deny any claim without valid eligibility information on file.			
POS.88	Ability to verify Member eligibility using demographic data as determined by BMS.			
POS.89	Ability to identify Medicaid vs. Non-Medicaid Members.			
POS.90	Ability to support a pharmacy lock-in capability for each Member when necessary. Lock-in to one pharmacy Provider.			
POS.91	Ability to support a customizable prescriber lock-in capability for each Member when necessary. Lock-in to one prescribing Provider for certain therapeutic classes.			
POS.92	Ability to capture and display HMO plan information (fields for display to be defined by BMS).			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.93	Ability to edit all FFS claims submitted for Members identified to have third-party coverage, including Medicare, according to BMS policies.			
POS.94	Ability to process claims when Date of Service does not exceed 12 months from the date the prescription was written.			
POS.95	Ability to set a maximum day supply as defined for BMS.			
POS.96	Ability to allow exceptions to the maximum day supply.			
POS.97	Ability to support the current NCPDP standard "Reversal" message which is to effectively 'debit' the named claim.			
POS.98	**6. Claims Processing - Edits/Audits**			
POS.99	Ability to process pharmacy claims, at a minimum, using all edits currently defined by the BMS.			
POS.100	The Pharmacy POS should perform real-time edit/audit processing.			
POS.101	Ability to modify edits and audits as necessary or as defined by the BMS when policy or coverage changes are implemented.			
POS.102	Ability to perform adjudication of unique claims (i.e. by-pass edits/audits) as specified by the BMS.			
POS.103	Ability to deny or override claim edits and audits in accordance with BMS determined guidelines.			
POS.104	Ability to identify and exclude from coverage certain National Drug Code (NDC) numbers as required by the BMS.			
POS.105	Ability to restrict a Provider to specific drugs they can prescribe (in accordance with BMS-specified list defined during DDI).			
POS.106	Ability to exclude prescriber NPIs when the OIG (Office of Inspector General) or BMS has determined they are ineligible for participation.			
POS.107	Ability to limit dollar amounts as defined by BMS.			
POS.108	Ability to provide an edit to alert pharmacies when incorrect units are billed for drugs based on package size including those with decimals.			
POS.109	Ability to edit controlled substance claims in accordance with Federal regulations.			
POS.110	Ability to limit coverage by age, gender, quantity, and edits going backwards and forwards, and other as determined by BMS.			
POS.111	Ability to apply the Federal rebate requirements.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.112	Ability to approve for payment exceptions to the Federal rebate requirements as defined by BMS.			
POS.113	Ability to edit and deny on certain NDC levels or therapeutic classes for drugs contraindicated during pregnancy.			
POS.114	Ability to limit drugs based on diagnosis or drug history.			
POS.115	All brand name multi-source drugs, which have a therapeutically equivalent generic available, should be denied for payment. A suitable generic drug is to be substituted, unless the Dispense as Written (DAW) is submitted per BMS guidelines.			
POS.116	Ability to recognize a preferred brand and not require the submission of a DAW code, as determined by BMS.			
POS.117	Ability to allow the BMS to define use criteria for use of DAW codes.			
POS.118	**7. Claims Processing - Benefit Plans**			
POS.119	Ability to configure claims processing benefit plans, as defined by the BMS.			
POS.120	Ability to process pharmacy claims using plan limitations as defined on the date of service.			
POS.121	Ability to support limits on scripts per month following benefit coverage rules (as defined by BMS).			
POS.122	Ability to apply, at the minimum, the primary, secondary coverage hierarchy (as defined by BMS) to claims processing.			
POS.123	Ability to block coverage of a benefit for certain Members as determined by BMS.			
POS.124	**8. Claims Processing - Coordination of Benefits (COB)/Third Party Liability (TPL) Requirements**			
POS.125	Ability to deny any claim that should be submitted for Medicare payment first (where the Member is identified as Medicare eligible).			
POS.126	Ability to allow Providers to submit a third party's carrier identification number and plan/policy numbers for insurance carriers not listed on the Member eligibility file. (BMS currently contracts with a vendor that uses the POS information to research unreported TPL. Once identified, the vendor updates the BMS eligibility files. BMS may identify other methods of collecting eligibility information in the future).			
POS.127	Ability to edit to ensure that TPL has been satisfied in accordance with BMS policies.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.128	Pharmacy POS Coordination of Benefits (COB) for pharmacy claims is expected to be able to deny a claim when other insurance or Medicare coverage is present.			
POS.129	Ability to accept TPL information in a submitted claim, per NCPDP standards.			
POS.130	Capable of tabulating the one or more TPL payments towards the Medicaid cost of the claim.			
POS.131	Ability to not wrap around the Medicare Part D Benefit. (Wrap around references payment of drugs not covered by Part D plan formularies. BMS does not pay any Medicare Part D copayment or cover any drugs not covered by Part D plan formularies, other than the CMS defined list of drugs that are excluded by Part D and remain the responsibility of Medicaid).			
POS.132	Ability to capture the reject reason for the denial by the primary payer.			
POS.133	Ability to recognize the co-payment requirement from the primary insurance and calculate the Medicaid payment per BMS requirements.			
POS.134	Ability to deny hospice claims unless for a non-hospice covered drug. Hospice is considered a third-party payer.			
POS.135	Ability to support reject codes submitted from a Provider for each TPL submitted per NCPDP standard.			
POS.136	**9. Claims Processing - Compounds Requirements**			
POS.137	Ability to support the requirement that at least one ingredient is a covered legend drug.			
POS.138	Ability to edit for PA and quantity limits, and other edits as required by BMS, for each line of the compound.			
POS.139	Ability to pay a compound claim whose ingredients may include a non-allowable NDC; OTC priced at lowest determined cost; DME items and non-rebate drugs priced at $.00.			
POS.140	Ability to support processing of compounds containing up to 25 ingredients per prescription.			
POS.141	Ability to price compound ingredients based on the individual prices of each ingredient quantity contained in the compound.			
POS.142	A compound drug containing a DESI (also known as Less than Effective Drug Efficacy Study Implementation -- LTE DESI) ingredient should be denied. (All drugs that are CMS DESI 5 or 6 designation should be denied for payment when billed as a single ingredient or if billed as an ingredient in a compounded prescription).			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.143	**10. Claims Processing - Refills**			
POS.144	Ability to limit the number of 3 day Emergency fills during the life of a prescription as specified by a configuration parameter.			
POS.145	Ability to enforce 11 refills per prescription within 12 months resulting in a total of a maximum of 12 fills in 12 months (for non-controlled substances)			
POS.146	Ability to enforce 5 refills per prescription within 6 months for controlled substances.			
POS.147	Ability to enforce early refill limits using different percentages of supply used across different drug categories as determined by BMS.			
POS.148	Ability to restrict replacement lost/stolen drugs in order to disallow the pharmacy to enter override code per BMS policy. Current BMS policy requires a call to the help desk for approval.			
POS.149	**11. Drug Utilization Review (DUR)**			
POS.150	Ability to provide and support point-of-sale with prospective DUR edits.			
POS.151	Ability to use existing Medicaid Member pharmacy claim history records to evaluate the current prescription for possible interactions between the patient's active history prescriptions and the drug being currently prescribed.			
POS.152	Ability to use ProDUR communications that comply with current specifications used in NCPDP Version 5.1 or the most current HIPAA compliant version.			
POS.153	Ability to provide online access to Prospective Drug Utilization Review (ProDUR) criteria/screening data files.			
POS.154	Ability to support the following requirements for ProDUR:			
POS.155	Support an edit process that should be parameter or table-driven and be flexible			
POS.156	Provide the capability to update system parameters without complex programming within one (1) business day of receipt of request			
POS.157	Provide BMS users with role-based access to DUR data (on-line) for the purpose of displaying module groupings (therapeutic classes), dosing, and other criteria used for editing.			
POS.158	Other as identified by BMS during DDI and accepted via formal change control			
POS.159	**12. Drug Utilization Review (DUR) - Claims Review**			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.160	The DUR Clinical Modules should be configurable and customizable and provide edits per BMS policy. The modules should include (at a minimum):			
POS.161	Drug Drug Interaction (DD)			
POS.162	Therapeutic Duplication (TD)			
POS.163	Ingredient Duplication (ID)			
POS.164	Early Refill (ER) if applicable			
POS.165	Pregnancy Precaution (PG)			
POS.166	High Dosage (HD)			
POS.167	Maximum Duration (MX)			
POS.168	Breastfeeding Precaution (SX)			
POS.169	Low Dosage (LD)			
POS.170	Late Refill (LR)			
POS.171	Drug/Allergy alerts			
POS.172	Ingredient/therapeutic duplication crossover			
POS.173	Other as identified by BMS during DDI and accepted via formal change control			
POS.174	RxDUR should have capability to modify the ON/OFF status of clinical modules. (BMS expects the Vendor's solution to have the flexibility to set to "ignore" status such DUR edits as late refill or pregnancy for certain therapeutic classes, but be able to apply them to other therapeutic classes. An example is to deny ACE inhibitors for members who are pregnant, but do not deny Penicillins for members who are pregnant).			
POS.175	Ability to implement a ProDUR system using online real-time intervention at the POS with clinical edits to detect, at a minimum, maximum/minimum daily dosages for all applicable NDCs.			
POS.176	Ability to capture and store chronic disease states in the Member file.			
POS.177	**13. Drug Utilization Review (DUR) - Alerts & Overrides**			
POS.178	Ability to display multiple POS messages as a return response to the billing Provider.			
POS.179	Ability to user-define text of messages to be returned to pharmacies.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.180	Ability to user-define business rules which allow different messages under different circumstances.			
POS.181	Ability to apply alerts according to BMS specifications.			
POS.182	For each alert/denial, the ability to include, at a minimum, the following information (to the Provider):			
POS.183	Alert conflict type (e.g., drug allergy alert)			
POS.184	Alert severity (e.g., minor, major, etc.)			
POS.185	Available data related to the alert (e.g., other drug or condition in conflict)			
POS.186	Other as identified by BMS during DDI and accepted via formal change control			
POS.187	Ability to support a role-based override capability for all edits.			
POS.188	Ability to support special situations where State/Federal programs/exceptions exist with "soft edits" to allow Provider override.			
POS.189	Ability to support "hard edits" to prevent Provider override.			
POS.190	Ability to support a special "BMS Management Override" for paper claims where normal editing is bypassed.			
POS.191	Ability to require the Provider to enter codes for actions taken in response to the drug interaction alerts/warnings and the outcomes of those actions in accordance with NCPDP response codes. The system should maintain these acknowledgment codes in history, as well as report them when requested by the BMS.			
POS.192	Ability to user-define additional text to accompany standard NCPDP DUR reject codes and their associated return messages.			
POS.193	Ability to edit against data elements in a Provider file of the prescriber identified in the prescriber ID field of a submitted claim for the purpose of overriding or producing claim (e.g., not requiring PA for scripts written by certain doctors, or denying a claim within a certain drug class when written by a specific prescriber).			
POS.194	Ability to override PA/Electronic Prior Authorization (EPA) requirement based on submitted diagnosis code or previously recorded chronic disease regardless of the claim type the diagnosis was submitted on.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.195	Ability to produce a report, upon request, listing all ProDUR alerts encountered for specified Members, Providers, and/or prescribers.			
POS.196	Ability to systematically by-pass or suppress Pro-DUR alerts based on prescriber/Provider/Member/program and/or drug file parameters as defined by the BMS.			
POS.197	**14. Drug Utilization Review (DUR) - Default Screening**			
POS.198	The initial values for DUR Default Screening Parameters page should be set as specified by the BMS.			
POS.199	Capability for modification of the default Screening Parameters.			
POS.200	Ability to rank the severity of adverse events.			
POS.201	Ability to modify the ranking of Severity Events.			
POS.202	Ability to establish initial Severity Rankings as specified by the BMS.			
POS.203	Ability to reject claims when certain drug combinations are used (as defined by BMS).			
POS.204	Capability of posting or not posting DUR events to the Provider, as determined by BMS.			
POS.205	**15. Drug Utilization Review (DUR) - Reporting**			
POS.206	Ability to generate the following reporting:			
POS.207	Alerts/claims denials by reason (e.g., therapeutic duplication, drug/drug interaction, excessive utilization)			
POS.208	Cost saving and cost tracking reports (e.g., savings amounts, co-pays).			
POS.209	Drug file update reporting (e.g., therapeutic class, update descriptions, low/high dose criteria)			
POS.210	Other as identified by BMS during DDI and accepted via formal change control			
POS.211	**16. Prior Authorization (PA) - Processing**			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.212	Ability to process PAs using the NCPDP standard guidelines. (Full support of processing PAs using NCPDP Standards is desired. BMS acknowledges that most PA requests currently are included with claims submission. However, the proposed solution should reach into the future and should support D.0 and any subsequent version during the life of the contract).			
POS.213	Ability to utilize prior authorization information in claims processing.			
POS.214	Ability to approve a 3-day Emergency Fill without a Prior Authorization. This fill should not count towards the refill count of the prescription. (A 3-day supply of medications is allowed to be dispensed to members for drugs that require prior authorization, per Federal regulations. The current system allows a 3-day supply to be processed using NCPDP standard codes).			
POS.215	Ability to provide edits in the claims processing system to identify drugs requiring prior authorization.			
POS.216	Ability to integrate with the BMS Prior Authorization call center vendor (Currently the PA Vendor enters drug prior authorization records directly into the POS system. The Vendor is expected to provide this functionality to the PA Vendor and to provide support to the PA Vendor for the PA module).			
POS.217	Ability to automatically generate and track prior authorization using a unique identifier.			
POS.218	Ability to maintain prior authorization at the eligibility group level, program or plan (i.e., prior authorization criteria should be applied to different defined groups. BMS currently has the capability to apply PA criteria to different drugs, within different eligibility plans. Example: Drug X requires PA for Medically Needy. Drug X does not require PA for ADAP).			
POS.219	Ability to edit for Prior Authorization in accordance with BMS policies and guidelines. (Prior authorization criteria is currently applied to different defined groups. BMS currently has the capability to apply PA criteria to different drugs, within different eligibility plans. Example: Drug X requires PA for Medically Needy. Drug X does not require PA for ADAP. On the Med/Dent side, PA criteria policies and guidelines are contained in the Provider Manuals).			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.220	Ability to maintain a map of NDC code, where the map would be provided by BMS or designee, to diagnosis code to edit for valid/invalid combinations. (There is no current mapping of NDCs and diagnostic criteria. In the future, BMS desires this capability in order to allow certain drugs to process only if the pharmacy enters an appropriate diagnosis code approved by BMS).			
POS.221	Ability to set PA requirements at various BMS determined levels (e.g., NDC, therapeutic class).			
POS.222	Ability to administer prior authorization processing in a real-time mode.			
POS.223	Ability to accept online real-time entry and update of prior authorization requests. (The current pharmacy POS clinical prior authorization services vendor has access to the POS PA module and enters PA information directly into the pharmacy processing system).			
POS.224	Ability to deny claims where the NDC is not covered. (Even though a PA is indicated at the BMS-specified level, the NDC is checked to see if it is a covered drug.)			
POS.225	Ability to apply the PA requirements effective on the date of service.			
POS.226	Ability to match the prior authorization to the claim. The Pharmacy POS should not always require that a Provider submit a PA number before processing a POS claim.			
POS.227	Ability to allow BMS to specify criteria for requiring the Provider to supply a PA number before the transaction may be processed. (In the current system, providers do not have to enter a PA number when submitting a POS claim. However, the current system can require a PA number should BMS wish to require the PA number. Providers obtain the PA numbers manually).			
POS.228	Ability to support emergency PA capability (as defined by BMS, using NCPDP standards). (This requirement is the same as a 3-day emergency fill for drugs that require a prior authorization).			
POS.229	Ability to provide a mechanism for the Vendor and the State to enter Prior Authorization data, based on role-based security as determined by BMS.			
POS.230	Ability to provide on-line access to all prior authorization information.			
POS.231	Ability to accept on-line, real-time entry and update of PA determinations.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.232	Ability to utilize prior authorization restrictions to include, but not limited to:			
POS.233	Drug data (e.g., NDC (9 to 11 digits), HIC, GCN sequence)			
POS.234	Member data			
POS.235	Provider data			
POS.236	Day specific, or span dates of the prior authorization			
POS.237	Frequency restrictions			
POS.238	Dollar/unit dispensing limitations (the POS should have the ability to limit prescriptions based on a dollar threshold amount and to limit prescriptions based on dispensed units)			
POS.239	Other as identified by BMS during DDI and accepted via formal change control			
POS.240	Ability to link to eligibility data when reviewing the PA request.			
POS.241	Ability to automatically identify and update active or pended PA records when a reference file has been updated (e.g., drug code, drug category). (Claims are not pended in the Pharmacy POS system. BMS expects the POS system to be capable of updating the PA parameter (generic sequence number, generic code, etc) when the drug file changes the parameter, so that PA requirements and processing are maintained).			
POS.242	Ability to require and process PA for service to Member in LTC. (The same level of editing/auditing that are done for pharmacy claims outside of a LTC, but the LTC would be a separate eligibility group with distinct PA requirements).			
POS.243	Ability to "grandfather" Members on identified services when a new PA requirement is identified. (BMS currently uses a Preferred Drug List. In the past, it has been desired to allow current users of a drug to continue, but new users require a prior authorization. An example is Zyprexa. Current users were allowed to continue to receive this drug, but new users were required to receive a prior authorization for coverage of the drug).			
POS.244	Ability to add back the unused units if a claim is reversed			
POS.245	Ability to generate denial notices to Members.			
POS.246	**17. Prior Authorization - Automated Prior Authorization**			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.247	Ability to provide automated approval of authorizations based upon any Federal, State, and BMS policy and guidelines, for use in determining if pre-established criteria for selected drugs have been met. The data queried is expected to include diagnosis codes, procedure codes and pharmacy claims data (for both fee-for-service and encounter data).			
POS.247a	Ability to provide an integrated automated prior authorization system which can incorporate Federal, State and BMS policy and guidelines and determine if pre-established criteria for selected drugs has been met through a review of historical claims data. The data should include pharmacy claims, medical claims and diagnosis codes.			
POS.247b	Ability to automatically adjudicate claims for drugs requiring prior authorization for which criteria has been met.			
POS.247c	Ability to send a message to the Prior Authorization Help Desk to request manual review of claims for drugs not meeting criteria for automatic approval. The Prior Authorization Help Desk should have access to the prior authorization criteria and steps performed in the automated PA review process.			
POS.248	Ability to search up to twenty-four (24) months of member pharmacy and medical claims and diagnosis codes. (Medical claims should include out-patient visits, in-patient admissions and procedure codes).			
POS.249	Ability to identify and retain once-in–a lifetime codes (such as hysterectomy, etc.) as identified by BMS for review in prior authorizations.			
POS.250	Ability to provide table-driven criteria that is customized and can be adapted within at least ten (10) days of BMS' request to meet changes in pharmacy policy and criteria updates.			
POS.251	Ability to provide data analysis tools and analysis by the MMIS Vendor on an ongoing basis to identify clinical and utilization issues that may warrant new screening criteria.			
POS 252	Ability to perform automated prior authorization review while meeting POS system performance metrics requirements for the adjudication of claims.			
POS.253	**18. Pricing**			
POS.254	Ability to price all claims in accordance with BMS policies and guidelines.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.255	Ability to accommodate and calculate payments applying various co-pay/cost sharing arrangements as defined or approved by the BMS.			
POS.256	Ability to pay different dispensing fees based on criteria established by the BMS.			
POS.257	Ability to support a Medicaid AWP (average Wholesale Price - Department of Justice) pricing methodology			
POS.258	Ability to enforce the reimbursement of only one dispensing fee per drug entity, per Member, per calendar month for Long Term Care (LTC) patients.			
POS.259	Ability to apply selected pricing methods for each claim payment and display in the claim record what method was used to determine final payment amount up to, but not to exceed, final claim charge.			
POS.260	Ability to display on a denied claim the pricing method that would have been used and the amount of the claim if it would have paid.			
POS.261	**19. Pricing - Pricing Formulas**			
POS.262	Ability to utilize industry standard pricing including, at a minimum:			
POS.263	AWP (Average Wholesale Price)			
POS.264	Medicaid AWP (average Wholesale Price - Department of Justice)			
POS.265	SMAC (State Maximum Allowable Cost)			
POS.266	WAC (Wholesale Acquisition Cost)			
POS.267	ASP (Average Sales Price)			
POS.268	FUL (Federal Upper Limit)			
POS.269	Direct price pricing where appropriate			
POS.270	Other as identified by BMS during DDI and accepted via formal change control			
POS.271	Ability to apply pricing algorithms to determine which of several pricing methods (such as AWP-14%, AWP-50%, SMAC, FMAC, etc.) are applicable to a specific NDC and determine which method yields the lowest net cost.			
POS.272	Compound prescriptions are to be reimbursed with an additional $1.00 Dispensing Fee.			
POS.273	Ability to manage the 340-B pricing as defined by BMS.			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.274	Ability to support different dispensing fees to different types of pharmacies as defined by BMS.			
POS.275	Ability to support a DAW 1 code and reimburse at the brand rate.			
POS.276	**20. Pricing - TPL and Co-Pay Processing**			
POS.277	Ability to deny any claim whose TPL is less than or equal to a parameter configured by the BMS (currently $0.00).			
POS.278	Ability to price POS claims with TPL amounts according to NCPDP standards and BMS policy. Ability to support, at a minimum, the application of data from 433-DX in conjunction with other coverage codes 2, 3, and 4.			
POS.279	Ability to support primary payer reject codes as defined by BMS.			
POS.280	Ability to support multiple co-pay requirements based upon the total price or status of the drug.			
POS.281	Ability to maintain co-pays based on BMS policy for various eligibility groups or product designation.			
POS.282	**21. Financial Processes**			
POS.283	Ability to include on-line access to the following:			
POS.284	Recoupments			
POS.285	Voids			
POS.286	Refunds made			
POS.287	Request for additional information sent			
POS.288	Number of outstanding requests pending			
POS.289	Other as identified by BMS during DDI and accepted via formal change control			
POS.290	Ability to reprocess pharmacy claims when needed.			
POS.291	Ability to perform mass claims reprocessing.			
POS.292	Ability to update the FFS claims payment to track all recoupment, refund and adjustment activity.			
POS.293	Ability to reimburse pharmacies as approved by the BMS in accordance with applicable Federal regulations.			
POS.294	Ability to provide a method to pay pharmacists an incentive (based upon rules approved by BMS).			
POS.295	**22. Reporting - General**			

6. Pharmacy Point-of-Sale (POS)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
POS.296	Ability to generate standard reports (as defined by BMS during DDI) and customized reports.			
POS.297	Ability to support an online/on-demand Member history report. The results should contain enough information to reflect the following:			
POS.298	A drug profile history, and should be in a format which can be either stored or displayed on an online screen.			
POS.299	A drug utilization history, and should be in a format which can be either stored or displayed on an online screen.			
POS.300	Ability to export reports for enhanced manipulation and analysis.			
POS.301	Ability to provide for the electronic delivery of reports to identified destinations.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.1	**1. Change Control**			
GT.2	Ability to provide an automated software modifications change request tracking system.			
GT.3	The system should enable BMS to control and monitor system change requests.			
GT.4	Change requests are expected to include all necessary documentation (as defined by the BMS-approved change management plan).			
GT.5	Ability for BMS to set and change priority levels on individual change requests.			
GT.6	Ability for BMS to track process metrics and other detail, including:			
GT.7	The estimated and actual hours allocated to each change request			
GT.8	Specific personnel assigned to each change request			
GT.9	Scheduled completion date for each change request			
GT.10	Total cost (if maximum allowable hours exceeded)			
GT.11	Total approved operations charge increase (if any)			
GT.12	A separate total for equipment requirements (if applicable) related to the modification			
GT.13	**2. Data Retention, Archival, Retrieval and Purge**			
GT.14	Ability to ensure that data is retained, archived, purged, protected from destruction and accessible, according to State and Federal requirements and in accordance with the BMS Data Retention Policy.			
GT.15	The Vendor is to ensure that hard copy documents are retained, stored, imaged, archived, and destroyed according to State and Federal requirements and in accordance with the BMS Data Retention Policy.			
GT.16	Ability for BMS to specify/modify auto archive rules.			
GT.17	Ability to provide archival and purge processes that do not degrade or interrupt the system.			
GT.18	Ability to easily retrieve archived data for online review, export and reporting.			
GT.19	Ability to restore archived data for reviewing, copying and printing.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.20	**3. Disaster Recovery and Business Continuity**			
GT.21	Ability to provide a Disaster Recovery/Business Continuity Plan that complies with Federal, State, Department and Bureau rules, regulations and applicable policies and procedures, including at a minimum:			
GT.22	Daily back-up which is adequate and secure for all computer software and operating programs; databases; files; and system, operation, and user documentation (in electronic and non-electronic form)			
GT.23	Full and complete back-up copies of all data and software on tape and/or disk			
GT.24	Storage of all back-up copies in a secure off-site location			
GT.25	Routine testing to verify the completeness, integrity, and availability of back-up information			
GT.26	Support for immediate restoration and recovery of lost or corrupted data or software from a disaster event			
GT.27	Provide for back-up processing capability at a remote site(s) from the primary site(s) such that normal payment processing, as well as other State defined systems and services can continue in the event of a disaster or major hardware problem at the primary site(s).			
GT.28	Ability to provide sufficient transaction logging and database back-up to allow it to be restored. If multiple databases are used for work item routing and program data, restoration should ensure that databases are synchronized to prevent data corruption.			
GT.29	Ability to provide point-in-time recovery of data to the last completed transaction.			
GT.30	Ability to allow for continued use of the system during back-up.			
GT.31	The Vendor is to perform back-ups during non-peak processing hours, minimizing the impact to operational activities.			
GT.32	**4. Problem Management**			
GT.33	Ability to write all errors to an error log.			
GT.34	Ability to allow for a BMS administrator to view, filter, sort and search the error log.			
GT.35	Ability to allow for an administrator (Vendor personnel) to archive error log entries based upon user-defined criteria.			
GT.36	Ability to allow for a user to define an alert message to be executed upon the occurrence of an error.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.37	The Vendor is to provide record-level reporting of inaccurate processing results (e.g., claims processed without required consent on file, valid claims denied).			
GT.38	**5. Release Management**			
GT.39	Major releases are to be evaluated and approved by BMS prior to application.			
GT.40	The Vendor is to send notification to BMS when releases are available to be evaluated.			
GT.41	The Vendor is to provide BMS with detailed documentation that lists all fixes and functionality for each release.			
GT.42	The Vendor is to proactively notify the System Administrator regarding which releases of third-party software (JAVA virtual machine, Internet Explorer, Mozilla, Safari, etc.) are known to create problems with the current version of the vendor software.			
GT.43	The Vendor is to maintain version control and provide BMS with current system and user documentation, and operating procedures manuals.			
GT.44	Ability to allow centralized deployment of system updates and system maintenance.			
GT.45	**6. Security Management**			
GT.46	Comply with all Federal, State, Department and Bureau rules, regulations and applicable policies and procedures related to security.			
GT.47	Ability to anticipate and provide a flexible solution that is positioned to effectively meet the requirements of current and future HIPAA security regulations.			
GT.48	Ability to provide a role-based Single Sign On (SSO) solution.			
GT.49	Requests for access are to come from an authoritative source(s) as defined by BMS.			
GT.50	Ability to require that all users (including all vendor support staff members) have a unique user ID and password, where:			
GT.51	Required passwords are to expire on a staggered schedule and can be reset at any time by appropriate personnel and/or automated system reset.			
GT.52	Passwords are to be strong passwords (e.g., contain caps/numbers, cannot use prior passwords, etc.).			
GT.53	Passwords are to be stored in encrypted form.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.54	Restriction of application and/or function within an application through role-based security. Role assignments are to be used to determine which user categories have permission to access which application and/or function within an application.			
GT.55	Ability to provide the following three types of controls to maintain the integrity, availability, and confidentiality of Protected Health Information (PHI) data contained within the system: These controls are to be in place at all appropriate points of processing.			
GT.56	**Preventive Controls:** Controls designed to prevent errors and unauthorized events from occurring.			
GT.57	**Detective Controls:** Controls designed to identify errors and unauthorized transactions which have occurred in the system.			
GT.58	**Corrective Controls:** Controls to ensure that the problems identified by the detective controls are corrected.			
GT.59	Allow properly authorized users to configure and maintain all system settings from any workstation on the local/wide area network using a browser.			
GT.60	Ability to provide audit trails of all updates to the security system (add/change/delete) by log-on ID (or batch update identifier), date and time of the change, and source of entry (workstation ID), including all attempted updates.			
GT.61	The system's import and export capabilities are to provide user-level security options to control access to sensitive information.			
GT.62	Ability to support file, record, and field-level security.			
GT.63	Ability to provide document-based security.			
GT.64	Ability to update all security roles automatically when a change in the "master" role is made.			
GT.65	Ability to provide functional security to control what processes can be performed by certain users.			
GT.66	Ability to allow local/central System Security Administrators to add and change permissions for local/central system access.			
GT.67	Ability to prohibit display of passwords on the sign-on screen when entered by the user.			
GT.68	Ability to log and report all unauthorized access attempts by terminal ID, user ID, date, and time.			
GT.69	Ability to allow System Administrator to re-set user passwords.			
GT.70	Ability to allow users to change their passwords.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.71	Ability to log a user off a system if there is no activity within a thirty (30) minute period of time, or other period of time designated by BMS.			
GT.72	Ability to terminate access if there is no activity on a user account within thirty (30) days, or other period designated by BMS.			
GT.73	Ability to generate a periodic report (as scheduled by BMS) of upcoming user account terminations.			
GT.74	Ability to immediately disable access to any user or user group after a predetermined number of attempts to log-on.			
GT.75	Ability to ensure that all applications comply and are compatible with existing State and Federal guidelines preventing unauthorized access.			
GT.76	Employ a security approach that integrates MMIS components to provide role-based access with a single log-on.			
GT.77	Ability to provide an audit trail of record changes, including user and date of change.			
GT.78	Ability to implement audit trails to allow information on source documents to be traced through the processing stages to the point where the information is finally recorded.			
GT.79	Ability to trace data from the final place of recording back to its source of entry.			
GT.80	The system is to comply with all HIPAA final, future rules as they become final and amendments to final rules (e.g., Privacy and Security, Transaction and Code Sets, National Provider Identifier).			
GT.81	Ability to transmit and receive HIPAA-compliant transactions using multiple methods (e.g., web-based, dial-up, batch file).			
GT.82	Ability to transmit and receive HIPAA-compliant transactions using a variety of devices including PCs and touch tone phones.			
GT.83	The system is to comply with the implementation of HIPAA compliant privacy and security measures across all DHHR systems and business functions as they impact or interact with the MMIS.			
GT.84	The system is to support multiple versions of HIPAA implementation guides concurrently (e.g., 4010/5010) as per HIPAA Transaction and Code Set (TCS) Rule.			
GT.85	**7. Standards**			
GT.86	The system is expected to be flexible and readily adaptable to changing State and Federal requirements.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.87	The Vendor is to provide BMS with an inventory of all hardware and software to be placed within the State government infrastructure.			
GT.88	The Vendor is expected to support current technologies for data interchange (e.g., XML).			
GT.89	Client desktop software is to work with new desktop operating system patches and upgrades based upon BMS patch management policies (see Procurement Library).			
GT.90	The system is to use a relational database management system (RDBMS).			
GT.91	**8. Support**			
GT.92	The Vendor is expected to provide a technical help desk, accessible to users via phone.			
GT.93	The Vendor is to provide web-based support, with a searchable database of common problems, to assist end-user in facilitating resolution of error messages.			
GT.94	The system is to have the "built-in" capability to provide BMS authorized support through remote access to the application.			
GT.95	Ability to allow for BMS-defined severity levels for support.			
GT.96	The following describe desired capabilities of the Vendor's support tool:			
GT.97	Provide functionality that creates, edits, sorts and filters tickets or electronic records of calls made to the Call Center to be used by both Vendor Help Desk and BMS staff.			
GT.98	Ability to create tickets that track the caller, the question(s) or issue(s), the resolution or response, the Vendor and BMS staff responding to the ticket, date(s), time(s) and status (open or closed).			
GT.99	Ability to add electronic attachments to a ticket.			
GT.100	Ability to allow configuration of call routing and delegation criteria, and severity, prioritization and escalation criteria.			
GT.101	Include knowledge base, Frequently-Asked-Questions (FAQ) components, and phone scripts that can be updated manually or via automatic imports.			
GT.102	Ability to facilitate mass e-mail and fax notifications to enrolled providers.			
GT.103	Ability to allow the recording of inbound and outbound communications with the ability to retain recordings as specified by BMS.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.104	The Call Center should have a central database for call tracking records that can be queried by both Vendor and BMS users.			
GT.105	Ability to use MMIS data repositories to automatically display information regarding the caller.			
GT.106	Ability to capture date-specific and user-specific free form text for each call center ticket.			
GT.107	Provide role-based system training for BMS personnel, their vendors and their business partners upon request of BMS.			
GT.108	Provide training to BMS or its subsequent vendor regarding:			
GT.109	Computer operations, including production control monitoring procedures			
GT.110	Controls and balancing procedures			
GT.111	Extension routines (pre/post SQL)			
GT.112	Other manual operations as necessary			
GT.113	**9. System Integration**			
GT.114	Ability to access all current and historical Member, Provider, Contractor (e.g., HMO) and other data necessary to meet the functional requirements outlined in this document.			
GT.115	MMIS modules and applications are to integrate successfully and effectively with minimal or no customization.			
GT.116	Utilize open architecture standards and scalability to promote integration throughout all MMIS business processes and sub-processes.			
GT.117	Provide a user-friendly, common "look and feel" which gives users a seamless MMIS experience across the "core system," including (at a minimum) the Member Management, Provider Management, Claims Processing, Reference File, and TPL modules, and maintains common user elements across the entire MMIS whenever possible.			
GT.118	Data changes made in one part of the system should automatically populate other parts of the system so as to avoid duplicate data entry.			
GT.119	All on-line claim/encounter information is to be available to authorized users regardless of the functional business area where the data is stored.			
GT.120	Ability to "lock" a claim to prevent concurrent updates to the same claim.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.121	Adjudicated claims are not to be changed outside an approved adjustment process. Once a claim is adjudicated and in a final status, the information is to remain static while it is displayed (e.g., users may not cut claim information from claim lines/data).			
GT.122	Ability to maintain an integrated repository of Member information, including a single unique identifier (which is not the SSN), for all Members where payments are made from the new MMIS system.			
GT.123	Ability to maintain an integrated repository of Provider information, including a single unique identifier (NPI), for all Providers.			
GT.124	**10. System Interfaces**			
GT.125	Ability to interface and/or integrate with the systems and applications as specified in the Integration Points Table of this document. (See the following Procurement Library folder/file: Interfaces/WV_MMIS_External_Interfaces.pdf).			
GT.126	The system is to receive and send electronic interface information from and to the State's eligibility systems, other agencies, and BMS's outside Vendors (as specified in the Integration Points Table of this document).			
GT.127	Ability to accept eligibility data from multiple source systems into a Vendor supplied common eligibility interface component. The common eligibility interface component is to edit for data accuracy, completeness, redundancy, etc., according to specified business rules, reformat the data and provide a single interface to the MMIS. The common eligibility interface component is to also assure data delivery.			
GT.128	The system is to interface with and provide data to a Decision Support System/Data Warehouse.			
GT.129	Ability to produce required Federal and State data sharing, including (but not limited to) the following:			
GT.130	Program management reports (formerly known as Management and Administrative Reporting Subsystem (MARS))			
~~GT.131~~	~~Program Integrity Reports (formerly known as Surveillance and Utilization Review Subsystem (SURS))~~	N/A	N/A	N/A
GT.132	Medicare Modernization Act (MMA)			
GT.133	Medicaid Statistical Information System (MSIS)			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.134	The system is to accept the same Provider electronic billing data set required by the Medicare program for crossover claims from COBA.			
GT.135	Ability to employ online real-time or batch updates of data between the MMIS and other systems, depending on the interface requirements.			
GT.136	Ability to produce a listing on an as-requested basis of all submitters with their submitter ID.			
GT.137	Ability to maintain the submitter ID on the claim record.			
GT.138	Able to accept and process or generate all HIPAA mandated transactions, other versions or standards that may be mandated, and other transactions, including all current and future releases of the following, such as HIPAA v.5010, D.0, by the mandated deadlines:			
GT.139	**Health Care Claims**			
GT.140	ASC X12N 837 Health Care Claim: Professional			
GT.141	ASC X12N 837 Health Care Claim: Institutional			
GT.142	ASC X12N 837 Health Care Claim: Dental			
GT.143	National Council for Prescription Drug Programs (NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1, Release 0			
GT.144	**Eligibility for a Health Plan:**			
GT.145	ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response			
GT.146	**Health Care Claim Status:**			
GT.147	ASC X12N 276/277 Health Care Claim Status Request and Response			
GT.148	**Referral Certification and Authorization:**			
GT.149	ASC X12N 278 Health Care Services Review - Request for Review and Response			
GT.150	**Health Plan Premium Payments:**			
GT.151	ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products			
GT.152	**Enrollment and Dis-enrollment in a Health Plan:**			
GT.153	ASC X12N 834 Benefit Enrollment and Maintenance			
GT.154	**Health Care Payment and Remittance Advice:**			
GT.155	ASC X12N 835 Health Care Claim Payment/Advice			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.156	**Coordination of Benefits:**			
GT.157	ASC X12N 837 Health Care Claim: Professional			
GT.158	ASC X12N 837 Health Care Claim: Institutional			
GT.159	ASC X12N 837 Health Care Claim: Dental			
GT.160	**National Council for Prescription Drug Programs:**			
GT.161	(NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1			
GT.162	**Acknowledgements:**			
GT.163	ASC X12 824: Application Reporting Version 4010/5010			
GT.164	ASC X12 277: Health Care Payer Unsolicited Claim Status (Claims in Process Report)			
GT.165	**New transaction content to include:**			
GT.166	ASC X12N 269: Health Care Coordination of Benefits Request and Response			
GT.167	ASC X12N 270/271: Health Care Eligibility/Benefit Inquiry and Response (with commercial insurance carriers)			
GT.168	ASC X12N 274: Health Care Provider Inquiry and Information Response Guide			
GT.169	ASC X12N Health Care Provider Credentialing Implementation Guide			
GT.170	ASC X12N Health Care Provider Directory Implementation Guide			
GT.171	ASC X12N Health Care Provider Information Implementation Guide			
GT.172	ASC X12N Additional Information to Support a Health Care Services Review			
GT.173	ASC X12N 275: Additional Information to Support a Health Care Claim or Encounter			
GT.174	ASC X12N 841: Specifications/Technical Information			
GT.175	The system is to accommodate future versions of the HIPAA electronic PA transactions.			
GT.176	The system is to comply with all HIPAA EDI standards adopted by the BMS.			
GT.177	The Vendor is to provide for both an online DDE (direct data entry) process and receipt of electronic prior authorizations.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.178	Ability to receive electronic data from another source and create an authorization (i.e., OHFLAC data for nursing home, ICFMR via web application).			
GT.179	Ability to use high speed data transfer functionality to send and receive information (where available).			
GT.180	Ability to reflect updates to MMIS (e.g., when procedure codes and/or modifiers which require prior authorization have been deleted and/or replaced with new or revised HIPAA-compliant codes) without interruption to service.			
GT.181	Vendor should ensure that file standardization is supported by all interfaces, so that data standards are maintained according to BMS-specified and Federally mandated file specifications for data element lengths, field format, and type.			
GT.182	Ability to use FTP, web interface, or other industry standard electronic means (such as Gentran, Connect: Direct) or media to transfer files, as approved by the BMS.			
GT.183	Ability to schedule and support file transfer as requested and agreed upon by the Bureau.			
GT.184	Ability to automatically populate the appropriate data elements when supplied in any approved electronic format, including the execution of the necessary edits, business rules, and calculations.			
GT.185	Ability to include balancing control information when required by the BMS. The BMS is to approve the format along with the file layout, media, naming conventions, trailer records and other interface processing details.			
GT.186	Ability to generate load statistics which include the number of records, time taken, successes and failures, and exceptions. These statistics are to be saved to the system for reporting purposes.			
GT.187	Ability to generate exception files, when necessary, for manual edits, error corrections, and additions to the interface records by Vendor or BMS/State users, prior to being loaded within the MMIS.			
GT.188	The Vendor is to implement edits, processes and reporting to eliminate undesired duplication of records and transactions, including:			
GT.189	Automatically edit fields for reasonableness, validity, format and consistency with other data present in update transaction.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.190	Transaction reconciliation reporting for file/data reconciliation with external data sources (e.g., totals and detail information, difference reports, change reports).			
GT.191	Ability to generate error reports at the summary and detail levels that include all data necessary to resolve errors.			
GT.192	Ability to reload or resend records if they have not been applied correctly to the appropriate data repository.			
GT.193	Ability to detect duplicate files or records and isolate them for manual review and further processing.			
GT.194	Ability to incorporate a method to view and edit interface files for investigation and further processing.			
GT.195	Ability to provide a method to "roll back" data to a pre-interface status.			
GT.196	Ability to create messages that accurately describe errors received as a result of a data transfer.			
GT.197	Ability to provide ad-hoc query capability against interface source files.			
GT.198	Ability to export records identified by BMS, when required by the BMS.			
GT.199	The system is to create and retain an audit trail of all interface activity in accordance with BMS Data Retention Policy.			
GT.200	**11. Workflow Management**			
GT.201	Ability to include comprehensive workflow management functionality that supports:			
GT.202	Definition, and possibly modeling, of workflow processes and their constituent activities.			
GT.203	Run-time control functions concerned with managing the workflow process in the Medicaid environment and sequencing the various activities to be handled as part of each process.			
GT.204	Run-time interactions with users and Information Technology (IT) application tools for processing the various activity steps.			
GT.205	Ability to support a role-based interface for process definition that leads the user through the steps of defining the workflow associated with a business process, and that captures all the information needed by the workflow engine to execute that process to include:			
GT.206	Start and completion conditions			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.207	Activities and rules for navigation between them			
GT.208	Tasks to be undertaken by BMS staff involved in the process			
GT.209	Authorized approvers			
GT.210	References to applications which may need to be invoked			
GT.211	Definition of other workflow-relevant data			
GT.212	Ability to support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.			
GT.213	Ability to incorporate simple low-level workflow processes into more complex higher-level workflow processes.			
GT.214	Ability to support supervisory operations for the management of workflow including:			
GT.215	Assignments/re-assignments and priorities			
GT.216	Status querying and monitoring of individual documents and other work steps or products			
GT.217	Work allocation and load balancing			
GT.218	Approval for work assignments and work deliverables via a tiered approach			
GT.219	Ability to take necessary action or provide notification when corrective action is needed, including the ability to modify or abort a workflow process			
GT.220	Monitoring of key information regarding a process in execution, including:			
GT.221	Estimated time to completion			
GT.222	Staff assigned to various process activities			
GT.223	Any error conditions			
GT.224	Ability to utilize automated workflow to transfer documents to BMS for review, editing, and approval, and back to external stakeholders for re-writes and production.			
GT.225	Ability to use workflow management functionality to route and assign cases to the appropriate State and county staff and offices.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.226	**12. Test Environments**			
GT.227	Ability to maintain four regions/environments: (1) a development test region/environment, (2) a user acceptance test (UAT) region/environment, (3) a production region/environment, and (4) a training region/environment, all of which are to be independent regions. Under no circumstances should the development test, UAT, and training regions be housed on the same hardware as the production region. The training region should include all data elements that are in the production region, and contain sufficient and representative data records for training purposes. Vendors are not to invoke additional license fees for the test, UAT, and training environments.			
GT.228	Vendor should use a UAT region/environment that would mirror all programs in production through the life cycle of the claim, to include reports and the financial records. (This region/environment should be one of the four major regions/environments described in GT.227).			
GT.229	Vendor should use utilities to assist in identifying selected claim samples to use for testing (i.e., identify claims that currently test true for a specified edit).			
GT.230	Ability to create MMIS data (Provider, health plan, Member or claim) in a test environment, as needed for testing.			
GT.231	Ability to modify MMIS data (Provider, health plan, Member or claim) in a test environment, as needed for testing, in compliance with Federal guidelines.			
GT.232	Ability to maintain a test case library with search capability that is cross-referenced to the code (i.e., edit) that it tests.			
GT.233	**13. Automated Voice Response System (AVRS)**			
GT.234	The AVRS is to support the following Provider inquiries:			
GT.235	Prior Authorization status			
GT.236	Check Medicaid Member eligibility, third party insurance and managed care coverage for a specific date.			
GT.237	Query coverage limitations for the Member.			
GT.238	Query the co-pay requirement for a service.			
GT.239	Query Member restrictions.			
GT.240	Query for status of any claim or PA request they submit whether electronically or manually submitted.			
GT.241	Query warrant status and amounts.			
GT.242	Query Remittance Advice information.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.243	The AVRS is to support the following Member inquiries:			
GT.244	Check Medicaid Member eligibility for a specific date.			
GT.245	Query and update managed care enrollment.			
GT.246	AVRS system is to be compatible with the State's phone systems and with industry telephony standards. (State's telephone systems consist of POTS, PBX, and IP telephony phone systems).			
GT.247	Ability to provide separate toll-free AVRS telephone numbers for Providers, Members, and other entities as identified by the BMS.			
GT.248	Ability to validate the AVRS caller/user (according to BMS defined criteria).			
GT.249	The AVRS should accept payment inquiries based on either NPI or Provider ID.			
GT.250	Ability for callers using the contact/call center management system to transfer to the AVRS system.			
GT.251	The system should use automated menus, including an easily accessible option for reaching a live operator.			
GT.252	**14. Call Center**			
GT.253	Ability to provide separate toll-free Call Center telephone numbers for Providers, Members, and other entities as identified by the BMS.			
GT.254	The Vendor is expected to require Provider to give NPI or atypical provider identifier, at a minimum, before responding to inquiries.			
GT.255	Ability to authenticate the caller/user (per BMS specified criteria).			
GT.256	Ability, as applicable, to auto-populate call center screens with caller information when the call representative answers the call. Would include ability to access contact and correspondence history, as well as information such as Accounts Receivable detail, benefits information, and enrollment status.			
GT.257	Ability to use automated repeat call options.			
GT.258	Ability to integrate with an automated phone messaging system.			
GT.259	Ability to use automated message purge function with activity reporting.			
GT.260	Ability to define phone routing that allows the system to forward calls to the individual/entity (internal and external agencies included) capable of handling the caller's needs.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.261	Ability to configure navigation paths and prompts based on the caller's anticipated information needs.			
GT.262	Ability to record customized messages directed to selected Provider or Member groups.			
GT.263	Ability to route or transfer calls (as defined by the user) without having to redial (e.g., call may be transferred to an external agency, such as an enrollment broker, without additional phone charges to the caller).			
GT.264	Ability to configure navigation paths and prompts based on information from the MMIS (e. g., transfer call based on Provider specialty).			
GT.265	**15. Contact Management**			
GT.266	The Vendor is to provide a contact management system for managing communications with BMS staff, Providers, Members (current and potential), health plans, and other entities as identified by the BMS.			
GT.267	Ability to manage all MMIS related contacts (telephone, email, web portal, AVRS, mail, fax, etc.).			
GT.268	Ability to maintain a record (including an audit trail) of all contacts.			
GT.269	Inquiry responses are expected to be provided to the requestor in the same mode that it was received; therefore, the system is expected to have the ability to identify and maintain a record of the format/media of incoming communications.			
GT.270	Ability to query on the history of each contact.			
GT.271	Ability to view related contact records from a single contact record.			
GT.272	Ability to assign a unique tracking or control number to each contact.			
GT.273	Ability to accommodate searches on contact records by characteristics such as contact type, Member ID, caller phone number, Provider number, Provider name, contact tracking/control number, and any combinations thereof.			
GT.274	Ability to use caller phone number and/or ID number to access related MMIS data and previous contacts.			
GT.275	The system is expected to receive and track summary level mailing data from the enrollment broker for reporting purposes.			
GT.276	Ability to upload attachments to contact records.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.277	Ability to link scanned images to contact records to provide one view of all related materials (e.g., images, letters, and interactions).			
GT.278	Ability to provide correspondence functions to include the following:			
GT.279	Template development and the ability for users to select desired correspondence from a list of available templates			
GT.280	Display, print, and save correspondence via the EDMS component of the MMIS			
GT.281	Regenerate correspondence			
GT.282	Allow users to suppress or allow auto generation of correspondence based on user configurable event-driven criteria			
GT.283	Allow users to insert and override address information on correspondence			
GT.284	Allow users to add free form text to individual or groups of correspondence			
GT.285	Other as identified by BMS during DDI and accepted via formal change control			
GT.286	Ability to provide an electronic RTP tracking system to allow the ability to catalogue, track and report on RTP (return-to-Provider) documentation (e.g., Sterilization/Hysterectomy forms, claims, etc.).			
GT.287	**16. EDI Portal**			
GT.288	Ability to support Electronic Data Interchange (EDI) transactions for all EDI users and trading partners. Transactions should include, but not be limited to:			
GT.289	Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant)			
GT.290	Interactive Claims Inquiry (276/277 – DDE compliant)			
GT.291	Interactive Claim Submission (DDE compliant) to allow a Provider to submit a claim, including HIPAA/EDI compliant responses			
GT.292	Remittance Advice (RA) (835)			
GT.293	Interactive claim submission (837 transactions)			
GT.294	Ability to support an EDI Translator and Validator.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.295	**17. Electronic Document Management System (EDMS)**			
GT.296	Integrate EDMS functionality into the MMIS that supports, at a minimum, the following capabilities:			
GT.297	Document management			
GT.298	Content management			
GT.299	Records management			
GT.300	Document capture and imaging			
GT.301	Document-centric collaboration			
GT.302	Workflow management including document workflow			
GT.303	Ability to store both electronic and imaged paper documents and make them available on-line through a single user interface to promote a total view of current and historical information.			
GT.304	Provide multiple search options (e.g., Structured Query Language (SQL), various index search options, content-based searches, etc.) to view contents.			
GT.305	Ability to track all versions of each document.			
GT.306	Ability to present users with the latest revision of a document with the option to view previous versions.			
GT.307	Ability to support the management of documents created in BMS standard office applications.			
GT.308	Ability to allow drag-and-drop functionality to be used when creating or editing a document.			
GT.309	Ability to include, at a minimum, the following document management capabilities:			
GT.310	Accessible letter templates and forms			
GT.311	On-line, updateable templates that allow users to customize on an as-needed basis			
GT.312	Store documents and files			
GT.313	Generate materials in both hard copy and electronic format, including forms and letters			
GT.314	Ability to create letter templates and forms for the following areas:			
GT.315	Provider enrollment materials			
GT.316	General correspondence/notices for Providers and Members			
GT.317	Letters (financial, denial, EOMB, etc.)			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.318	Coordination Of Benefits (COB) letters			
GT.319	Managed Care Plan/Care Management Plan (MCP) letters			
GT.320	Prior Authorization (PA) letters			
GT.321	Ability to generate pre-populated forms.			
GT.322	Ability to easily match up related documents such as claims and supporting attachments in a many to one relationship.			
GT.323	Ability to support cataloging/indexing of all imaged documents.			
GT.324	Ability to utilize bar code technology that minimizes manual indexing and automates the retrieval of scanned documents.			
GT.325	Provide backup capability for manually indexed scanned documents.			
GT.326	Ability to use imaging/document management technology that handles multiple types of letters, forms, publications, and other BMS designated documents, and automates workflow processing to include:			
GT.327	Provider enrollment materials and licensure			
GT.328	Claim forms and attachments			
GT.329	PA forms and attachments			
GT.330	COB/TPL (including Medicare)			
GT.331	Provider correspondence including but not limited to RTP			
GT.332	Member correspondence			
GT.333	Contractor correspondence			
GT.334	Business partner correspondence			
GT.335	Web portal correspondence			
GT.336	Member enrollment materials			
GT.337	Notices			
GT.338	Letters			
GT.339	Audit materials			
GT.340	Others as identified by BMS and accepted via formal change control			
GT.341	**18. Reports**			
GT.342	Ability to download reports in various formats, such as PDF, Excel, Word, etc.			
GT.343	Ability to export reports for enhanced manipulation and analysis.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.344	Provide integrated print capability for any interface page within the MMIS.			
GT.345	The Vendor is to provide a searchable data dictionary.			
GT.346	Ability and flexibility for multiple simultaneous users to create and run in near real-time, ad hoc and canned reports without going through a formal change control process.			
GT.347	Provide for the electronic delivery of reports to identified destinations.			
GT.348	Provide role-based access to BMS staff to view reports and current manuals online.			
GT.349	Ability to produce multi-dimensional, flexible, ad hoc reports across business functions which meet the following reporting needs:			
GT.350	Financial reporting			
GT.351	Budget forecasting			
GT.352	Fiscal planning and control			
GT.353	Claims payment accuracy			
GT.354	Cash flow			
GT.355	Timely reimbursement analysis			
GT.356	Recipient cost and user of services			
GT.357	Cost/benefit analysis			
GT.358	Third party recovery			
GT.359	Prescription drug policy			
GT.360	Cost and user of prescription drugs			
GT.361	Recipient participation			
GT.362	Eligibility and benefit design			
GT.363	Geographical analysis			
GT.364	Program planning			
GT.365	Policy analysis			
GT.366	Federal waiver program evaluation			
GT.367	Program performance monitoring			
GT.368	Provider reimbursement policy			
GT.369	Institutional rate-setting			
GT.370	Medical assistance policy development			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.371	Provider participation			
GT.372	Service delivery patterns			
GT.373	Adequacy of and access to care			
GT.374	Quality of care			
GT.375	Outcomes assessment			
GT.376	Disease management			
GT.377	External reporting			
GT.378	Public information			
GT.379	Managed Care Plan (MCP) planning and analysis			
GT.380	Ability to generate a listing of all standard on-line reports available, the description of each report, and provide a link to the most recent report.			
GT.381	Provide a process by which reports may be delivered by email in accordance with HIPAA rules.			
GT.382	Provide archival storage of reports that complies with BMS records retention standards.			
GT.383	Ability to store reports for rapid retrieval.			
GT.384	Provide ability for users to extract data, manipulate the extracted data, and specify the desired format and media of the output.			
GT.385	Ability to display consistent BMS-approved headers and footers.			
GT.386	Ability to identify and use consistent report fields.			
GT.387	Ability to provide a user-friendly way to schedule when, with what frequency, or on what regular days within a month various reports are generated and disbursed.			
GT.388	Ability to track and store detailed information regarding all reporting requests including, but not limited to:			
GT.389	Who requested the information			
GT.390	Date			
GT.391	Time			
GT.392	What the report included			
GT.393	Report storage upon completion			
GT.394	Route the entire history on-line.			
GT.395	Ability to categorize and organize reports by source system, data content, purpose, frequency and other staff selected options.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.396	Ability to search the reports repository by date, time, report title, report ID, run date and key words.			
GT.397	Ability to highlight, cut, paste, and print any selection of the report.			
GT.398	Ability to sort the reports list by date, time report title, run date, and other criteria.			
GT.399	Ability to establish and apply archival and purge parameters to reports.			
GT.400	Ability to easily and flexibly create new reports through an automated and user-friendly report writer tool.			
GT.401	Ability to use identifier mathematical functions format and manipulate data within reports.			
GT.402	**19. User Interface - MMIS User Screens**			
GT.403	Ability to incorporate systems navigation technology that allows all users to move freely throughout the system.			
GT.404	The system user interface is to be compatible with user defined display settings.			
GT.405	Provide integrated print capability for any interface page within the MMIS.			
GT.406	Include at minimum the following features and capabilities:			
GT.407	Drill down and look up functionality to minimize re-entry of information across multiple screens.			
GT.408	Multi-tasking and multiple window capability, including split screens.			
GT.409	Search capabilities to allow retrieval by Provider, Member, ad pay (i.e., advance payment, defined as a financial non-member specific transaction/claim), procedure code, NDC or others as defined by BMS.			
GT.410	Ability to tab and mouse through data fields and screens.			
GT.411	The system should provide menus that are understandable by non-technical users and provide secure access to all functional areas.			
GT.412	Ability to incorporate a non-restrictive environment for experienced users to directly access (direct call) a screen or to move from one screen to another without reverting to the menu structure.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.413	The system should provide an online help system, available from any screen and any screen field, that provides a description of and the processing performed by a screen or window, data entry format and restrictions, explanation of error messages and other information helpful to the user.			
GT.414	Ability to generate drop-down lists to identify options available, valid values, and code descriptions, by screen field.			
GT.415	Ability to utilize the following standards for all system screens, windows, and reports:			
GT.416	All headings and footers standardized			
GT.417	Current date and local time displayed			
GT.418	All references to dates displayed consistently throughout the system			
GT.419	All data labels and definitions consistent throughout the system and clearly defined in user manuals and data element dictionaries			
GT.420	All MMIS generated messages should be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text			
GT.421	**20. User Interface - Notifications/Alerts**			
GT.422	Ability to generate alerts to notify staff of possible options when known running process(es) may result in problems (e.g., timeouts, slowed processing).			
GT.423	Ability to generate alerts when changes are made to policies and procedures and system tables or functionality.			
GT.424	Ability to generate alerts when the anticipated return time on a query or report job exceeds a defined time limit.			
GT.425	Ability to generate alerts that assist in monitoring time-sensitive activities.			
GT.426	Ability to generate alerts to a user-defined group or individual.			
GT.427	Ability to generate alerts to notify staff when they need to take action in connection with workflow events.			
GT.428	**21. Web Portal**			
GT.429	Provide and maintain a secure website with authentication and encryption to protect interactions and transactions. This should include, at a minimum, the use of Secure Sockets Layer, or SSL. The authentication process should be verified through a third party that has registered and identified the server.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.430	Web portal functionality should address the needs of a variety of entities/stakeholders, including Medicaid consumers (including current and potential Members), Providers, and other business partners as specified by BMS.			
GT.431	Web applications are to satisfy the Priority 1 Checkpoints from the Web Content Accessibility Guidelines 1.0 developed by the World Wide Web Consortium (W3C), as detailed at: http://www.w3.org/TR/WCAG10/full-checklist.html.			
GT.432	Ensure web portal design, development, implementation and operations are in accordance with State and Federal regulations and guidelines related to security, accessibility, confidentiality, and auditing.			
GT.433	Information and documentation captured via the web portal is expected to conform to the user access, user inquiry, update, retention, archival, and other relevant data management specifications outlined in this RFP.			
GT.434	Include secure and non-secure tabs.			
GT.435	Provide public information without requiring authentication.			
GT.436	Provide Internet security functionality to include firewalls, intrusion detection, and encrypted network/secure socket layer.			
GT.437	Handle PHI through authentication, along with encryption methods to secure PHI.			
GT.438	Ability to display and require the user to accept web site terms of agreement when entering the web portal.			
GT.439	Utilize an authentication process to handle multiple layers of security levels as defined by BMS.			
GT.440	Establish user access to predefined BMS levels such as page level, field and data element level.			
GT.441	The system is to provide a protected web site with secure passwords and log-ons to include:			
GT.442	Instructions on how to use the secure site			
GT.443	Site map			
GT.444	Contact information			
GT.445	Send users their initial password via email and require that they change their password at next sign-on.			
GT.446	Provide the ability to expire a password in a given number of days according to BMS standards.			
GT.447	Provide self-service password resets.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.448	Prohibit the display of passwords at the sign-on screen when entered by the user.			
GT.449	Notify MMIS users at regular intervals defined by BMS that security access tables are to be cleared unless otherwise directed. (This is in reference to any security access tables the Vendor may propose as part of their solution, where an example may be a user log table).			
GT.450	Delete account profiles after a period of inactivity as defined by BMS.			
GT.451	Inactive users should not be deleted from history.			
GT.452	Allow Providers to be authorized to access only their own claim information.			
GT.453	Ability to require qualifying information (e.g., Provider number, prior authorization number, Member number, date of service, or claim number) to access various information via the web portal.			
GT.454	Include static and easily updated Web pages.			
GT.455	Include a desktop environment with browser capability for easy navigation.			
GT.456	Provide a user interface that allows all users to move easily throughout the system.			
GT.457	Support a menu and control system with highly flexible navigation.			
GT.458	Provide a user-friendly menu system that is easily navigable by the non-technical user while not restricting direct access to any screen to experienced users.			
GT.459	Provide user interface features and capabilities including:			
GT.460	Pull down menus and window tabs			
GT.461	Scalable true type screen and printing fonts			
GT.462	Upper and lower case alphabetic characters			
GT.463	Ability to tab and mouse-click through data fields and screens			
GT.464	Use the following standards for all system screens, windows, and reports:			
GT.465	Maintain a consistent theme throughout the site and standardize all headings and footers with index tabs as identified by BMS.			
GT.466	Display current date and time in a system-wide consistent format.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.467	Utilize data labels and definitions in a system-wide consistent manner and as defined in user manuals and data element dictionaries.			
GT.468	Generated messages are to be available in both mixed font and mixed case formats.			
GT.469	Screens should distinguish between production and test environments.			
GT.470	Comply with the American Disabilities Act (ADA) standards for user screens, where applicable.			
GT.471	Comply with the Older Americans Act standards for user screens, where applicable.			
GT.472	All generated messages are to be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text.			
GT.473	Conform to any State, Department or Bureau specified standards regarding the look and feel of the web.			
GT.474	Support multiple communication lines and provide fail-over capability.			
GT.475	Provide growth capacity for high volumes of activity.			
GT.476	Ability to interface, receive, send, and download specified content and reporting information directly from/to entities such as Provider associations, vendors, and other State agencies.			
GT.477	Include email address in the authorization table. The confidentiality of email addresses is to be protected and only used for official State business.			
GT.478	Allow for (HIPAA-compliant) email submission by user initiated from a link on the website.			
GT.479	Provide flexible web-based reporting that meets external reporting needs and requirements defined by BMS.			
GT.480	Ability to ensure that web portal field definitions comply with system field definitions.			
GT.481	Provide inquiry capabilities for categories including:			
GT.482	Prior Authorization (PA)			
GT.483	Remittance Advice (RA)			
GT.484	Provider 1099 information			
GT.485	Other as identified by BMS during DDI and accepted via formal change control			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.486	Ability to generate tracking numbers for web portal-submitted Provider enrollment applications and updates.			
GT.487	Ability to provide interactive/dynamic online forms that may be completed and submitted online, completed and printed for hard copy submission (i.e., mail, fax), or printed to be completed by hand and submitted in hard copy format.			
GT.488	Ability to allow users to download or print a copy of completed submitted forms.			
GT.489	Ability to accept electronic attachments via the web portal and match them to the corresponding system record (including enrollment applications).			
GT.490	Ability to require applicants to state that they meet the State-defined Provider eligibility rules (WV code referencing digital signature: http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=39a&art=1).			
GT.491	The web portal should allow authorized users to perform Electronic Data Interchange (EDI) transactions, such as, but not limited:			
GT.492	Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant)			
GT.493	Interactive Claims Inquiry (276/277 – DDE compliant)			
GT.494	Interactive Claim Submission (DDE compliant) to allow a Provider to submit a claim, including HIPAA/EDI compliant responses			
GT.495	Remittance Advice (RA) (835)			
GT.496	Interactive claim submission (837 transactions)			
GT.497	Other transactions as specified by BMS (which may include, but not necessarily limited to: eprescribing, personal health record, health information exchange of lab and/or clinical data)			
GT.498	Provide the capability to display confirmation messages for requestor transactions.			
GT.499	Provide help screens and tutorials (e.g., guides to the Provider enrollment and Prior Authorization processes).			
GT.500	Provide on-line option for end-users to report any technical problems with the web application and web pages.			
GT.501	Ability to report and maintain web portal activity statistics (as defined by the BMS). For instance: new and repeat visitors, number/percent of abandoned enrollment applications, etc.			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without custom-ization	**YES** with custom-ization	**NO** unable to provide
GT.502	**22. Web Portal - Long Term Care (LTC) Provider Rate Submission & Inquiry**			
GT.503	Ability to allow Providers to submit and upload to BMS (via the web portal) the following:			
GT.504	Cost reports			
GT.505	Provider acceptance of the verification report			
GT.506	Rate reconsideration requests			
GT.507	Provider correspondence			
GT.508	Ability to accept and transfer specified files to and from Providers to the MMIS via the web portal.			
GT.509	Ability to send cost report verification to user if no errors are found during edits and supply Providers with a method to agree to the verification.			
GT.510	Ability to provide a private document page that displays a list of the available documents for each logged-in Provider.			
GT.511	Ability to upload rate information in batch or in bulk (i.e., reimbursement rates information that it is provided to RAPIDS. Vendor should propose the most economical format).			
GT.512	Ability to provide Provider-specific inquiry access to secured information. Vendor should propose the more economical format. The pay-to amounts are expected to be provided to the Vendor. Examples include:			
GT.513	Automated Cost Report (ACR) (data and reports)			
GT.514	Error reports as part of the cost verification process			
GT.515	Rate setting package report			
GT.516	Cost verification report			
GT.517	Provider acceptance of the Verification report			
GT.518	MDS error/authorization reports			
GT.519	Individual Assessment Form (IAF) scores			
GT.520	IAF error reports			
GT.521	**23. Web Portal – Patient Care Web Portal**			
GT.522	Ability to provide system functionality that allows Providers access to Member claims data (pharmacy, medical and MCO encounter data) for the purposes of coordinating patient care and reducing duplications in medical procedures, diagnostic testing and medications			

7. General and Technical (GT)				
Req #	**Description of Requirement**	**YES** without customization	**YES** with customization	**NO** unable to provide
GT.523	Provides access only for designated healthcare providers, e.g. prescribers and pharmacists, through an authorized log in to access their patient's medical and pharmacy history. This information should be protected so that it can only be accessed with the correct combination of the member's Medicaid Identification Number, birth date, and name.			
GT.524	Is updated at a minimum of once weekly with claims data (medical and pharmacy) in order to provide access to current patient history for Medicaid prescribers and providers. This data is expected to be in an easily readable format.			
GT.525	Displays twenty-four (24) months of fee-for-service and MCO encounter data that includes, but is not limited to, medical, pharmacy, laboratory, x-ray, institutional, emergency room visits, outpatient visits, diagnosis codes, procedure codes, member demographic information, medical providers identified by name and NPI number, DEA and DEAX numbers, and pharmacy providers identified by name and NPI number.			
GT.526	Meets all Health Insurance Portability and Accountability Act HIPAA requirements for the protection of Medicaid member's personal health information (PHI). Accepts web-based prior authorization requests on smart forms, created in the LiveCycle, program for creating forms with expandable text fields, and transfers them to the Prior Authorization Help Desk for processing through a secure and HIPPA compliant electronic method of transmission.			

APPENDIX F
Vendor Operations Requirements

Table of Contents

I. General

1. Ensure information and documentation captured via the MMIS conforms to the user access, user inquiry, update, retention, purge, archival, destruction, and other relevant data management specifications outlined in this RFP.
2. Operate and maintain the MMIS in accordance with all existing and new requirements of Federal MMIS certification requirements, the CMS State Medicaid Manual, Medicaid Quality Control (MQC), and State and Federal policy. Changes enacted post-award will be handled via formal change control.
3. Provide all Federally mandated and BMS specified production and operational reports per BMS-defined specifications and report distribution schedule.
4. Provide role-based user and system training for BMS personnel, their vendors and their business partners, as specified by BMS, initially and on an ongoing basis.
5. Develop, produce, and distribute system, Provider and user manual sections and other documentation as specified by BMS. Perform version control of all documentation, including archiving per BMS policy/specification.
6. Operate and maintain a Customer Service Support Services unit to provide technical and business policy and procedure support to Providers, Members, MMIS users, BMS staff, and others as approved by BMS. Customer Services Support Services is to be accessible via the Web Portal, email, and telephone.
7. Collect and report on all operational performance standards as defined by BMS, including the metrics defined in Appendix G (Service Level Agreements), Appendix H (Performance Metrics), and all other areas of this RFP (including all Appendices).
8. Make recommendations to BMS in any area in which the Vendor feels improvements can be made.

II. Member Management

Appendix F Member services apply to all Medicaid members (both FFS and Mountain Health Trust).

General

1. Retain MMIS Member change transactions received from BMS or its designee in the format received, for control, balance, and audit purposes.
2. Apply Member update transactions (including POS) by 7 a.m. the next day and on an as-needed emergency basis.
3. Identify and correct errors and discrepancies resulting from the Member update process within 48 hours or alert BMS.
4. Supply and maintain eligibility interfaces.
5. Perform reconciliation of the MMIS Member file to State Member files on a monthly basis, as defined by BMS.
6. Supply, maintain, and provide assistance with interfaces between MMIS and the MCOs.
7. Provide online inquiry for parties designated by BMS.

8. Ensure that the system maintains appropriate controls and audit trails so that the most current Member eligibility data, claims and encounters are used for automated eligibility verification (transactions including real time, online verifications).
9. Resolve error reports and discrepancy lists produced from sampling and reconciliation activities.

Member Services

10. Operate and maintain a Member Services function within Customer Support Services. Receive and respond to all Member eligibility and benefits questions received telephonically and through email, letter, phone, fax, Web Portal, and AVRS. The Vendor will, at a minimum:
    a. Respond to Member inquiries about Member eligibility and benefit packages.
    b. When necessary, the Vendor should contact the Bureau to resolve complex eligibility inquiries and complaints.
    c. Log all Member related inquiries into the contact management system, including identification of the Member, topic of inquiry, response, resolution, and comments.
11. Conduct periodic Member satisfaction surveys
12. Track and notify Members of date-dependent events (as defined by BMS).
13. Perform Member outreach communication, as approved by BMS. Track outreach communication detail, to include but not limited to:
    a. Target population
    b. Quality measure/s addressed
    c. Purpose (e.g., implement programs like enrollment campaigns for waiver programs or other plan/benefits change, privacy notice)
    d. Date of distribution
    e. Method of distribution

    Note that this program is currently under development, but at a minimum would include outreach activities such as web presence for announcements, mailing lists, survey tools, attendance at designated town hall style meetings. The frequency of these activities will be defined prior to implementation.
14. Review and approve all Member communications, ensuring compliance with BMS guidelines, including:
    a. DHHR Communications Office is to review and approve all Member communications materials sent on behalf of BMS.
    b. All Member materials, including correspondence and Web Portal content, should be written for comprehension at the 6th grade reading level.

III. Benefit Administration

1. Support the administration and claims processing of multiple programs and multiple plans including (but not limited to) the addition of any other State Agency, United States Territory or political subdivisions.

2. Monitor changes due to the release of new policies, codes, or services from CMS and/or other national sources and make recommendations to BMS for implementation.
3. Support the administration and claims processing of a variety of benefit packages and service delivery models (e.g., fee-for-service, managed care, pharmacy preferred drug list, and waiver programs).
4. Support the administration and claims processing of non-Medicaid programs (e.g., Limited Pharmacy (ADAP), Tiger Morton, and Juvenile Justice Services).
5. Receive request for benefit package updates. Enter, validate, test, receive BMS approval, and then implement according to BMS specifications.

IV. Provider Management

Provider Services

1. Operate and maintain a Provider Services function within Customer Support Services. Receive and respond to all Provider enrollment and relations questions received telephonically and through email, letter, phone, fax, Web Portal, and AVRS. The Vendor will, at a minimum:
    a. Respond to Provider inquiries about Provider enrollment.
    b. Respond to Provider inquiries about Member eligibility and benefit packages.
    c. Respond to Provider inquiries regarding prior authorization.
    d. Respond to Provider inquiries about claims processing.
    e. Log all Provider related inquiries into the contact management system, including identification of the Provider, topic of inquiry, response, resolution, and comments.
2. Outgoing correspondence to include email, mail, phone, fax, Web Portal, fax (including “fax blast”), and other as defined by BMS.
3. Generate and distribute Provider-related correspondence, information requests, and notifications, to include, at a minimum:
    a. Enrollment applications
    b. Enrollment rejection notifications
    c. Billing instructions
    d. Relevant State policy information
    e. Request for information to support enrollment/contracting process
    f. Mailing labels
    g. Program memorandum
    h. Referral to appropriate licensing board
    i. Notifications of pending expired Provider eligibility
4. Track and notify Providers of date-dependent events (as defined by BMS).
5. Perform Provider outreach communication to both prospective and current Providers, as approved by BMS. Track outreach communication detail, to include:
    a. Target population

b. Issue or measure/s addressed (e.g., new immigrant population in need of language-compatible Providers)
c. Purpose (e.g., corrections to billing practice, public health alerts, Public Service Announcements)
d. Date of distribution
e. Method of distribution

6. Receive and respond to eligibility and claim status inquiries in a variety of medium, to include at a minimum:
    a. X12 270/271 and 276/277 transactions through portal and in batch file process
    b. Mail
    c. Phone (agent)
    d. Fax
    e. Phone (AVRS)
    f. Provider Enrollment Tracking System (PETS) (receive only)
7. Provide, develop and make available free of charge, software or a web-based application, including updates, for Providers to submit electronic transactions using the Internet.
8. Inform Providers through multiple media about electronic billing, automated remittance (835 HIPAA transaction), and electronic fund transfer options, and work with Providers to finalize appropriate formats for the data transfer, including testing of interface.
9. Maintain and update the Provider Web Portal; post weekly Provider Remittance Advices.
10. Generate, distribute and mail out the paper Remittance Advice for those Providers identified by BMS to receive the paper Remittance Advice.
11. Present all messages on the Remittance Advices in non-technical language that is understandable to Providers.

Provider 1099 Production

12. Produce and mail 1099 earnings data annually to Providers.
13. Maintain 1099 process including, but not limited to, annual Internal Revenue Service (IRS) updates.

Provider File Maintenance, Update and Edit

14. Establish methods to edit and verify accuracy of Provider file data.
15. Make available to BMS, online inquiry and update capability for prompt access to the Provider files.
16. Accept and process online updates authorized by BMS or its designee.
17. Enter BMS-approved individual, Provider-specific payment rate updates, including mass or paper updates, into the MMIS.
18. Maintain online Provider and reference data used to support MMIS processing of laboratory claims and encounters in accordance with CLIA requirements.
19. Cross-reference individual Providers to groups, including MCO(s) as defined in BMS policy.

20. Research National Provider Identifier (NPI) discrepancies using the National Plan and Provider Enumeration System (NPPES).

Provider Enrollment

21. Establish a Provider Enrollment organizational unit within the Vendor's West Virginia contract operations staff. This unit is expected to receive requests for enrollment, and process all Provider enrollment applications, including review submitted packets for completeness and conduct follow-up to obtain missing information and/or documentation.
22. Perform initial re-enrollment of all Providers prior to startup of operations for the new MMIS. Full provider reenrollment is expected: a complete application will be expected from the providers; and documentation (including certifications, licenses and ownership information) should be validated.
23. Re-enroll all Providers every three (3) years for DME and all others every five (5) years.
24. Accommodate online and paper Provider enrollment.
25. Enter all Provider enrollment and certification information into the MMIS.
26. Credential and enroll Providers using the criteria established by BMS. The Vendor will be expected to perform the necessary activities to support this requirement. BMS does not currently utilize an existing service to do so. (Enroll providers utilizing specific criteria needed to enroll by provider type, e.g., license, DEA Certification, etc. Not full credentialing).
27. Verify annual licensure status of licensed Providers. The Vendor will be expected to perform the necessary activities to support this requirement. BMS does not currently utilize an existing service to do so.
28. Check all Federal fraud/abuse/exclusion databases prior to enrolling Providers, including the Office of Inspector General's (OIG's) List of Excluded Individuals/Entities (LEIE), Health and Human Services (HHS) OIG Exclusion, General Services Administration (GSA) Excluded Parties List System (EPLS), and Continuous Information Bulletin (CIB). The Vendor will be expected to perform the necessary activities to support this requirement. BMS does not currently utilize an existing service to do so.
29. Refer evidence or reports of Provider fraud/abuse/exclusion to BMS and/or its designee on a monthly basis.
30. Maintain official and legally recognized documentation necessary for Provider enrollment documentation (electronic signatures are acceptable).
31. Develop, print and distribute enrollment materials approved by BMS, including but not limited to a Provider manual, enrollment packet, and notification letters.
32. Send accepted Providers a start-up packet containing all the information for participation in and for billing the State for Medicaid services provided to eligible Members. This packet should be available online and in hard copy.
33. Assign Provider numbers according to BMS policies for those providers without an NPI (Atypicals).
34. Provide BMS with reports giving a weekly summary of enrollment activity, including name, Provider number, and eligibility dates of Providers terminated or suspended.

35. Receive and maintain enrollment information from the MCOs for identification of encounter data and prescriber information.

Provider Training

36. Establish a Provider Training organizational unit within the Vendor's West Virginia contract operations staff responsible for Provider training.
37. Manage and conduct Provider training in accordance with the Provider Training Plan, to include (but not be limited to) training on the West Virginia Medicaid Program, the claims processing system, proper billing, and prior authorization procedures.
38. Offer Provider training through a variety of presentation methods (as approved by BMS). For example: web-based, workshops, training sessions, presentations at professional association meetings, individual training as needed, and distribution of Provider manuals and bulletins.
39. Target for special training those Providers that have been identified as having an abnormal number of claims denied or suspended (as defined by BMS).
40. Conduct specialized training for individual Providers as requested by the provider or BMS.
41. Conduct Provider training at least once annually for the Provider community as well as training for other State designated organizations, including, when necessary, personnel from BMS, and other State agencies.
42. Provide ongoing claims billing training to FFS Providers on a group or individual basis.
43. Develop, distribute, and evaluate Provider-training questionnaires from all training sessions, and provide BMS with a summary of the Provider responses and recommendations for future training activities.
44. Maintain and submit to BMS records of all Providers (by Provider type) who participate in training sessions.

Provider Publications

45. Write, print, and distribute/post Provider materials per BMS approval.
46. Create and issue quarterly Provider bulletins.
47. Update and maintain Provider information user manuals and system documentation as changes are made.
48. Mail Provider manuals and/or Provider manual updates (on a schedule as defined by BMS).
49. Provide Web Portal access to the most recent versions of Provider manuals and bulletins, Medicaid policies, and other Provider materials (as defined by BMS) in downloadable format.
50. Update web-based information and publications upon approval by BMS (on a schedule as defined by BMS).
51. Issue notices of transition issues and processes, new Provider-relations phone numbers, and new billing and submission procedures as appropriate (within a time period defined by BMS).

V. Prior Authorization

1. Provide real-time access via various methods (e.g., Web Portal, AVRS,) for PA status inquiries.
2. Enter and/or accept PA requests, approvals, etc., into the MMIS, online from authorized sources, including Vendor staff when BMS delegates the PA decision and BMS staff when BMS directly preauthorizes services. (The Vendor would be expected to enter Nursing Home Hospice and ICF/MR PAs, which are determined by an outside vendor. The current pharmacy POS clinical prior authorization services vendor is expected to enter all POS PAs).
3. Assign unique PA control numbers and batches to PAs and accompanying documentation.
4. Generate PA approval and denial notices within two (2) business days of on-line entry to BMS and processing or according to an auto-generation distribution schedule defined by BMS.
5. Provide online inquiry and access to the PA data set.

VI. Pharmacy Point-of-Sale (POS)

1. Establish and staff POS Pharmacy (Provider) Help Desk which is dedicated to the State of West Virginia and serves no other Vendor customer.
2. Maintain and implement updates to the Preferred Drug List and State Maximum Allowable Cost (SMAC) pricing files as approved by BMS.
3. Maintain and implement updates to the drug reference file as approved by BMS.
4. Correct drug data file errors deemed critical by BMS within two (2) hours.
5. Maintain and implement updates to the JCode/NDC crosswalk as approved by BMS.
6. Change NDC drug records online to correct all errors identified in the update process within one (1) business day.
7. Maintain and update drugs identified by BMS for the auto prior authorization process.
8. Provide direct access for the staff of the clinical pharmacy prior authorization vendor to the system in order to respond to real-time provider requests.
9. Provide a portfolio of suggested prior authorizations with appropriate criteria and ongoing suggestions for drugs that should require prior authorization, based on utilization and cost of drugs to BMS.
10. Provide the following automated prior authorization system reports:
    a. Utilization of and savings generated by the system
    b. Number of requests processed per month
    c. Number of routine prior authorizations processed per month
    d. Number of calls routed to the Help Desk for a manual prior authorization

e. Savings generated by reduced administrative costs for routine prior authorizations

f. A tracking report logging the amount of time required for the prior authorization request.

VII. Reference Data Maintenance

1. Maintain all Reference files and ensure that the correct information is used in claims processing.
2. Provide BMS with online inquiry and update capabilities to all Reference files.
3. Establish a procedure whereby one of the certified coders employed by the Vendor reviews all updates processed in response to BMS or its designee's requests.
4. Perform mass updates to the Reference Files as specified by BMS.
5. Provide the required reports and listings of the Reference Files to BMS.
6. Accept and process online updates.
7. Provide fee schedule to BMS upon request.

VIII. Claims Processing

1. Maintain a claims control and inventory system approved by BMS.
2. Enter electronic media claims into the MMIS using the appropriate HIPAA compliant format.
3. Develop and implement procedures to ensure the integrity of claims submitted by Providers via Internet or other electronic submission of claims.
4. Assign unique claim control numbers and batches to claims and accompanying documentation.
5. Perform data entry of all hardcopy claims.
6. Pre-screen hardcopy claims before entering into the system, including verification that claims are submitted on the correct claim form (i.e., UB-04, CMS-1500, ADA (Dental), Pharmacy Universal Claim Form (UCF)). Return claims not meeting certain criteria (e.g., no Provider number) to Providers and log returned claims daily and copy them into EDMS.
7. Establish claims balancing processes to ensure control within the MMIS processing cycles.
8. Reconcile all claims (hardcopy and electronic media) entered into the system to batch processing cycle input and output figures.
9. Produce online and hardcopy balancing and control reports according to BMS specifications and make available to BMS.
10. Take images of all claims, electronic media claims, and accompanying documentation.
11. Verify the quality and readability of all imaged claims and documentation.

12. Produce all claims entry statistics reports and submit (email or hand delivery) to BMS.
13. Perform data entry and adjudication of reversal forms including electronic reversals.
14. Perform editing for valid values on all entered claims, according to BMS specifications and using current information on Provider enrollment, Member eligibility, and Reference data. The system is expected to perform daily online edit processing functions.
15. Propose edit criteria, including duplicate or suspect-duplicate edit criteria.
16. Implement all approved edit criteria.
17. Propose criteria and procedures for adjudication of "special" claims (e.g., bypass edit conditions).
18. Manually and systematically review claims that suspend for edits as specified by BMS.
19. Override claim edits in accordance with BMS guidelines.
20. Adjudicate suspended claims after review by the Vendor or BMS staff.
21. Process "special" claims, including late billing, Member retro-eligibility, and any other BMS-defined situation in accordance with BMS instructions.
22. Perform keying and problem claim resolution services on short notice (within current business day) for priority items.
23. Price all claims in accordance with Medicaid Program policy, benefits, and limitations as defined by BMS, including pricing for DRG and FQHC and RHC "encounter."
24. Perform online entry of manual pricing of certain claims.
25. Maintain a method to process for payment any specific claim(s), as directed by BMS, on an exception basis. Maintain an audit trail.
26. Refer claims to BMS for correction/approval according to policy determined by BMS.
27. Use BMS-defined guidelines to monitor the use of override codes during the claims correction process and provide override reports to BMS to identify potential abuse.
28. Produce and distribute Recipient EOMB(s) according to BMS guidelines.
29. Provide online inquiry access to claims history and the status of suspended claims to BMS staff and to enrolled Providers concerning their specific claims.
30. Provide BMS with imaged or hardcopy original claims, adjustments, attachments, non-claim transaction documents, and all electronic transactions (formatted same as hardcopy) processed, as requested by BMS.

IX. Financial Management

1. Render Provider reimbursements promptly and correctly, in accordance with Appendix G (Service Level Agreements), specified contracts, 42 CFR Part 447.45(d) – Payment for Services, and all other requirements in this RFP (including Appendices).
2. Process emergency payment requests within one (1) business day of receipt of BMS request.

3. Produce or reproduce Remittance Advices (RAs), in hardcopy or standardized electronic format, in non-technical language that is understandable.
4. Process capitation payments to MCO(s) and other Providers on a schedule defined by BMS.
5. Process FFS payments on a schedule defined by BMS.
6. Produce, mail and transmit provider 1099 earnings to ensure full reporting compliance as prescribed in the Internal Revenue Code.
7. Maintain audit trail of all adjustments to original paid and previously adjusted claims.
8. Update paid claims history and online financial files with check number or equivalent transaction control number, date of payment and the amount paid.
9. Provide a process to withhold/recoup a fixed dollar amount or a percentage of payments for any MCO or Provider from current payments
10. Provide expenditure data, in the format and media specified by BMS, to designated entities.
11. Accept data in the format and media specified by BMS from the designated entities.
12. Provide at minimum weekly, monthly and quarterly reports to monitor aging of account receivable Follow and monitor compliance with written procedures to meet State and Federal guidelines for collecting outstanding accounts receivable.
13. Provide online access to financial information according to BMS specifications.
14. Process non-claim-specific financial transactions received from BMS.
15. Provide a reconciliation process ensure to ensure all claim financial transactions are accounted for in all Federal and State reporting.
16. Provide a refund process to allow full system accounting of cash receipts including claim history.
17. Provide claim audit trail.

X. Management and Administrative Reporting (MAR)

1. Maintain complete payment data, encounter data, claims history data, and supporting reference data for all claim types.
2. Produce all MAR reports and other outputs within the timeframes and according to the format, input parameters, content, frequency, media, and number of copies specified by BMS.
3. Generate BMS-specified reports to be sent to CMS in the Federally required format.
4. Deliver reports on a variety of media, including hardcopy or electronic media as specified by BMS.
5. Modify MAR reports to meet the changing information needs of the Medicaid Program and ensure compliance with changes in Federal, State and BMS regulations, procedures, or policies.

6. Ensure changes made to programs, category of service, line category, etc., are accurately reflected in MAR reports.
7. Balance MAR report data to comparable data from other MAR reports to ensure internal validity, and to non-MAR reports to ensure external validity, and provide an audit trail. Deliver the balancing report to BMS with each MAR production run.
8. Respond to BMS requests for information concerning the reports.
9. Provide technical assistance as needed to assist users in researching problems, reviewing production outputs, and understanding report formats.
10. Ensure the accuracy of all reports before delivery to BMS.
11. Provide automated input, to the extent feasible, to the creation of the CMS-64 report.
12. Provide to BMS on a specified schedule the Vendor's administrative cost information necessary to accurately complete the administrative portion of the CMS-64.
13. Generate and mail cost settlement data reports (paid claims listings) to Providers or BMS contractors.

XI. Drug Rebate

1. Generate and send out drug rebate invoices (including cover letter) for each labeler that has a rebate agreement signed with CMS or the State.
2. Maintain the drug rebate data to facilitate automatic updating with information from CMS and BMS.
3. Perform direct data entry of all historical data from State sources.
4. Reconcile all data sources to ensure accuracy of invoicing.
5. Maintain and update data on manufacturers with whom rebate agreements exist, including:
    a. Manufacturer ID numbers and labeler codes
    b. Indication of collection media
    c. Indication of invoicing media
    d. Contact name, mailing address, and phone numbers (voice and fax) for manufacturers
    e. Manufacturer (labeler) enrollment dates and termination dates
6. Generate invoice cover letters, collection letters, and follow-up collection letters according to BMS criteria.
7. Maintain an audit trail of all correspondence, invoices, payments, and adjustments.
8. Generate manufacturer mailing labels on request.
9. Provide drug manufacturers HIPAA-compliant access to their respective accounts receivable information. (A portal for the Drug Rebate Program would allow access by the drug manufacturers to their invoices, claims level data, payment data and statements of account. The portal would have to be secure).

10. Provide a system that supports full Federal, State supplemental and managed Care drug rebate reporting requirements.
11. Prove a system that supports non-drug supplemental rebate processes.
12. Provides a system that supports State administered drug rebate programs (IE ADAP).

XII. Contact Management

1. Log and track all information requests from time of receipt to disposition, capturing at a minimum the following:
    a. Unique, automatically assigned control number
    b. Identification of requesting party
    c. Date of inquiry
    d. Topic of inquiry
    e. Response
    f. Resolution/disposition
    g. Date/time information sent to requestor
    h. System query detail (where applicable; e.g., query parameters, user, authorization detail, date/time of system query)
    i. Comments/narrative entries in a free-form text field (including date/time entered)
2. Receive, scan, and initiate a workflow for all correspondence. Link scanned images and related system documentation to contact records to provide one view of all related materials (e.g., images, letters, notifications, and interactions).
3. Develop and provide BMS for approval standard/routine Member and Provider correspondence (e.g., templates). Support use of standard correspondence and the development of customized correspondence, depending on communication needs.
4. Generate/suppress outgoing Member and Provider correspondence according to BMS defined parameters.
5. Comply with all BMS, State, and Federal policies and regulations in regards to communication of information. Deny requests not in compliance with BMS information access/privacy policies and HIPAA guidelines.

XIII. Customer Service Support Call Center

1. Maintain and staff a Customer Service Call Center to include toll-free telephone lines that are accessible according to the following schedule:
    a. POS Pharmacy Provider Help Desk Call Center: 8:30 a.m. to 9:00 p.m., ET, Monday through Saturday; and 12:00 p.m. to 6:00 p.m., ET, on Sunday.
    b. Medical/Dental Provider Help Desk Call Center: 8:00 a.m. to 5:00 p.m., Eastern Time (ET), Monday through Friday.

c. General Customer Service Call Center functionality: will be available during BMS working hours, which are 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday, and on an emergency basis if requested by BMS.

2. Maintain sufficient staff and a sufficient number of telephone lines to perform all Customer Services Call Center duties defined by this RFP.
3. Utilize same telephone system for all Customer Service users (e.g., Providers, Members, MMIS users) and have the ability to record and report statistics by customer type.
4. Use separate, dedicated toll-free telephone numbers for use by Providers (in- and out-of-state), Members, health plans, and other stakeholders, as defined by BMS.
5. Maintain a toll-free telephone line to receive/respond to Member inquiries regarding a denied claim.
6. Maintain a toll-free telephone line to receive/respond to Provider faxes (including PA requests and claims).
7. Provide tools and processes for monitoring and reporting call metrics, such as call abandon rate, call length, hold time, ring busy time, peak hour statistics, and speed of answer.
8. Respond to an unlimited number of calls per Provider.
9. Provide voice messaging system for after hours callers indicating hours of operation and provide options for leaving messages in addition to voice messaging option at BMS designated intervals during the queue hold times. Scripts to be approved by BMS.
10. Provide BMS approved educational scripts for callers on hold or waiting in queue.
11. Review scripts monthly to determine if revisions are necessary and report recommendations to BMS.
12. Document call information as specified by BMS.
13. Monitor, record, and audit calls for quality control, customer service, and training purposes. Vendor shall document and retain results on all calls and submit documentation to BMS upon request.

XIV. Member Eligibility Verification System (MEVS)

1. Provide role-based access to Member eligibility information using a variety of secure methods, including the following: Web Portal (directly through portal or via BMS-approved VAN); by telephone to Customer Services Call Center; and via the AVRS.
2. On a daily basis, process Member eligibility update information received from the eligibility sponsor systems, (in the sequence in which they were created) for use in claims processing, and generate all applicable update reports according to an agreed upon processing schedule.
3. On a daily basis, verify that Medical/Dental and Pharmacy POS Member eligibility data match, according to BMS approved schedule. If the two eligibility sources are not in the same database they must be synchronized and reconciled on a schedule that ensures that eligibility data used for all claims adjudication matches.

4. Reconcile RAPIDS data with the MMIS monthly.
5. Provide RAPIDS and FACTS an interface containing HMO/PAAS assignments, TPL, and lock-in information 2-3 days prior to the cut-off date to print on the Medicaid ID cards.
6. Provide the necessary training to Providers and BMS and its designee's staff in how to use the MEVS.
7. Provide a contingency resource, including use of Vendor staff, for situations when MEVS is down.
8. Provide for logging all MEVS calls.
9. Access the system using: NPI or Medicaid ID if provider and MAID or SSN AND date of birth if member.
10. Allow a search of eligibility retroactively for one (1) year for past dates of service.
11. Update MEVS nightly for batch transactions and real-time for system updates.
12. MEVS response information should include HMO/PAAS, range of eligibility dates, plan information and other insurance information as defined by BMS.

XV. Automated Voice Response System (AVRS)

1. Provide, operate and maintain a touch-tone, telephone-based Automated Voice Response System (AVRS) for toll-free use by Providers, Members, MMIS users, health plans and other external stakeholders.
2. Maintain sufficient in-bound AVRS access lines to maintain all performance standards in Appendix G (Service Level Agreements) and all other areas of this RFP.
3. Provide real-time access to PA status inquiries via AVRS.
4. Produce and maintain recorded messages/prompts/responses. All recordings (including script content and recording voice quality) are subject to the approval of BMS.
5. Make updates to the AVRS recorded messages/prompts/responses within two (2) business days of receiving a request from BMS, unless otherwise agreed upon by the BMS.

XVI. Mail Room

1. Maintain and staff a Mail Room to prepare and control all incoming and outgoing program-related mail, claims, Member and Provider inquiries and other communications.
2. Develop and maintain a document control and inventory system approved by BMS.
3. Log all correspondence received within a timeframe agreed upon by BMS.
4. Provide separate post office boxes according to BMS specifications, including a mailbox address dedicated to Member and Provider inquiries.
5. Date-stamp all mail on the day of receipt.

6. Pick up and deliver Vendor mail to BMS once in the morning and once in the afternoon of each BMS business day.
7. Mail program applications and other program information as requested.
8. Maintain paper claims and all other hard copy materials per BMS specifications.
9. Log postage costs daily and submit within BMS-defined reporting requirements.
10. Prepare weekly and monthly reports (as specified by BMS) indicating the number of claims received, returned to Provider, or processed.

XVII. Web Portal

1. Provide and maintain a secure website with authentication and encryption to protect interactions and transactions. This should include, at a minimum, the use of Secure Sockets Layer, or SSL. The authentication process should be verified through a third party that has registered and identified the server. The secure website includes (at a minimum) the following components and functionality (where all access is individualized and role-based):
    a. MMIS user content
    b. Member and Provider Services content (as specified by BMS).
    c. Member and Provider inquiry submission.
    d. Provider enrollment.
    e. Provider information updates.
    f. Prior authorization real-time inquiry.
    g. Patient Care functionality (see Appendix E Business and Technical Requirements GT.521-GT526).
    h. HIPAA compliant functionality that supports electronic submission of Prior Authorizations for the BMS-specified programs.
    i. Other information from BMS-specified external entities (such as enrollment brokers and HMOs).
2. Supply an e-mail address for Web Portal users to submit written inquiries.
3. Publish current, updated source documents, Vendor developed policy/procedure manuals, system documentation, Provider manuals and forms to the web for BMS access. File access is to be secure and role-based.
4. Review Frequently Asked Questions (FAQ) monthly and recommend changes, deletions, and additions.
5. Develop and maintain help screens to assist users in completing processes such as enrollment and prior authorization submission.
6. Provide links to State agencies and other external entities according to BMS specifications.
7. Ensure Web Portal design, development, implementation and operations are in accordance with State and Federal regulations and guidelines related to security, accessibility, confidentiality, and auditing.

8. Provide Internet security functionality to include firewalls, intrusion detection, and encrypted network/secure socket layer.
9. Handle PHI through authentication, along with encryption methods to secure PHI.
10. Provide for secure, “once only” web survey responses.

XVIII. Technical

System Availability

1. Meet all system availability, failover and reliability requirements as specified in Appendix G (Service Level Agreements).
2. Provide BMS staff, Providers, Members, and other users (as authorized by BMS) access to all Web Portal, AVRS, Pharmacy POS, and other system components as required by BMS, for one hundred (100) percent of the time 24 hours per day, 7 days per week, except for negotiated down time for system maintenance during off-peak hours.
3. Operate and maintain a BMS Technical Support Desk function within Customer Support Services, to provide first-level support as defined by BMS. The system is to be accessible, at a minimum, for one hundred (100) percent of the time during BMS working hours (except for negotiated downtime). The system should be accessible via the Web Portal, email, and telephone.
4. Submit for BMS approval a schedule of all system maintenance 30 days in advance of the event.
5. Schedule and complete maintenance during the hours of 1:00 am and 6:00 am or submit justification to BMS for approval for utilizing a different time period.
6. Make available a daily system availability schedule, distributed via email to MMIS users and staff.
7. Provide a solution that allows switchover to the failover environment in no more than 10 minutes in the case of a production environment failure.

Security and Privacy

8. Provide secure email for all users, including mail services to determine when email shall be encrypted as specified by BMS.
9. Provide access to all new MMIS users (including Vendor and Vendor staff) within one (1) work day of employment/notification, following all required security checks and protocols. Access shall be limited to authorized users.
10. Terminate access for all terminated BMS users by the end of their last business day, and within one (1) hour of notification by BMS.
11. Identify email and Internet spam and scams and restrict or track user access to appropriate web sites.
12. Detect and prevent hacking, intrusion, and other unauthorized use of system resources.
13. Provide BMS a report of any incidents of intrusion and hacking regardless of outcome.
14. Prevent adware or spyware.

15. Update virus blocking software daily and aggressively monitor for and protect against viruses.
16. Run a penetration test utilizing a tool on a schedule defined by BMS (e.g., every six months) providing logical and physical security assessments.
17. Provide any additional security and confidentiality capabilities based on industry trend, knowledge, and capability as defined by BMS requirements.
18. Conduct monthly physical security audit of selected requirements to ensure HIPAA compliance. Forward results of audit to BMS.
19. Review MMIS access to all non-BMS employees to make certain access is appropriate.
20. Provide BMS authorized IT staff read access to all databases in all regions.
21. Secure all software at Vendor's site by individual, group, or type of requestor.
22. Provide record-level reporting of inaccurate processing results (e.g., claims processed without required consent on file, valid claims denied).

APPENDIX G
Service Level Agreements

BMS will monitor the Vendor's performance during the Fiscal Agent Operations Phase using a performance reporting system to be implemented by the Vendor. Each Service Level Agreement (SLA) presented in Appendix G establishes the performance level expected by BMS in a particular area. Key Performance Indicators (KPIs) are identified within each SLA, and are to be measured and reported each month by the Vendor. Service Level Agreements found in this appendix are:

1. System Availability
2. System Performance
3. Database Updates
4. Operational Problem Management
5. Customer Service Support
6. Claims Adjudication
7. Claims Payment
8. Reporting
9. Drug Rebate

SLAs and Performance Monitoring
The KPIs used to define the following service levels are an adjunct to the performance standards established in Appendix H, Performance Metrics. BMS has identified the KPIs to be key indicators of the Vendor's operational performance. Failure to achieve a KPI may, at the discretion of BMS, result in financial retainage; failure to meet any other performance standard defined in Appendix H is not directly tied to fiscal hold-back. BMS reserves the right to promote any performance metric to the status of Key Performance indicator.

Monthly Reporting
The Vendor is expected to monitor performance against the BMS-specified KPIs in this document, and is to develop operations reports to demonstrate compliance with applicable KPIs. The Vendor is to submit a performance report card monthly on all KPIs, regarding the prior month's performance, no later than the 10th of the month. The Vendor may include additional information regarding SLA compliance in its report. The Vendor is to make available to BMS upon request all reports or data used in the determination of SLA compliance and calculation of KPI metrics.

Corrective Action
When a Key Performance Indicator is not met, the Vendor is expected to provide BMS with a written detailed Corrective Action Report which describes:

1. The missed KPI.
2. Full description of the issue.
3. Cause of the problem.
4. Risks related to the issue.
5. The resolution, including any failed solutions implemented prior to resolution.
6. Proposed corrective action going forward to avoid missing the KPI in the future.

Upon receipt of the report, BMS may request a meeting to further discuss related issues. The Vendor is to implement proposed corrective action (#6 above) only upon approval of BMS.

Periodic Reviews

Prior to commencement of Phase 2a Routine Operations, BMS and the Vendor are to review all KPIs to determine if revisions are needed. Thereafter, similar reviews are to be held annually, upon the implementation of a change that impacts existing KPIs, and/or at the request of BMS.

Right to Retainage

BMS and the Vendor agree that failure by the Vendor to perform in accordance with established Key Performance Indicators results in a loss to BMS. If the Vendor fails to meet the Key Performance Indicators identified in the Service Level Agreements located in Appendix G, BMS may retain a percentage of the total monthly administrative fee as identified in each SLA and deduct said amounts from the fees due to the Vendor for services satisfactorily performed.

1. Service Level Agreement – System Availability	
Performance Standard	**Retainage**
System availability is to be defined as the percentage of possible uptime in a month that the MMIS environments (including all associated components) are available to users or to perform in a back-up capacity, including all weekends and holidays. Negotiated downtime for system maintenance during off-peak hours is not to be included in the calculation of system availability. **Downtime.** Downtime is to be defined as the time during which the MMIS is not functioning/available due to hardware, operating system or application program failure. Production downtime is to be defined as the time during which the system is not available for production use. Failover downtime is to be defined as the time required to move from an unavailable production system to a functioning back-up system. Outages during planned downtime approved by BMS do not count towards downtime. System availability is to be based on the following hours of operation: **MMIS Hours of Operation.** MMIS access is to be available at a minimum 100% of the time during BMS working hours, which are 7:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday, with access on the weekends and holidays as agreed upon by BMS, and on an emergency basis if requested by BMS. **Other Components Hours of Operation.** The Web Portal, AVRS, Pharmacy POS, Automated Prior Authorization system, and other system components, as required by BMS, are to be available 100% of the time 24 hours per day, 7 days per week, except for agreed upon down time. The Vendor is to ensure system availability meets the following performance standards: **Production Downtime** 1. **POS.** POS production downtime is to be 0.1% or less. 2. **All Other MMIS Components.** Production downtime for all MMIS components except the POS is to be 1% or less. **Failover Downtime** 3. **POS.** POS failover downtime is to be 0.1% or less. 4. **All Other MMIS Components.** Failover downtime for all MMIS components except the POS is to be 1% or less. **Vendor Network Connectivity Downtime** 5. Vendor network connectivity downtime for all MMIS components, including POS, is to be 1% or less. **Test Downtime** 6. Test downtime for all MMIS components, including POS, is to be 5% or less.	Up to **6%** of the monthly operating fee, as follows: • Any 1 of 6 not met: **1%** • Any 2 of 6 not met **3%** • Any 3 of 6 not met: **5%** • 4 or more of 6 not met: **6%**

2. Service Level Agreement – System Performance	
Performance Standard	**Retainage**
System performance is to be defined as MMIS response time to user queries. BMS working hours, which are 7:00 a.m. to 7:00 P.M., Eastern Time, Monday through Friday, with access on the weekends and holidays as agreed upon by BMS, and on an emergency basis if requested by BMS. The Web Portal, AVRS, Pharmacy POS, and Automated Prior Authorization system response times are to be measured 7 days a week, 24 hours a day, except during agreed upon downtime. The Vendor is expected to only be responsible for that portion of the system and communication link for which the Vendor has responsibility and control. For system response time performance measures, Vendor control is to be defined as any Subcontractor/Vendor service or point up to and including the BMS side of the router. The Vendor is to provide a system to monitor and report on response times as defined and approved by BMS. All metrics are to be measured and evaluated in seconds. The Vendor is to ensure system performance meets the following performance standards: 1. **Record Search and Retrieval Time.** Within four (4) seconds 95% of the time, where record retrieval time is defined as the time elapsed after the retrieve command is entered until the record data loads to completion on the monitor. 2. **Screen Edit Time.** Within two (2) seconds 95% of the time, where screen edit time is defined as the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor. 3. **New Screen/Page Time.** Within two (2) seconds 95% of the time, where new screen/page time is defined as the time elapsed from the time a new screen is requested until the data from the screen loads to completion on the monitor. 4. **Web Portal Response Time.** Within four (4) seconds 99% of the time, where Web Portal response time is defined as the time elapsed from the command to view a response until the response appears or loads to completion on the monitor. 5. **EDMS Image Retrieval Time.** Within 10 seconds 95% of the time, where EDMS image retrieval time is defined as the time elapsed after the retrieve command is entered until the image data loads to completion on the monitor. 6. **POS On-Line Claims Response Time.** Within 3 seconds 95% of the time, where POS on-line claims response time is to be measured as the time elapsed after the receipt of Provider on-line claim transaction until response notification is sent to Provider.	Up to **6%** of the monthly operating fee, as follows: • Any 1 of 6 not met: **1%** • Any 2 of 6 not met **3%** • Any 3 of 6 not met: **5%** • Any 4 or more of 6 not met: **6%**

3. Service Level Agreement – Database Updates	
Performance Standard	**Retainage**
Database updates are to be defined as the activities necessary to maintain current and accurate data as required to conduct the functions outlined in this RFP, in compliance with all requirements herein. The Vendor is to ensure database update activities meet the following performance standards: 1. **Provider Database Electronic Updates Turnaround Time.** Update Provider data received electronically within one (1) business day of receipt of file. 2. **Provider Database Error Correction Turnaround Time.** Identify and correct errors within one (1) business day of error detection. 3. **Provider Licensure and Participation Requirements Updates Turnaround Time: On-Line Interfaces.** Update the system with Provider licensing and participation requirements updates at least once a month for Providers licensed by West Virginia licensing agencies with on-line interfaces (including West Virginia business licensing). 4. **Provider Exclusion Updates Turnaround Time: On-Line Interfaces.** Update the system with Provider exclusion updates at least once a month for Providers licensed by West Virginia licensing agencies with on-line interfaces (including West Virginia business licensing). 5. **Provider Licensure Updates Turnaround Time: Other.** Update the system with Provider licensing/certification information for Providers licensed by agencies for which there is no on-line interface at least once a month. 6. **Member Eligibility Database Update Turnaround Time.** The Member eligibility database update is to begin within two (2) hours of receipt of the updates and is to be complete prior to daily claims processing. 7. **Member Eligibility Update and Error Reporting Turnaround Time.** Provide the BMS with update and error reports within 24 hours of receipt of the update.	Up to **6%** of the monthly operating fee, as follows: • Any 1 of 10 not met: **1%** • Any 2 of 10 not met: **2%** • Any 3 of 10 not met: **3%** • Any 4 or more of 10 not met: **6%**

3. Service Level Agreement – Database Updates	
Performance Standard	**Retainage**
8. **Member Eligibility Error Resolution Turnaround Time.** Resolve eligibility transactions that fail the update process within two (2) business days of error detection. 9. **Pricing Files Updates Turnaround Time.** Perform rate updates to pricing files within one (1) business day of BMS approval. 10. **Automated Prior Authorization System Criteria Updates Turnaround Time.** Perform criteria updates within ten (10) business days of BMS approval.	

4. Service Level Agreement – Operational Problem Management	
Performance Standard	**Retainage**
The Vendor is to provide operational problem management to manage MMIS problems as they occur during the Operations Phase of the project, including issues associated with all system components (e.g., AVRS, Web Portal, Pharmacy POS, Electronic Document Management System (EDMS), interfaces) at BMS, BMS-contracted vendors (as specified by BMS during DDI), and Fiscal Agent physical locations. Operational issues are to be classified, communicated to BMS, documented, addressed and tracked per policies and procedure in the BMS Operational Problem Management Policy. The Vendor is to provide software tools to enable the tracking of a specific defect from identification through correction, including all testing performed to ensure the correct fix is in place. Issues are to be documented in the form of an Impact Statement Report. During the Operations Phase the Vendor is to categorize and resolve errors in accordance with the BMS Operational Problem Management Policy, as follows: **a. Priority 0 Errors.** Critical business impact. Indicates MMIS is unavailable for use resulting in a critical impact on operations. Requires immediate BMS notification and resolution within two (2) hours. **b. Priority 1 Errors.** Serious business impact. Indicates serious production issues where the MMIS is usable but is severely limited and no workaround exists. Requires immediate BMS notification and resolution within 24 hours. **c. Priority 2 Errors.** Significant business impact. Indicates moderate production issue where MMIS is usable but a workaround is available (not critical to operations). Requires BMS notification within one (1) hour of problem discovery and resolution within 5 business days. **d. Priority 3 Errors.** Minimal business impact. Indicates the problem results in little impact on operations or a reasonable circumvention to the problem has been implemented. Requires BMS notification within one (1) hour of problem discovery and resolution within an agreed-upon schedule between the Vendor and BMS (as defined by BMS).	Up to **6%** of the monthly operating fee, as follows: • Priority 0 Errors standard not met: **3.00%** • Priority 1 Errors standard not met: **1.25%** • Priority 2 Errors standard not met: **1.25%** • Priority 3 Errors standard not met: **0.50%**

5. Service Level Agreement – Customer Service Support	
Performance Standard	**Retainage**
The Vendor is to provide customer service support, where customers are to be defined as Providers, Members, BMS, and other system users. The Vendor is to maintain sufficient staff and systems to manage, track and report on Customer Services via multiple channels, including telephone, AVRS, web portal, email, and mail. The Vendor is to provide an integrated contact management system to be used in tracking and managing Customer contacts from all channels, and can report on Customer contact metrics separately. Customer Service support is to be available 100% of the time as defined in Appendix F Customer Service Support Call Center. The Vendor is to ensure customer service support meets the following performance standards:	
1. **Average Speed of Answer.** At least 90% of all calls are to be answered within 30 seconds (and within three (3) rings), where "answer" means for each caller who elects to speak to a live representative.	**1%** of the monthly operating fee
2. **Ring Busy Rate.** No more than 5% of incoming calls are to ring busy.	**1%** of the monthly operating fee
3. **On Hold Time.** On hold time is to be less than two (2) minutes for at least 90% of all calls, where on hold time is defined as the time (in seconds) elapsed before response by a live representative (excluding speed of answer).	**1%** of the monthly operating fee
4. **Provider Phone Inquiry Response Timeliness.** Respond to 100% of verbal (telephone) Provider inquiries within one (1) business day of receipt.	**1%** of the monthly operating fee
5. **Provider Written Inquiry Response Timeliness.** Respond to at least 90% of written Provider correspondence within five (5) business days of receipt.	Up to **3%** of the monthly operating fee, as follows: • >85% to <90% response: **1%** • >80% to ≤85% response: **2%** ≤80% response: **3%**
6. **Remittance Advice Web Posting Timeliness.** Post 100% of Remittance Advice concerning paid and denied claims on Web Portal within one (1) business day of the completion of payment cycle.	**1%** of the monthly operating fee

6. Service Level Agreement – Claims Adjudication

An adjudicated claim is defined as a claim that requires no further adjudication or a claim suspended from adjudication processing due to error condition/s, including those errors resulting from issues outside of the Vendor's claims processing system. The calculation for claims adjudication metrics is to be based upon monthly claims volume within each measure, unless otherwise noted.

The Vendor is to ensure claims adjudication meets the following performance standards:

Performance Standard	Retainage
1. **Clean Claims Adjudication Rate – Electronic Claims.** Adjudicate 95% of all clean electronic claims for payment or denial within two (2) working days of receipt, where clean claim is defined as a claim that is properly completed and contains all required data elements necessary for processing. Electronic claims are those claims submitted via the following channels: direct data entry (DDE), Web Portal, Pharmacy Point-of-Sale, and electronic batches. Electronic claims account for approximately 93% of BMS's overall claim volume.	**0.5%** of the monthly operating fee
2. **Clean Claims Adjudication Rate – Paper Claims.** Adjudicate 95% of all clean paper claims for payment or denial within five (5) working days of receipt, where clean claim is defined as above. Paper claims are those claims submitted in hard copy. Paper claims account for approximately 7% of BMS's overall claim volume.	**0.5%** of the monthly operating fee
3. **POS Claims Adjudication Rate.** Adjudicate 100% of all Pharmacy Point-of-Sale claims for payment or denial within 3 seconds of receipt.	**0.5%** of the monthly operating fee
4. **Suspended Claims Finalization Rate.** Finalize 100% of all suspended claims and submit to Accounts Payable for payment processing within fifteen (15) days of receipt. Suspended (or "pended") claim is defined as a claim suspended from adjudication processing due to error condition/s, including those errors resulting from issues outside of the Vendor's claims processing system. A claim is not to be submitted for payment processing until all error conditions have been resolved.	**0.5%** of the monthly operating fee
5. **POS Daily Time-Out Rate.** Maintain a less than 100 claims/day time-out rate for Pharmacy Point-of-Sale 100% of the time.	**1%** of the monthly operating fee per daily occurrence

7. Service Level Agreement – Claims Payment

The Vendor is to be responsible for timely and accurate claims payment. The Vendor is to ensure claims payment meets the following performance standards:

Performance Standard	Retainage
1. **Payment Cycle Schedule.** Run at least one (1) payment cycle weekly based on release criteria entered by BMS. Failure to meet the defined threshold one or more weeks in the defined month constitutes failure to achieve for the full month.	Up to **1%** of the monthly operating fee, as follows: • Any 1 of 2 not met: **0.5%** • Any 2 of 2 not met: **1%**
2. **Notification of Overpayment.** Provide BMS written notification within 48 hours of discovery of any overpayments, duplicate payments, or incorrect payments (regardless of cause).	

8. Service Level Agreement – Reporting

Reporting is to be defined as the processes, activities, and deliverables associated with regular reporting.

The Vendor is to ensure reporting meets the following performance standards:

Performance Standard	Retainage
1. **Daily Reports Availability Schedule:** accessible to users by 7:00 a.m. of the next BMS business day.	**0.5%** of the monthly operating fee
2. **Weekly Reports Availability Schedule:** accessible to users by 7:00 a.m. the next BMS business day after the scheduled run.	**0.5%** of the monthly operating fee
3. **Monthly Reports Availability Schedule:** accessible to users by 7:00 a.m. of the next BMS business day following the end of the month (as determined by BMS).	**0.5%** of the monthly operating fee
4. **Quarterly Reports Availability Schedule:** accessible to users by 7:00 a.m. of the next BMS business day following the end of the quarter.	**0.5%** of the monthly operating fee
5. **Annual Reports Availability Schedule:** accessible to users by 7:00 a.m. of the next BMS business day following end of the year (Federal fiscal, State fiscal, or other annual cycle).	**0.5%** of the monthly operating fee
6. **Federal and State Reporting and File Production/Distribution Schedule.** Produce and submit all required Federal and state reports and data files on a schedule defined per regulation and by BMS.	**0.5%** of the monthly operating fee

9. Drug Rebate

The Vendor is to be defined as the processes, activities and deliverables necessary to support the administration of the BMS Drug Rebate program.

The Vendor is to ensure drug rebate meets the following performance standards:

Performance Standard	Retainage
1. **Manufacturer Data Update Turnaround Time.** Update the manufacturer rebate data within 24 hours of receipt of the update from CMS. 2. **Invoice Production Turnaround Time.** Generate and mail invoices (including federal, physician administered, and MCO) to manufacturers within sixty (60) days of the end of the quarter. 3. **Data Update Schedule: CMS Tape.** Load the CMS tape quarterly. 4. **Data Update Schedule: Provider File.** Update the Provider file weekly. 5. **Data Update Schedule: Claims File.** Load the claim files monthly. 6. **Data Update Schedule: T-Bill Rate.** Update the US T-Bill rate weekly. 7. **Data Update Schedule: System Update.** Update the system nightly.	Up to **3%** of the monthly operating fee, as follows: • Any 1 of 7 not met: **0.5%** • Any 2 of 7 not met **1%** • Any 3 of 8 not met: **2%** • Any 4 or more of 7 not met: **3%**

APPENDIX H
Performance Metrics

Overview
BMS will monitor the Vendor's performance during the Fiscal Agent Operations Phase using a performance reporting system to be implemented by the Vendor. Each performance standard presented in Appendix H establishes the performance level expected by BMS in a particular area. These documents are to become part of the contract resulting from this RFP.

Service Level Agreement (SLA) and Performance Monitoring
The Key Performance Indicators (KPIs) used to define the service levels found in RFP Appendix G (Service Level Agreements) are performance standards, and are an adjunct to the performance standards established in this appendix. The KPIs differ from the performance metrics defined in this Appendix in that BMS has identified them to be key indicators of the Vendor's operational performance. Failure to achieve a KPI may, at the discretion of BMS, result in financial retainage; failure to meet any other performance standard defined in Appendix H is not directly tied to fiscal withholding. BMS reserves the right to promote any performance metric to the status of Key Performance indicator.

Monthly Reporting
The Vendor is expected to monitor and provide automated monthly reporting against all BMS-specified performance standards in this document. The automated reports are to be flexible and adaptable to changes in the performance measurements through a rules-based engine, or component of a rules-based engine, in the MMIS. Reports regarding the prior month's performance are to be available no later than the 10th of the following month.

Periodic Reviews
Prior to commencement of Phase 2a Routine Operations, BMS and the Vendor are to review all performance standards to determine if revisions are needed. Thereafter, similar reviews are to be held annually (at a minimum), upon the implementation of a change that impacts existing performance standards and/or at the request of BMS.

The following describes the performance standards established at the time the RFP was published.

1. System Availability
None identified at this time. See Appendix G – Service Level Agreements.

2. System Performance	
2.1	**Ad-Hoc and On-Demand Reports Access Time.** Within a timeframe as requested by BMS, where ad-hoc and on-demand reports access time is defined as the time elapsed from the time the report is requested until the report loads to completion on the monitor.
2.2	**Data Transfer Response Time.** Within a timeframe as agreed upon by BMS, where data transfer response time is defined as the time elapsed from the time the interface file is sent/received until confirmation response (receipt, acceptance, failure or rejection response) is sent to interface partner.

3. Database Updates	
3.1	**Member Eligibility Reconciliation Turnaround Time: State Eligibility Systems.** Reconcile the MMIS eligibility data with the all State eligibility systems monthly, and provide the BMS with reconciliation reports within 24 hours of receipt of the reconciliation file.

4. Operational Problem Management
None identified at this time. See Appendix G – Service Level Agreements.

5. Customer Service Support	
	Call Center
5.1	**Average Speed of Connection to Live Representative.** Address at least 90% of all calls with a live representative within 30 seconds of call answer, where a live representative is defined as the primary issue resolution operator, who will not transfer the call to another representative.
5.2	**Call Abandonment Rate.** Call abandonment rate not to exceed 5% of the total daily call volume, where abandonment is defined as caller hang-up before a live representative is reached.
5.3	**Daily Average Hold Time.** Average hold time should not exceed three (3) minutes for 95% of the total daily call volume, where hold time is defined as the time elapsed before response by a live representative (excluding speed of answer).
5.4	**Daily Maximum Hold Time.** Maximum hold time is not to exceed 10 minutes for 100% of calls each day. This includes all hold time experienced during the call, where hold time is as defined above.
5.5	**Accuracy Rate.** Monthly accuracy of responses to Call Center inquiries is to be at least 90%, based on a sampling of all calls monitored based using a process established by BMS and the Vendor.

5. Customer Service Support (Continued)	
AVRS	
5.6	**Timely Connection Rate.** Callers are connected with the AVRS system within three (3) rings at a rate of at least 99% of total daily call volume.
5.7	**Call Abandonment Rate.** The daily average call abandonment rate shall not exceed 5%, where abandonment is defined as caller hang-up before a live representative is reached.
5.8	**Dropped Call Rate.** Dropped call rate shall not exceed 1% of the total daily call volume, where dropped call refers to unexpected disconnection of the call.
5.9	**Script Update Timeliness.** Make updates to the AVRS recorded messages/prompts/responses within two (2) business days of receiving a request from the BMS, unless otherwise directed by the BMS.
Web Portal	
5.10	**Claims-in-Process Report Posting Timeliness.** Post claims in process report on web portal the same day as of completion of payment cycle.
5.11	**FAQ Updates Timeliness.** Update Frequently Asked Questions within two (2) business days of receipt of approval by the BMS.
5.12	**Survey Deployment Timeliness.** Deploy surveys by web portal within two (2) business days of BMS approval.
5.13	**Survey Reporting Timeliness.** Summarize survey responses for BMS review within five (5) business days of completion of survey.
Provider Inquiry	
5.14	**Faxed Inquiry Response Timeliness.** Respond to faxed Provider inquiries within five (5) business days of receipt (measured as of the date stamp on the fax).
5.15	**Electronic Inquiry Response Timeliness.** Respond to electronic Provider inquiries (including email and web portal submissions) within one (1) business day of receipt.
Provider Enrollment	
5.16	**Enrollment Packet Distribution Timeliness.** Mail Provider enrollment packets within two (2) business days of receipt of request (regardless of media of request -- paper, phone, electronic).
5.17	**Provider Information Update Timeliness.** Enter all changes to Provider information within two (2) working days of receipt of the input from a BMS-authorized entity.
5.18	**Application Processing Timeliness.** Process complete (clean) Provider applications, including entry of all Provider information, within five (5) business days of receipt (regardless of media of application -- paper, electronic).
5.19	**Enrollment Decision Letter Distribution Timeliness.** Mail approval or denial notification letters to Providers within one (1) business days of completing application processing.

5. Customer Service Support (Continued)
Member Inquiry
5.20 **Phone Inquiry Response Timeliness.** Respond to verbal (telephone) Member inquiries within one (1) business day of receipt.
5.21 **Written Inquiry Response Timeliness.** Respond to at least 90% of written Member correspondence within five (5) business days of receipt.
5.22 **Electronic Inquiry Response Timeliness.** Respond to Members' electronic (including email and web portal submissions) inquiries within one (1) business day of receipt.
Provider Publications
5.23 **New/Updated Publication Distribution Timeliness.** Produce and distribute new publications and publications with extensive changes in final form no more than 30 calendar days from the date of the BMS written request for the new or updated publication.
5.24 **Newsletter Publishing Schedule.** Publish quarterly newsletters.
5.25 **Requested Materials Distribution Timeliness.** Distribute Provider manuals and updates or bulletins within three (3) business days of receipt of a request from a Provider.
5.26 **Web Portal Update Timeliness.** Publish updates on the Provider web site within one (1) business day of the date of the BMS written approval for publication.
5.27 **Web Portal New/Updated Publication Posting Timeliness.** Announce and make available via web site, for download and printing by the Provider, all new or updated Provider manuals within three (3) business days of written approval by the BMS.
5.28 **RA Message Timeliness.** Publish Remittance Advice messages within one (1) payment cycle from the date of the BMS approval of the message.
Member Publications
5.29 **New/Updated Publication Distribution Timeliness.** Prepare and deliver in final form updates to publications to the BMS for review and approval within three (3) business days of the date requested by the BMS or the date changes proposed by the Fiscal Agent were approved by the BMS.
5.30 **Web Portal Update Timeliness.** Publish updates on the Fiscal Agent web site within one (1) business day of the date of the BMS written approval for publication.

6. Claims Adjudication
6.1 **Rejected Claim File Reporting Timeliness.** Report rejected electronic claim files back to the submitter within one (1) working day of receipt.

7. Claims Payment	
7.1	**Payment File Transmission Schedule.** Transmit payment file to DHHR OMIS by 8:00 p.m. on the day of the payment processing cycle.
7.2	**Payment Cycle Reporting Schedule.** Provide payment cycle reports to BMS by 7:00 a.m. on day of the payment processing cycle.
7.3	**Payment Data Update Schedule.** Append payment information (e.g., check number and/or EFT confirmation) within one (1) calendar day of receipt of the payment file from DHHR OMIS.
7.4	**1099 Federal Reporting Schedule.** 1099 must be mailed to providers by January 31.

8. Reporting
None identified at this time. See Appendix G – Service Level Agreements.

9. Drug Rebate
None identified at this time. See Appendix G – Service Level Agreements.

Appendix I - MED 96 Agreement Addendum

This agreement addendum becomes part of any contract resulting from this RFP. This form may also be found at the following url:

http://www.dhhr.wv.gov/bms/ProcurementNotices/Documents/MED96.pdf

MED-96 **AGREEMENT ADDENDUM**

In the event of conflict between this addendum and the agreement, this addendum shall control:

1. **DISPUTES** - Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.
2. **HOLD HARMLESS** - Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.
3. **GOVERNING LAW** - The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.
4. **TAXES** - Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.
5. **PAYMENT** - Any references to prepayment are deleted. Payment will be in arrears.
6. **INTEREST** - Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.
7. **RECOUPMENT** - Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.
8. **FISCAL YEAR FUNDING** - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.
9. **STATUTE OF LIMITATION** - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.
10. **SIMILAR SERVICES** - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.
11. **ATTORNEY FEES** - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.
12. **ASSIGNMENT** - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.
13. **LIMITATION OF LIABILITY** - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.
14. **RIGHT TO TERMINATE** - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay Vendor for services rendered or goods received prior to the effective date of termination.
15. **TERMINATION CHARGES** - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.
16. **RENEWAL** - Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.
17. **INSURANCE** - Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.
18. **RIGHT TO NOTICE** - Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.
19. **ACCELERATION** - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.
20. **CONFIDENTIALITY** - Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.
21. **AMENDMENTS** - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

ACCEPTED BY DHHR OFFICE OF PURCHASING:	VENDOR
Spending Unit: _____	Company Name: _____
Signed: _____	Signed: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix J – MED Purchasing Affidavit

This form must be signed by the vendor and returned with the proposal. This form may also be found at the following url:
http://www.dhhr.wv.gov/bms/ProcurementNotices/Documents/RFPs/MED_PURCHASING_AFFIDAVIT.pdf

BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing ***(West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: _____

Authorized Signature:. _____ Date: _____

State of _____

County of _____ , to-wit:

Taken, subscribed, and sworn to before me this day of _____, 20 __.

My Commission expires _____, 20__ .

AFFIX SEAL HERE **NOTORY PUBLIC** _____

Appendix K - HIPAA Business Associate Addendum

This addendum becomes part of any contract resulting from this RFP. Use the link provided below to obtain a complete and recent version of the HIPAA Business Associate Addendum. http://www.dhhr.wv.gov/bms/ProcurementNotices/Documents/HIPAA BAA_20100802.pdf

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective on the date of execution of a binding Agreement with the Agency.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. Definitions. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy and Security Rules, including the HITECH Act.

a. Breach shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

b. Business Associate shall have the meaning given to such term in 45 CFR § 160.103.

c. Electronic Health Record shall mean an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

d. Electronic Protected Health Information means Protected Health Information that is transmitted by Electronic Media (as defined in the Security and Privacy Rule) or maintained in Electronic Media.

e. Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and Part 164, Subparts A and E, as amended.

1

f. Personal Health Record shall mean an electronic record of identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared and controlled by or primarily for the individual.

g. Protected Health Information or PHI shall have the meaning given to such term in 45 CFR § 164.501, limited to the information created or received by Associate from or on behalf of Agency.

h. Security Incident means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.

i. Security Rule means the Standards for the security of Electronic Protected Health Information found at 45 CFR Parts 160 and 162, and Part 164, Subparts A and C. The application of Security provisions Sections 164.308; 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to Associate of Agency in the same manner that such sections apply to the Agency.

j. Unsecured PHR Identifiable Health Information is information that is not protected through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of the HITECH Act.

k. Vendor of Personal Health Records shall mean an entity, other than a covered entity, that offers or maintains a personal health record.

2. PHI Disclosures; Permitted Uses.

a. PHI Described. PHI disclosed by the Agency to the Associate, PHI created by the Associate on behalf of the Agency, and PHI received by the Associate from a third party on behalf of the Agency are disclosable under this Addendum. The disclosable PHI is limited to the minimum necessary to complete the tasks, or to provide the services, associated with the terms of the original Agreement.

b. Purposes. Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency.

3. Obligations of Associate.

a. Stated Purposes Only. The PHI may not be used by the Associate for any purpose other than stated in this Addendum or as required or permitted by law.

b. Limited Disclosure. The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate will refrain from receiving any remuneration in exchange for any individual's PHI, unless Agency gives written approval, and the exchange is pursuant to a valid authorization (that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Individual), or satisfies one of the exceptions enumerated in Section 13405(e)(2) of the HITECH Act. Associate will refrain from marketing activities that would violate HIPAA, specifically Section 13406 of the HITECH Act. Associate will report to Agency

any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. Safeguards. The Associate will use appropriate safeguards to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

(i) Limitation of the groups of its employees or agents, otherwise known as workforce members, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary;

(ii) Appropriate notification and training of its employees or agents to whom the PHI will be disclosed in order to protect the PHI from unauthorized disclosure;

(iii) Maintenance of a comprehensive written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations.

d. Compliance With Law. The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. Support of Individual Rights.

(i) Access to PHI. Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

(ii) Amendment of PHI. Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

(iii) Accounting Rights. Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §§ 164.528 and 164.316. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;

- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure.

(iv) Request for Restriction. Under the direction of the Agency, abide by any Individual's request to restrict the disclosure of PHI consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522.

g. Retention of PHI. Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. Agents, Subcontractors Compliance. The Associate will ensure that any of its agents, including any subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder.

i. Amendments. The Associate shall make available to the specific Individual to whom it applies any PHI; make such PHI available for amendment; and make available the PHI required to provide an accounting of disclosures, all to the extent required by 45 CFR §§ 164.524, 164.526, and 164.528 respectively.

j. Federal Access. The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504.

k. Security. The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required. Except with respect to Associate owned devices or equipment, if Associate chooses not to adopt such methodologies as defined in 74 FR 19006 based on its Security Risk Analysis, Associate shall document such rationale and submit it to the Agency.

l. Notification of Breach. During the term of this Agreement, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the Office of Technology immediately by telephone call plus e-mail, web form or fax upon the discovery of Breach of security of PHI, where the use or disclosure is not provided for by this Addendum of which it becomes aware, if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency contract manager at www.state.wv.us/admin/purchase/vrc/agencyli.htm and, unless otherwise directed by the Agency in writing, the Office of Technology at mailto:incident@wv.gov.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency contract manager, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) What data elements were involved and the extent of the data

involved in the Breach; (b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (c) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (d) A description of the probable causes of the improper use or disclosure; and (e) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

m. Assistance in Litigation or Administrative Proceedings. The Associate shall make itself and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, employee or agent is a named as an adverse party.

4. Addendum Administration.

a. Duties at Termination. Upon any termination of the underlying Agreement, if feasible, the Associate shall return or destroy all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

b. Termination for Cause. Agency may terminate the underlying Agreement if at any time it determines that the Associate has violated a material term of the Agreement or this Addendum. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material Breach before termination.

c. Judicial or Administrative Proceedings. The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

d. Survival. The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. General Provisions/Ownership of PHI.

a. Retention of Ownership. Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option.

b. Secondary PHI. Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an Individual must be held confidential and is also the property of Agency.

c. Electronic Transmission. Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an Individual must not be transmitted to another party by electronic or other means for additional uses not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. No Sales. Reports or data containing the PHI may not be sold without Agency's or the affected Individual's written consent.

e. No Third-Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. Interpretation. The provisions off this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. Amendment. The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. Additional Terms and Conditions. Additional discretionary terms may be included in the release order or change order process.

Form - WVBAA-012004
Amended 07-2010

APPROVED AS TO FORM THIS 2nd
DAY OF August .2010
DARRELL V. McGRAW, JR.
ATTORNEY GENERAL

By: Dawn E. Warfield
DEPUTY ATTORNEY GENERAL

Appendix L – Special Terms and Conditions

Disclosure by Fiscal Agents: Information on ownership and control.

42 CFR 455.104 requires Medicaid agencies to obtain ownership and control disclosures from entities including fiscal agents. These regulations require that disclosures be made:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

To ensure compliance with these regulations, the following disclosures must be submitted with each proposal

(1)(a) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity or fiscal agent. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(b) Date of birth and Social Security Number (in the case of an individual).

(c) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or fiscal agent or in any subcontractor in which the disclosing entity or fiscal agent has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity or fiscal agent is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling: or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity or fiscal agent has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.

(3) The name of any other disclosing entity or fiscal agent in which an owner of the disclosing entity or fiscal agent has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity or fiscal agent.

This information must be submitted in a separately labeled attachment within the proposal and will not count in previously defined page limitations.

Ownership and Control Interest Disclosures

Any person with an ownership or control interest in the disclosing entity or fiscal agent or subcontractor in which the disclosing entity has a 5% or more interest must be listed. This includes owners and managing employee(s) of the disclosing entity. The address for corporate entities must include primary business address, every business location and P.O. Box Address. If you are required to provide this information for multiple persons (individuals and corporations) you may attach a separate page. For the attached page label it at the top of the page with **Supplement, Ownership Disclosures.**

Name _____

Address: _____

Address: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

Federal Employer ID Number:_____

Relationship and Subcontractor Disclosures:

For each ownership or control interest listed, disclose any relationship to another person (parent, spouse, child or sibling) including control interest in subcontractors who has an ownership or control interest in the disclosing entity. If additional space is needed, you may attach a separate page. For the attached page, label it at the top of the page with **Supplement, Owner Relationships.**

Owner Name	Relationship	Owner Name

Contract Application

Notwithstanding any other provision of this Contract to the contrary, unless the Vendor objects in writing to notice from the State, the prices, terms and conditions set forth in the original Contract and subsequently executed change orders and amendments shall be extended to any state agency, United States Territory, or political subdivision seeking such services. The Vendor shall negotiate a separate agreement for any such entity regarding the terms and conditions for billing the entity directly for those contracted services, and all preliminary services related to implementing the contractual provisions, including but not limited to feasibility studies, equipment purchases and software purchases.

Appendix M – Resident Vendor Preference Certificate

This form is optional, and may also be found at the following url:
http://www.dhhr.wv.gov/bms/ProcurementNotices/Documents/RFPs/MS_Venpref.pdf

Bureau for Medical Services

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**
Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**
__ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
__ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61 -5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: **Signed:**

Date: _____ **Title:** _____

**Check any combination of preference consideration(s) indicated above, which you are entitled to receive*