1.0 EXECUTIVE SUMMARY [3.1, 4.1.4]

The State of West Virginia and its Bureau for Medical Services (BMS), in conjunction with its MMIS partner, Molina Medicaid Solutions (Molina), has long stood on the cutting edge of public sector healthcare innovation. Throughout this partnership, Molina has proven its commitment to service excellence by working with the BMS to meet Medicaid innovation and service delivery challenges. This highly effective partnership has positioned West Virginia and the BMS to meet future healthcare environment challenges.

In this Executive Summary section, Molina affirms our ability and capability to provide experienced personnel to accomplish each RFP requirement of part 3.1.1 through 3.1.49.

The healthcare field is continuing to dramatically evolve. These evolutions have transformed Medicaid management into a complex, highly regulated business, one that is fragmented into areas of management requiring special knowledge and a variety of skill sets.

Escalating involvement of third parties in administrative decision making has made traditional planning and operational management highly difficult. While the Centers for Medicare and Medicaid Services (CMS), the Office of the National Coordinator for Health IT (ONC) and professional agencies are requiring that the standards of Medicaid services be raised to higher levels of quality, other agencies, financial institutions, and officials are demanding that these services be monitored for compliance. General economic conditions and competition for funding are forcing Medicaid agencies to realize that success no longer rests solely on vendor competence, but also on the ability of state vendor partners to identify and capture cost savings through greater administrative and technological innovation, efficiency, and productivity.

While the healthcare service industry at large is generally perceived to be in a quandary and a state of flux, it is now confronted with new challenges that will forever change the shape of this industry. With the inception of the American Recovery and Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (PPACA), in conjunction with the HITECH Act, Medicaid agencies and their service vendors must now seek ways of providing advanced problem-solving approaches based on a new and refined set of capabilities. This is particularly relevant if their respective organizations expect to survive in today's complex environment.

The HITECH Act of 2009 was designed to position the health care industry to have an information technology infrastructure necessary to support healthcare reform. Nowhere is this clearer than in the information technology (IT) model needed to support future MMIS requirements. In this model, organizations must band together to coordinate and improve patient care and population health while at the same time reducing unsustainable annual increases in costs. States with MMIS partners that reach those goals will be rewarded via shared savings programs as well as a healthier population with measurable outcomes.

Since the prior MMIS fiscal agent procurement, the Unisys Health Information Management Division has become Molina Medicaid Solutions, a wholly owned subsidiary of Molina Healthcare, Inc. Molina Medicaid Solutions is a healthcare corporation that is 100 percent committed to public sector health care management and improvement of health outcomes of the nation's low income, and, often, most vulnerable citizens. While Molina Medicaid Solutions will continue to bring into play cutting edge technology solutions and sophisticated administrative capabilities that the Bureau for Medical Services has come to expect, we can also draw upon the vast clinical experience of our parent company which manages Medicaid populations in 10 other states. Molina Healthcare's clinical excellence has been recognized both through their multiple NCQA certifications and their recurring recognition by the *U.S. News and World Report* as one of the country's top Medicaid health plans. Molina has the breadth and commitment of corporate resources including the personnel, information technology, facilities, clinical expertise,

Pages 1-2 through 1-3 contain confidential and proprietary information and have been redacted.

10.0 REQUIREMENTS CHECKLIST [Attachment II]

The following table provides a cross-reference between the RFP Attachment II's requirements (A) and the proposal section (B) and page number (C) in which each requirement is addressed.

A		B	C
MMIS RFP Requirement		**Proposal Section**	**Proposal Page No.**
3.1	**Mandatory Requirements**		
3.1.1	Establish a Charleston, WV-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.	1.0, 2.0	1-1, 2-1
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. Reserved or paid parking spaces must be provided to accommodate limited designated BMS staff.	2.0	2-1
3.1.3	Provide one named Vendor staff member/position, to be selected by the Bureau, who will be located at the BMS to facilitate communication and coordination between the Bureau and the Vendor.	4.1	4-1
3.1.4	Provide the Bureau access to conference space at the Vendor's site that is adequately sized, 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.	2.0	2-1
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 established by the Bureau and documented in the Disaster Recovery and Business Continuity Plan.	2.0	2-1
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.	2.0	2-1
3.1.7	Agree to incur all costs associated with accessing and acquiring Provider licensure and certification data.	6.2.2	6-10
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 links:	6.2.8	6-18

A		B	C
MMIS RFP Requirement		Proposal Section	Proposal Page No.
	http://www.technology.wv.gov/about-wvot/Pages/policies-issued-by-the-cto.aspx http://www.wvdhhr.org/mis/IT/index.htm.		
3.1.9	Perform all work associated with this contract within the continental United States.	2.0	2-1
3.1.10	Host the MMIS and maintain a secure site and secure back-up site within the continental United States.	2.0	2-1
3.1.11	Warrant that the proposed and implemented MMIS will meet CMS certification requirements within 12 months of go-live of the replacement MMIS, 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.	5.5.3.2	5-159
3.1.12	Warrant that the proposed and implemented Pharmacy POS system will be certified for ePrescribing with Surescripts.	6.2.7	6-16
3.1.13	Ensure the point-of-sale drug file will be independent and not a shared file with other clients.	6.2.7	6-16
3.1.14	Provide a system that will support multiple programs and multiple plans including but not limited to the addition of any other State Agency, United States Territory or political subdivision.	5.5.1.1	5-13
3.1.15	Ensure all hardware, software and communications components installed for use by Bureau staff are compatible with the WVOT currently supported versions of the Microsoft™ Operating System, Microsoft Office™ Suite and Internet Explorer™; and current technologies for data interchange.	6.0	6-1
3.1.16	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.	6.0	6-1
3.1.17	Align the proposed MMIS with MITA principles and employ service-oriented architecture.	6.2	6-8
3.1.18	Develop any bridges and integration code necessary for the replacement MMIS to interface with other State software and systems.	6.2.8	6-18
3.1.19	Agree to incorporate all applicable 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, including, but not limited to, ICD-10, HIPAA v5010, NCPDP Claims Processing Standards D.0, the Patient Protection and Access to Care Act (PPACA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).	5.5.1.1	5-13
3.1.20	Adhere to the current National Council on Prescription Drug Programs (NCPDP) version standards, or the most current HIPAA required version for single drug claims and compound prescriptions.	5.5.1.1	5-13
3.1.21	Provide right of access to systems and facilities to the Bureau or its designee to conduct audits and inspections.	6.2.8	6-18
3.1.22	Provide access to data, systems, and documentation required by auditors.	6.2.8	6-18

A		B	C
MMIS RFP Requirement		Proposal Section	Proposal Page No.
3.1.23	Respond to BMS requests for system enhancements as described in Sections 3 and 4 of this RFP.	5.8	5-209
3.1.24	Supply all deliverables and meet all milestones as described in Appendix C of this RFP.	5.5.2, 5.5.3, 5.5.4, D02	5-35, 5-127, 5-183, D02-1
3.1.25	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.	5.5.2, 5.5.3, 5.5.4, D02	5-35, 5-127, 5-183, D02-1
3.1.26	Meet all CMS Certification Requirements as described in Appendix D.	5.5.3.2	5-159
3.1.27	Operate the MMIS and perform all functions described in Appendix F (Vendor Operations Requirements) of this RFP and continue all operations 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, including any optional additional periods or extensions.	5.5.3	5-127
3.1.28	Agree to perform according to approved Service Level Agreements listed in Appendix G of this RFP.	5.5.3.1.1.2	5-151
3.1.29	Forfeit agreed-upon retainage as described in Section 4 of this RFP if approved service levels are not achieved.	5.5.3.1.1.2	5-151
3.1.30	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.	5.5.3.1.1.2	5-151
3.1.31	Provide project status information to the MMIS Re-procurement Project Manager in the timeframes and in the agreed-upon format.	5.9	5-291
3.1.32	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.	5.9	5-291
3.1.33	Provide a software and hardware solution that is upgradeable and expandable to meet current and future needs.	5.5.1.1	5-13
3.1.34	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.	5.5.1.1	5-13
3.1.35	Ensure that the Pharmacy prior authorization system is available 24 hours per day, seven (7) days a week, except for scheduled maintenance.	6.2.7	6-16
3.1.36	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.	5.1	5-3
3.1.37	The system should provide role-based access for authorized users, ensuring confidential access to the data at the individual and group security levels.	6.2.8	6-18

A		B	C
MMIS RFP Requirement		Proposal Section	Proposal Page No.
3.1.38	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).	5.5.1.1	5-13
3.1.39	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 or 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.	5.1	5-3
3.1.40	Provide Key Staff members as described in Section 3.2.3 must be available for assignment to the project on a full-time basis, must be solely dedicated to this project, and must be located onsite in the Charleston facility. Each Key Staff member must have the required experience described in Table 3-2. Any proposed change to this staff	4.1	4-1

A		B	C
MMIS RFP Requirement		Proposal Section	Proposal Page No.
	after contract execution must have prior written approval by BMS. In all circumstances, Key Staff shall be replaced only with persons of equal ability and qualifications.		
3.1.41	Designate one named Key Staff as described in Section 3.2.3 as the project's HIPAA Compliance Officer.	4.1	4-1
3.1.42	Provide Continuously Dedicated (CD) Staff members as described in Section 3.2.3. CD Staff are required to be maintained by the Vendor in agreed-upon quantities by category. These persons must be 100% dedicated (unless otherwise noted in Section 3.2.3) to the West Virginia account, and must not hold any other concurrent positions (on this or any other project), but may be located off site.	4.2	4-2
3.1.43	Provide Support Staff members as described in Section 3.2.3. Support Staff are those staff with specific skills or expertise that support certain stages throughout the life of the contract These persons must be 100% dedicated for the time in which their services are required (unless otherwise noted) to the West Virginia account, must not hold any other concurrent positions (on this or any other project), and must be located onsite in the Charleston facility.	4.3	4-3
3.1.44	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.	4.4.1	4-6
3.1.45	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.	5.5.2.1.1	5-42
3.1.46	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.	5.5.1.1	5-13
3.1.47	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.	5.5.1.1	5-13
3.1.48	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.	5.5.1.1	5-13
3.1.49	Comply with prompt pay regulations in accordance with Federal requirement 42CFR 447.45(d).	5.5.1.1	5-13
4.	**PROPOSAL FORMAT AND RESPONSE REQUIREMENTS**		
4.1	Technical Proposal Format	iv	iv

A		B	C
MMIS RFP Requirement		Proposal Section	Proposal Page No.
4.1.1	Title Page	i	i
4.1.2	Transmittal Letter	ii	ii
4.1.3	Table of Contents	iv	iv
4.1.4	Executive Summary	1	1-1
4.1.5	Vendor's Organization	III	iii
4.1.6	Location	2	2-1
4.1.7	Vendor Capacity, Qualification, References and Experience	3	3-1
4.1.8	Staff Capacity, Qualifications and Experience	4	4-1
4.1.9	Project Approach and Solution	5	5-1
4.1.10	Solution Alignment with BMS' Business and Technical Needs	6	6-1
4.1.11	Subcontracting	7	7-1
4.1.12	Special Terms and Conditions	8	8-1
4.1.13	Signed Forms	9	9-1
4.1.14	RFP Requirements Checklist	10	10-1
4.1.15	Cost Summary	See Cost Volume	See Cost Volume
4.1.16	Invoicing and Retainage	See Cost Volume	See Cost Volume
4.1.17	RFP Requirements Checklist (Attachment II)	10	10-1

Molina abides by the 300-page limitation as shown in the table below:

Section #	Section Name	Pages
1	Executive Summary	3
2	Location	5
3	Vendor Capacity, Qualification, References and Experience	19
4	Staff Capacity, Qualifications and Experience	27
5	Project Approach and Solution	8
5.5.1	Design, Development and Implementation Approach	26
5.5.2	Phase 1: Approach to DDI Tasks	92
5.5.3	Phase 2: Approach to Operations Phase	56
5.5.4	Phase 3: Turnover and Close-Out	6
5.6	Drug Rebate Solution	11
5.9	Project Management	15
6	Solution Alignment with BMS' Business and Technical Needs	24
7	Subcontracting	1.5
8	Special Terms & Conditions	0.5
	TOTAL	294

2.0 LOCATION [3.1.1-3.1.4, 3.1.6, 3.1.9, 3.1.10, 3.2.4, 3.2.4.1, 4.1.6]

Over the last seven years, Molina has worked closely with the committed professionals within the West Virginia BMS. Molina's business relationships with BMS staff are facilitated by direct face-to-face interactions, and Molina's proposed facilities will contribute to enhancing this close working relationship. Facilities have been selected that are convenient for BMS employees. We look forward to sharing these facilities with BMS personnel during both the new contract's DDI and operations phases.

Molina has significant experience in providing Medicaid operational services, both for MMIS and managed care programs. Developing strong partnerships with customers enhances the success of these programs, and one of the key parameters for successful partnerships is close proximity with the partner. Molina has and will continue to maintain an operations site easily accessible to the Bureau's team to encourage the sharing of information, not only for the day-to-day DDI and operations activities, but for continuous business process improvement and to enact change aligned with the West Virginia MMIS vision.

Molina cares about its staff and guests, and understands that its facilities, environment, and infrastructure form the foundation for effective and efficient operations. Molina uses that objective to establish a work environment within which the Molina team and co-located Bureau partners can successfully and comfortably complete their appointed tasks.

The location and facilities will meet or exceed the requirements established by BMS as subsequently defined in the Molina responses.

Molina's responsibility as Contractor is to provide the necessary facilities to conduct the DDI and Operations phases in a Charleston, West Virginia-based facility. These facilities will be located within five (5) miles of the BMS office in Charleston where all key staff members designated in Section 3.2.3 will be located. The facility will have one individually lockable private office for a BMS staff member. This office will be fully equipped with furniture, telephone service, a personal computer (with access to the MMIS, Microsoft Office™ Suite, and the Internet) as well as access to a printer and copier. Seven reserved parking spaces will be provided to accommodate designated BMS staff members. Engaging the BMS staff and other key stakeholders in various DDI sessions is an important part of Molina's DDI process. Our work plan includes identifying, well in advance, essential participants and scheduling their participation in appropriate sessions. The facility will have multiple meeting rooms outfitted with high quality telephone conferencing, Cisco TelePresence video conferencing, and computer projection equipment for use in project team meetings and work sessions, and web-based application sharing for attendees. The Bureau will have access to this conference space for the DDI review, planning, testing, and training sessions.

Molina intends to continue to conduct business out of its existing site at 1600 Pennsylvania Avenue, Charleston, West Virginia, which is 1.3 miles from the BMS office at 350 Capitol Street. Arrangements have been made to expand our office footprint at this location to accommodate the additional space required to successfully execute the RFP requirements. Molina will assume all costs associated with securing and maintaining this facility for the duration of the contract including hardware and software acquisition necessary to maintain approved performance requirements, maintenance, lease hold improvements, utilities, office equipment, supplies, janitorial services, security, storage, transportation, and insurance.

Pages 2-2 through 2-5 contain confidential and proprietary information and have been redacted.

3.0 VENDOR CAPACITY, QUALIFICATION, REFERENCES AND EXPERIENCE [4.1.7]

The experience and qualifications of Molina and its proposed subcontractors cannot be equaled by any other vendor. The Health PAS solution, comprised of the required COTS products, is not a new, hybrid solution; it has been successfully installed and is currently being operated in three Medicaid programs. As the incumbent fiscal agent, Molina is the only vendor that can propose an operations staff with hundreds of cumulative West Virginia MMIS staff-years of experience. Molina is an innovative healthcare leader for managing and providing quality care. These best practices are leveraged for enhancing and responding to West Virginia Replacement MMIS programs and initiatives.

Molina has more than three decades of experience in providing premier Medicaid implementation and fiscal agent services to state programs in both fee-for-service and managed care programs. The proposed Health Payer Administration Solution (Health PAS) is a proven product. Health PAS is not being newly constructed for the West Virginia Replacement MMIS and it is not a hybrid of legacy solutions cobbled together; Molina developed the proposed Health PAS over eight years ago with the objectives of a low risk installation and effective and efficient healthcare program administration. Health PAS is an integration of the best commercial off the shelf products (COTS) appropriate to Medicaid processing. This Health PAS solution will be implemented as the West Virginia Replacement MMIS.

Molina's combination of the right solution, the right approach, and the right team of experienced professionals will provide the West Virginia BMS with:

- The ability to leverage and maintain cutting edge health care industry best practices and approaches using proven, commercially available products
- A proven low-risk iterative approach to implementation
- A solution that has been certified by CMS and is MITA aligned
- A solution based on robust, service-oriented architecture that is flexible and allows growth
- Rapid and accurate policy and programmatic changes reflecting the BMS strategic direction by configuring user-defined parameters
- Administrative and stakeholder communication and information retrieval efficiencies using web-based self service capabilities
- Processes and systems built to manage program expenditures, improve outcomes and quality of care, and deliver optimum administrative efficiencies and quality.

Molina's Health PAS solution and its current experience as the West Virginia Medicaid fiscal agent offer the State of West Virginia a winning combination of technology and experienced personnel to administer the West Virginia Replacement MMIS. Medicaid agencies will be required to implement upgrades and modifications in a timely manner to reflect:

- Health Information Portability and Accountability Act (HIPAA)
- State Medicaid reform strategies
- Medicaid Information Technology Architecture (MITA)
- American Recovery and Reinvestment Act (ARRA) of 2009
- Patient Protection and Affordable Care Act (PPACA)
- Health Information Technology for Economic and Clinical Health (HITECH) Act
- Future Federal and West Virginia-initiated healthcare reform efforts.

Molina's proposed Health PAS solution for the West Virginia Replacement MMIS includes the products, services, and experience to implement and operate these initiatives.

Molina's Health PAS is aligned with the MITA initiatives and is positioned to manage upcoming directives from the Centers for Medicare and Medicaid Services (CMS). Health PAS supports fee-for-service managed care strategies and capitated plans. It features web-based capabilities for all authorized users and online access to internal and external MMIS information in a format and with the speed required to support processing requirements and reform initiatives.

Health PAS is a CMS-certified MMIS solution. Molina has installed and configured Health PAS to meet CMS certification requirements and to meet the rigid demands presented by the state in its search for a new state-of-the-art Medicaid system. This experience enabled Molina to craft an MMIS solution that easily responds to the challenges of Medicaid day-to-day requirements and imminent reforms while remaining aligned with MITA guidelines. Molina looks forward to continuing our long-term relationship with the West Virginia Bureau for Medical Services (BMS) and providing a Medicaid solution and environment that meets the ever-changing West Virginia healthcare and Medicaid requirements.

"Molina is known among dental practitioners as providing expedient and efficient services while managing the dental benefit program. Among other attributes are timely payments and excellent provider services, including timely responses to inquiries and requests. Molina's administrative procedures are very responsible in maintaining the financial integrity of the Medicaid dental program and assuring accuracy of claims processing, yet they are not cumbersome or costly to dental practices."

Richard Stevens
Executive Director,
WV Dental Association

Molina is well positioned to meet the BMS MMIS goals and objectives with Health PAS and our systems integration experience. Choosing the right fiscal agent allows West Virginia to meet the challenges of a changing MMIS environment. It is also a crucial step in making certain that sufficient administrative and policy support is present when needed to meet the state's goals and objectives. As a long-time partner with the BMS, Molina possesses unique historical and program knowledge vital to the healthcare business applications and business process management functions that are and will continue to be required by the State of West Virginia.

Molina's integration specialists using demonstrated delivery methodologies will work closely with the BMS and others during the Design, Development and Implementation (DDI) Phase to make certain that all support tools are implemented within timeline requirements and readily available to provide a low risk transition and CMS certification. Molina is well positioned to support the BMS' need to have a flexible, scalable solution to support the West Virginia integrated program and information management objectives.

In addition to offering a superior technical capability and significant integration experience, Molina is the right fiscal agent partnership choice to provide administrative and policy support to the BMS during the Operations Phase. Molina has been providing excellent operational services to the BMS for the last eight years. By proposing many of the same operational staff who have extensive West Virginia MMIS experience, Molina will maintain that service level during the period of the new contract. Molina's clients will also attest to the professionalism, continued dedication, and collaborative nature of its fiscal agent services.

Molina's Health PAS system will allow the BMS to rapidly and accurately respond to changes in policy, technology requirements, and the Medicaid market. The innovative Health PAS system, coupled with Molina's breadth of experience in West Virginia and as a leading systems integrator offers the BMS a solution that surpasses the capabilities of traditional legacy systems. Molina's experience in integrating component applications into a seamless, transparent solution and effectively operating the installed solution offers the BMS the benefits of a partner with the

ability, experience, and knowledge required for successful operations and continuous modernization as requirements evolve.

3.1 Corporate Organization Structure

Molina Medicaid Solutions is a wholly-owned subsidiary of Molina Healthcare, Incorporated. Molina Healthcare administers managed care services for Medicaid, CHIP, Medicare, and other government programs for approximately 1.6 million members in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin.

Molina also offers health information management and business process outsourcing solutions for state Medicaid programs through its subsidiary, Molina Medicaid Solutions, which holds MMIS contracts in Florida (drug rebate), Idaho, Louisiana, Maine, New Jersey, and West Virginia. Molina Healthcare, Inc. acquired the Health Information Management Division of Unisys Corporation as a wholly owned subsidiary on May 1, 2010. The Molina Medicaid Solutions unit provides fiscal agent services to state Medicaid programs. The acquisition allows Molina Healthcare and Molina Medicaid Solutions to collaborate to address a state's needs through the administration of its full-risk health plans or fee-for-service managed care programs. Molina can offer delivery of professional services that include Medicaid clinics, nurse advice hotlines, care management and disease management services, as well as Medicaid specialty population management.

The services of Molina's subsidiaries touch approximately 4.3 million Medicaid beneficiaries and 189,000 providers in 15 states, making it one of the nation's largest Medicaid vendors. Molina Healthcare shares services with its subsidiaries to streamline certain administrative functions within the organization that enable it to optimize economies of scale and provide better health outcomes. Shared services include claims payment, information technology, care management, and provider services.

MOLINA MEDICAID SOLUTIONS

Since entering the Medicaid market, Molina Medicaid Solutions has performed 18 successful implementations and consistently delivered in accordance with all contractual obligations. Its current contracts in Idaho, Louisiana, Maine, New Jersey, and West Virginia represent large-scale data processing system takeover, enhancement, implementation, operations, and maintenance projects. Molina provides drug rebate administration for Florida Medicaid.

Molina's proposed Health PAS system and its experience as a leading Medicaid fiscal agent, in conjunction with the solutions and experience of our proposed subcontractors, offer the State of West Virginia a winning combination of technology and experienced personnel to support the West Virginia Replacement MMIS. Molina's experience coordinating the work of its own partners, vendors, and proposed subcontractors to develop, integrate, and enhance Health PAS into a seamless, transparent solution offers the West Virginia BMS the benefits of an experienced partner who provides a low risk solution for West Virginia Replacement MMIS integration and operations.

The Molina Medicaid Solutions established implementation methodology provides the technologies and professional team required by state organizations to create a real-time, agile information technology (IT) infrastructure that can dynamically allocate computing resources based on a client's business needs and missions. Molina's projects provide consistent execution in accordance with a well-defined and experiential work plan as well as formal compliance with external standards and models such as Software Engineering Institute (SEI) Capability Maturity Model Integration (CMMI) and IT Infrastructure Library (ITIL). One of the key improvements that Molina implements with new contracts is the application of best practices into its processes and procedures. Molina staff incorporates these practices and methodologies into the day-to-day

Page 3-4 contains confidential and proprietary information and has been redacted.

MOLINA HEALTHCARE, INC.

Molina Healthcare, Inc. was founded in 1980 by C. David Molina, M.D., an emergency room physician, as a safety net provider for Medicaid under the name Molina Medical Centers. The initial clinic sites started by Dr. Molina served people who had often turned to emergency rooms for care because they lacked adequate access to primary care services. These populations had distinct social and medical needs characterized by unique cultural, ethnic and linguistic diversity. Today, Molina continues to focus on serving the needs of diverse underserved and underprivileged populations and responds to their unique healthcare delivery challenges with cultural expertise that overcomes simple language barriers. Molina Healthcare's wealth of experience tailoring programs and services for diverse and special needs populations are leveraged by Molina Medicaid Solutions to support the West Virginia Replacement MMIS specific goals and objectives.

Molina Healthcare, Inc., a Delaware corporation ("Molina Healthcare"), is a publicly traded (NYSE: MOH) multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. It conducts business primarily through ten licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization.

Molina Healthcare's core value is to be an exemplary organization and, as such, is committed to:

- Caring about the people served
- Delivering quality healthcare services to promote healthier populations and removing barriers to health services
- Being healthcare innovators and embracing change quickly
- Serving as a trustworthy Medicaid and Medicare partner and being prudent stewards of the public's funds
- Respecting the dignity of every member and valuing ethical business practices.

These core values are the same for the entire organization (i.e., Molina Medicaid Solutions encompass the commitments and objectives of Molina Healthcare to be an innovative healthcare leader providing quality services in an efficient manner.)

Molina Healthcare, Inc. has been recognized as a leader in providing quality healthcare to those who depend on government assistance programs since it was founded in 1980. Desiring to grow and expand, Molina became a publicly traded company in 2003. With 30 years of experience, Molina has become one of the most expertly managed healthcare companies in the country with a core competency rooted in a commitment to serving Medicaid and SCHIP beneficiaries. Molina's organizational structure and staffing, specifically designed to serve these populations, has aligned the company to serve the target population covered under this RFP.

Figure 3.1-2 depicts the Molina Healthcare, Incorporated's organization and highlights the relationship between Molina Healthcare and its subsidiaries, including Molina Medicaid Solutions. The West Virginia Replacement MMIS Account Manager, Ruth Ann Panepinto reports to Norm Nichols, the President of the Molina Medicaid Solutions.

The success of Molina's service depends on its documented ability to leverage certain administrative functions across its subsidiaries, including claims payment, case management, disease management, as well as member and provider services. Establishing local offices in each state has allowed Molina to tailor locally operated health plans to meet state-specific

Page 3-6 contains confidential and proprietary information and has been redacted.

Ms. Panepinto and Mr. Nichols have access to the resources required to make certain that all BMS' requirements are met.

Molina Healthcare includes personnel with specialized healthcare skills that are available to support the Molina Medicaid Solutions healthcare business. These corporate resources will be available to support the West Virginia Replacement MMIS project.

3.2 Fiscal Agent and Health Care Experience

The combined resources of Molina Medicaid Solutions and Molina Healthcare, Inc. provide qualifications and claims processing skill sets for multiple fee-for-service and managed care programs. Molina provides fiscal agent and health care experience for the states of Idaho, Louisiana, Maine, New Jersey and West Virginia. The Molina experiences and services provided to these accounts are defined in the following subsections.

3.2.1 Idaho MMIS Fiscal Agent

Contracting Entity: State of Idaho, Department of Health and Welfare, Idaho Division of Purchasing

Molina began its MMIS fiscal agent contract with the state of Idaho in 2007 with the installation of the certified West Virginia Health PAS and subsequent design, development, and implementation of Idaho-specific features, followed by operations (beginning in June 2010), maintenance and modification.

Idaho awarded Molina two seven-year, firm-fixed price contracts to provide systems and operational services as fiscal agent for the state's Medicaid Management Information System (MMIS) and Electronic Document Management System.

The contracts consist of a two-year system design, development and implementation phase, followed by five years of operations.

Molina designed, developed, and implemented a state-of-the-art healthcare information management system for Idaho Medicaid. Molina configured Health PAS in accordance with Idaho's specifications, conducted testing to verify functionality and implemented the new system. Built to meet the principles of the federal MITA standards, Molina's Health PAS helps Idaho reduce administrative and operating costs, better manage and control benefit expenditures, and adhere to increasing security and privacy standards.

The following is the scope of services Molina provides to the State of Idaho:

- Claims processing of all paper and electronic medical and dental claims
- Full support of all HIPAA EDI transactions
- Online portal for full member and provider support, including claims submission, prior authorization requests, member eligibility requests, and real time claims adjudication
- Full electronic data management system support for reports, letters, and workflows
- Integration of PBM, EDMS, DSS/DW, and SURS vendor solutions
- Client, provider and user help desk functions
- Provider enrollment, certification, outreach, training and support
- Third party recovery coordination.

Molina subcontracted with eServices and TriZetto in the performance of this contract. eServices provided web portal development, while TriZetto provided configuration consulting, architecture guidance, design and coding development.

The State of Idaho desired a truly COTS-comprised MMIS built on a modularized and scalable architecture that accommodates Idaho's changing needs. The Molina Health PAS framework

that was implemented in Idaho consists of eight core modules and operates on an n-tiered, client/server, Windows-based architecture. It uses a powerful rules-based processing engine that is proven to be the most flexible in the industry to accommodate Idaho's multiple benefit plans and changing payment methodologies. The Health PAS system is a user-configurable and web-based system and adaptable to accommodate a wide variety of programs.

Molina performs the services of this contract in its Boise, Idaho office and will serve as fiscal agent through 2014, with an additional three option years.

3.2.2 Louisiana MMIS Fiscal Intermediary

Contracting Entity: Bureau of Health Services Financing, Louisiana Department of Health and Hospitals

Molina has served as the Medicaid fiscal intermediary for the State of Louisiana since 1984, performing design, development, implementation, and fiscal intermediary operations, including claims processing, DSS, SURS, MARS, Rx-POS, Therapeutic DUR, Document Manager, Provider Web Portal, Call Centers, Managed Care, Third Party Liability (TPL), and Multiple Enhancement Phases. Molina's subcontractors in the performance of this contract are DataScan and UPI. CMS certification was received in 1984. Molina's contract with Louisiana has been successfully renewed or recompeted since 1984.

Molina has implemented numerous capabilities that have augmented the state's effectiveness in administering its medical assistance program and improved its level of service and responsiveness to providers and members, including: claims processing; check and remittance production and mailing; pharmacy service, including benefits management; TPL services; implementation of Medicaid policy, utilization review, and case management; provider relations, provider enrollment and also performs traditional claims processing functions. Molina's comprehensive pharmacy services include monitoring drugs that are prescribed, maintenance for the client server drug rebate system, operation of the clinical data inquiry data warehouse, pharmacy call center and processing pharmacy claims. Molina supplies pharmacy claims data to conduct research in partnership with the Northeast Louisiana University School of Pharmacy, and its provider relation services include training and help desk support.

Other support functions provided by Molina include imaging, graphical user interface, DSS and ad hoc reporting, local area networks (LANs), and desktops. The Molina financial unit for Louisiana Medicaid recoups overpayments at Louisiana's request (the State of Louisiana operates its own bank account). Most provider payments are made through electronic funds transfer (EFT); Molina also mails checks and remittance advices to Medicaid providers.

Molina installed TPL enhancements that provide an automated mechanism for cost avoidance and recoupment of retroactive coverage that uses claim and other coverage information stored in a TPL resource file that determines other sources of payment responsibility. Molina also provides TPL coding, tracking, and recovery, including estate recovery.

Molina and the Louisiana Medicaid program (through the University of New Orleans) work together to provide drug rebate services. Molina provides the system that enables Louisiana's compliance with the CMS-mandated requirements for drug rebate programs. Molina transferred a server based drug rebate system from Texas Medicaid that tracks invoices and the collection of rebates from pharmaceutical manufacturers and labels automatically. It also calculates the manufacturer's rebate to the Louisiana Medicaid Program based on the Medicaid drugs dispensed quarterly, enabling the recovery of millions of dollars each quarter. The system also supports the in-house pharmacy audit functions. The drug rebate system also provides additional reporting for Louisiana's supplemental rebate program.

3.2.3 Maine MMIS Fiscal Agent

Contracting Entity: State of Maine, Department of Health and Human Services

Molina was awarded the Maine fiscal agent contract in December 2007 to replace the state-operated "MeCMS" with Health PAS. The design and development of Health PAS began immediately after contract signing in February 2008**.** After successfully completing the implementation of Health PAS, Molina began the operations phase of the contract in September, 2010.

Molina holds a seven-year contract to provide a new MMIS to manage Maine's current and future Medicaid program. Molina designed, developed, implemented and operates the MMIS and assists the State with its technical expertise in managing the Medicaid program, known as MaineCare. Molina was responsible for the implementation of the new systems and working in partnership with the State to convert operations and transition State staff, when appropriate, to Molina for ongoing operations.

Molina assumed responsibility for many claims and customer service functions and provides systems to help administer health care management. Molina provided hardware and software hosting, information management, data warehousing and a connection to Maine's eligibility system. Designed to meet Maine's current program needs, the new MMIS allows for flexibility and for adjusting to any redesign within the MaineCare program as required by federal law.

The scope of services Molina provides to the state of Maine includes:

- Claims adjudication and payment
- Prior authorization
- Member management
- Provider services and enrollment
- Member Primary Care Case Management (PCCM) enrollment
- TPL identification and pre- and post-payment processing
- MaineCare web portal hosting and management
- Drug rebate payments (PRIMS)
- Mailroom and paper claim processing and scanning
- Data warehouse and decision support system
- Surveillance and Utilization Review System (the State performs the SURS functions; Molina provides and maintains the system)
- All administrative and operational functions, including call center, customer service, and document imaging.

The Health PAS solution features Windows and web-based presentation; point-and-click, drag-and-drop functionality; field-specific drop-down box item selection; object-oriented relational database architecture; server virtualization, and service-oriented architecture (SOA). Health PAS uses Microsoft's recommended approach for separating system services into logical tiers – presentation services, business logic, and data services – the current standard for encapsulating functionality for maximum reuse and maintainability. The architecture provides infinite flexibility for going beyond these basic tiers. Combined with familiar Windows and Web-based interfaces, Health PAS's underlying architecture provides numerous advantages with respect to navigating the system and entering data.

Molina subcontractors in the performance of this contract are GHS Data Management, Health Management Systems, Inc., Public Consulting Group, and Thomson Reuters.

During the DDI phase, Molina re-enrolled all Maine providers to validate HIPAA compliance for both the MeCMS and Health PAS systems via the MaineCare portal. Molina also expanded the MaineCare portal for members, providers, and other stakeholders at the start of operations.

The new fiscal agent system implemented by Molina replaced a non-CMS-certified system, following a challenging previous implementation. The incumbent system was not HIPAA

compliant, utilized State local codes, did not accept National Provider IDs (NPI), and had a limited electronic claims processing system. The State reporting system was limiting the State's ability to effectively manage the program with accurate and timely data.

During the DDI phase, Molina and state staff encountered and overcame significant design challenges in mapping and converting state local codes and policies to be compliant with federal standards. Through this process the state and Molina worked with the providers and conducted monthly communication meetings throughout the DDI phase to provide regular project status and to communicate impacts driven by the federal requirements. Molina conducted provider training through classroom and hands on sessions over a 10 month period. Post go-live, a web-based learning management system (LMS) has been made available and maintained to assist providers (via the MaineCare portal) in conducting refresher and new employee training. One of the key successes of the project was the close partnership and working relationship between the state and Molina teams. The DDI phase of the project integrated the state and Molina key staff into one location. This provided a positive working relationship at all levels within the project and facilitated direct and effective communication.

Molina was responsible for unit and system integration testing (SIT) and the state (using Deloitte) managed and conducted User Acceptance Testing (UAT) with support from Molina development staff. A seven step testing approach was mutually developed that segmented functionality of the system into logical groupings, and allowed for the sequencing of testing for SIT and UAT to overlap. Once functionality was fully tested with all defects remediated in the SIT phase, it was passed to the UAT team to commence UAT testing. This approach increased testing activities within the time constraints specified by the project work plan.

Due to the change from a non-HIPAA compliant system to a HIPAA compliant system utilizing NPI and national codes, the decision was made to adopt what was referred to as a "run out" strategy. The new system being deployed by Molina processes claims with dates-of-service on and after the operation's go live date; the state MeCMS processed claims for a period of six months post go live for claims with dates-of-service prior to the start of operations. Molina developed the interfaces to integrate MeCMS processed claims into the Health PAS system during this transition period. This did require providers to submit claims to two systems based on date of service; however, it greatly simplified the requirements of the new system to carry the logic, codes and provider IDs of the old system. This approach was successful in transitioning providers to Health PAS and significantly reduced risk when considering the scope of the changes being applied; moreover, this method was fully accepted by the Maine providers.

Molina has served the State of Maine since 2008, becoming operational in September 2010. Molina will serve as fiscal agent through 2015.

3.2.4 New Jersey MMIS Fiscal Agent

Contracting Entity: State of New Jersey, Division of Medical Assistance and Health Services

Molina has served as the fiscal agent for the New Jersey MMIS since 1989, performing design, development, and implementation of that system, as beginning ongoing operations, maintenance and enhancement activities in 1991. This enhanced baseline certified MMIS replaced the claims processing applications for two fiscal intermediaries, Blue Cross and Blue Shield of New Jersey and Prudential Insurance, as well as the State of New Jersey's responsibility for all long term care (LTC) claims. The enhanced MMIS also supported the transfer of MAR, SUR, and EPSDT subsystem processing from the State of New Jersey to Molina. Molina made numerous modifications and enhancements to the base MMIS to meet the diverse benefit assistance programs and healthcare delivery systems that New Jersey

administered. In 1992, the New Jersey MMIS was awarded federal certification retroactive to the start of operations in 1991; certification remains constant. Molina's contract has been renewed or successfully re-competed since 1989.

Molina provided the NJMMIS, including Pharmacy Point of Sale (POS) capabilities, DSS, call center, web portal, fraud and abuse, managed care, pharmacy, and transportation prior authorization processing; workflow-enabled provider enrollment; a diverse set of document management capabilities; and ongoing multiple system enhancement phases.

Since 1989, Molina has provided continuous support in successfully replacing existing NJ MMIS functionality, as well as introducing new functionality through web-enabled solutions. Molina won a recomplete of the original contract in 2000, which called for continued operations of the MMIS as well as over 100 enhancements, including a decision support system, a website, conversion of claims history to DB2, and numerous other systems and operational enhancements.

The NJMMIS includes a web process to provide the NJ Medicaid provider community with a browser-based "one stop" shopping approach for interaction with the NJ Medicaid Program. This solution includes functionality for Provider Newsletters and Alerts, Frequently Asked Questions, Provider Manuals, Billing Supplements, and EDI specifications that can be viewed online or downloaded as PDF files. Features also include an interactive Molina-developed-and-hosted provider enrollment application, secure view and download capabilities for provider weekly remittance advices, and view-and-download capabilities for the Provider Medicaid Roster. NJ Medicaid nursing home providers can file mandatory monthly census data through an interactive browser-based application – all providers can correct previously submitted claims that have failed one or more edits that require provider correction; and all providers approved for electronic billing can use the website for submitting HIPAA-compliant claim transaction files. In addition, the same web portal is used to deliver TA1 transactions to submitters acknowledging the receipt of their files, 997 transactions documenting the acceptance or rejection of their files as well as weekly HIPAA compliant 835 remittance advices.

The State of New Jersey has repeatedly entrusted Molina to design, develop, deploy, and operate creative business and technical solutions that satisfy the processing demands associated with the administration of a number of public assistance healthcare benefit programs and integrate the activities of diverse entities and technology. As the relationship between the State of New Jersey and Molina has matured, New Jersey has regularly extended to Molina the responsibility to assume a variety of business processes that the state and other vendors previously performed.

Molina developed and maintains an electronic interface with New Jersey's central financial system that allows the state to apply automated processes for drawing down funds needed to cover the weekly payment and posting actual weekly expenditures to the appropriate funding sources for ongoing fiscal management. Molina supports the automated application of liens and levies against any payments to be made to providers. State of New Jersey users can establish business rules for the amount of the weekly payment due to the provider that can be allocated to satisfy any outstanding liens or levies. These liens and levies are applied during the weekly payment process, automatically redirecting up to the full amount of the payment due to the provider to the holder of the lien or levy. Molina systemically generates the actual checks to the holder of the lien or levy as part of the regular weekly payment cycle and prepares and mails these checks.

Molina processes more than 132 million healthcare claim lines annually for the New Jersey MMIS, resulting in $8.8 billion in paid claims. More than 94 percent of all claims are received electronically. Claim transactions processed include fee for service claims, managed care

monthly premium capitation claims, and managed care encounter claims. Data on adjudicated claims are available online for a period ranging from two years to eight years, depending on claim type, with several alternate online search parameters that include claim status, edit code, and edit override data. Molina accepts claims submitted in hardcopy or electronically in HIPAA defined 837, NCPDP 5.1, and NCPDP 1.1 transactions.

In response to a Molina initiative, New Jersey hired Molina to implement a post-payment pharmacy review program. This program focuses on compounded prescriptions and provider billing/filling patterns for high-cost pharmacy claims. The Molina pharmacists have been able to recover more than $4 million a year. In 2001, Molina created a Fraud and Abuse Unit to help verify that Medicaid payments made to healthcare providers are for legitimate claims only. A primary method used in detecting questionable practices is to use pattern recognition and decision support strategies to examine data in the New Jersey MMIS. Since its implementation, the Fraud and Abuse Unit has assisted the FBI and various State of New Jersey divisions (including the Bureaus of Program Integrity and Criminal Justice and the Department of Health and Senior Services). Recoveries for New Jersey have been significant. The estimated cost avoidance/savings in the first year was approximately $3.5 million, increasing to $11.1 million in 2002.

Molina's subcontractors in the performance of the current contract are BizCore (data entry), Sungard (data entry) and Metasource (data preparation).

Contracting Entity: State of West Virginia, Bureau for Medical Services

Molina began its MMIS fiscal agent contract with West Virginia in 2003 with the design, development, and implementation of Health PAS, and subsequent operations, maintenance and modification. Molina provides web portals; document, process and communication management; contact management; and analytics. Molina has been operating the WV MMIS in partnership with the BMS since 2004 and currently processes more than 25 million claims annually, 85 percent of which are received electronically. Molina processes medical and dental claims, pharmacy claims, prior authorizations, and others. Molina performs drug rebate services, provider enrollment; help desk services, training, publications, coordination of benefits, reporting, system maintenance and enhancement. Molina's base contract ran through March 2007; the fourth option year was executed April 1, 2010.

West Virginia required a state-of-the-art technical solution that would meet the principles of the newly-mandated federal MITA standards. The system helps reduce administrative and operating costs, increase preventive care measures, effectively manage and control benefit expenditures, accelerate payment cycles, and adhere to security and privacy standards.

In January (medical/dental) and May 2005 (POS), the BMS received federal certification for Health PAS. This was the first time that the Centers for Medicare and Medicaid Services certified a new-generation, COTS system that conformed to MITA principles and had the flexibility needed to make quick modifications to the ever-changing health care environment. The certification was important to West Virginia because it ensured funding for the federal portion of the BMS, which represents savings of millions of dollars for the State's taxpayers.

As the fiscal agent, Molina provides West Virginia with the following business process outsourcing services:

- Systems operation, maintenance, and enhancement support
- Provider enrollment, training, and help desk services
- Final preparation and distribution of billing manuals and other provider training materials
- Administration of the authorization, adjudication, and resolution of claims
- Coordination of benefits, including Medicare Part A and Part B

- Output and delivery of claims payment, remittance advices, and explanation of benefits
- Clearinghouse services related to all ANSI X12 transactions
- Report generation ad hoc, daily, weekly, monthly, quarterly, and annually
- Electronic interface support and maintenance with business and trading partners
- Support-specialized eligibility information such as MCO enrollment, physician assured access system (PAAS) enrollment, long-term care client resource information, and State-funded eligibility groups
- Drug rebate system operation, maintenance and technical support.

With a mission to ensure access to appropriate, medically necessary quality healthcare for West Virginians, the West Virginia BMS searched for a partner to serve as the prime fiscal agent and administrator of processing services in mid-2002. Specifically, the BMS wanted a partner that could replace its non-HIPAA compliant, legacy mainframe system with an MMIS that would provide the flexibility to adapt to Medicaid modernization principles and business and regulatory needs, while improving the services offered to stakeholders. The BMS chose Molina based on the company's technology offering and experience as an MMIS fiscal agent and systems integrator to other Medicaid agencies. In 15 months, the BMS and Molina tailored and implemented the new Molina Health PAS to satisfy West Virginia Medicaid program requirements. More than 80 percent of the state's requirements were easily configured using the core system with its table-driven benefits and system design.

This installed Health PAS maximizes the ability to quickly implement both short and long term policy reform in the most flexible and cost effective manner – all while leveraging industry advances to deliver the most robust healthcare to West Virginia Medicaid members.

In addition to enabling the BMS to leverage state-of-the-art technologies, Health PAS facilitates achievement of West Virginia Medicaid's strategic business objectives: to incorporate recent improvements in PBM and to bring commercial healthcare efficiencies, transparency, and best practices to West Virginia Medicaid. Health PAS manages all Medicaid processes between the West Virginia state agency, Molina, providers, members and other stakeholders, including referrals, claims adjudication and payment, and administration of complex benefits plans. The Health PAS web portal enables providers to electronically deliver claims; check claim status; download electronic remittance advices; verify member eligibility; and access billing information. Providers can also use an AVRS to validate claim information.

As pioneers of implementing the "Made for MITA" Medicaid system, West Virginia and Molina worked hard to overcome challenges presented by new technologies and processes. Through this partnership, the team paved the road for West Virginia to achieve CMS certification and attain its Medicaid modernization goals.

Using Health PAS-OnLine, authorized providers and trading partners can use the West Virginia Medicaid Internet site to submit claims for payment. Claims can be submitted either by DDE in a web form wizard or by the EDI file-upload facility.

Using the Health PAS-Financial module, Molina supports West Virginia's ability to select the adjudicated claims to pay each week in accordance with criteria set by the state for each payment cycle. Financials also enable Molina to enter and track receivables, calculate and apply interest on outstanding balances, and support multiple recoupment methodologies. Molina provides printing and remittance voucher and explanation of benefits mailing services.

Molina plays a key role in assisting in the management of the Mountain Health Trust (MHT) and PAAS managed care programs – including maintaining provider and MCO information; maintaining member eligibility in relation to both Medicaid and managed care programs;

processing capitation payments; generating functional extracts for other BMS' vendors; and providing reports on the managed care programs.

Health PAS-Administrator helps efficiently maintain comprehensive records for all members of health plans administered by each organization. Using Health PAS-Administrator, member services staff have quick access to member demographic, eligibility, coverage, policy, benefit, and provider assignment information, and its interface is used to initiate and maintain relationships between members and programs and members and primary care providers.

Health PAS-Rx provides West Virginia with an extensive, user-friendly capability to process POS pharmacy claims. Health PAS Rx meets all NCPDP version 5.1 standards for processing real time and batch claim pharmacy transactions. POS claim information is tracked and maintained by the carrier and COB carrier components. Health PAS-Rx retains pertinent POS data in the online database where authorized users access and update POS information in real time. Pharmacy claims are edited by the real time processor against clinical rules and specific BMS' state policies. Edits can be set to ignore, warn, or deny.

To support Medicaid drug rebate processing, the West Virginia Health PAS-Rx solution includes drug utilization review (DUR) and our client/server based PRIMS. State staff use PRIMS to track the invoicing and collection of rebates from drug manufacturers. The invoices, generated quarterly, are based on the quantities of drugs dispensed by providers to eligible Medicaid members and paid for by a State of West Virginia program. PRIMS maintains all data on rebate unit amounts and other information necessary to process accurate drug rebate invoices. Its reporting capabilities facilitate generation of daily, weekly, monthly, and quarterly reports to monitor the success of the program.

The uniqueness of Health PAS enables West Virginia to keep those applications and interfaces that are preferred by the BMS.

3.3 Corporate Experience

Molina is uniquely qualified to successfully complete the requirements of the West Virginia Replacement MMIS with the qualifications of the Molina Medicaid Solutions unit and its regional managed care subsidiaries' experience. The combined resources of Molina provide healthcare services for over 4.3 million beneficiaries.

Molina Medicaid Solutions has been providing fiscal agent services for state Medicaid programs for over three decades. During the past eight years, Molina has been serving as fiscal agent to the State of West Virginia. This relevant experience, and especially the staff's knowledge of the Bureau and the West Virginia MMIS program's requirements, plus the successful execution of the required services, is unmatched. This knowledge, when combined with the proposed proven solution, Health PAS, provides the BMS a low risk solution to meeting the current and future needs of the West Virginia Replacement MMIS.

In addition to West Virginia, Molina has now installed and is operating the Health PAS solution in two states: Idaho and Maine. The West Virginia Health PAS solution has been in place for nearly eight years and was certified in 2005. The Health PAS solution became operational in Idaho and Maine during 2010 and is awaiting scheduling of certification reviews by CMS. In all three states, the solution requirements as well as the design and development effort, documentation, operational components, and certification planning have been aligned with MITA guidelines.

Based on this experience and the best practices of our existing operational accounts, Molina has the relevant experience and knowledge to provide both an on-time implementation in

accordance with the approved DDI Phase work plan and successful operations following documented processes and procedures.

Molina Healthcare, Incorporated, has relevant experience in healthcare administration and management, primarily for state Medicaid managed care initiatives and programs. The best practices and innovative care management solutions of the Molina Healthcare subsidiaries will be used by Molina Medicaid Solutions as fee-for-service states initiate managed care or managed care-like programs for their populations. **Figure 3.3-1** summarizes the claims processing experience of Molina Healthcare, Inc.

Figure 3.3-1: Molina Corporate Experience Snapshot

MOLINA HEALTHCARE

CATEGORY	EXPERIENCE
Operating Experience	• 30 years
Geographic Areas	• California, Florida, Michigan Missouri, New Mexico, Ohio, Utah, Texas, Washington, and Wisconsin, CMS Region VII (Medicare)
Approximate Members Served	• 1.6 million
Approximate Claim Lines Processed	• 37 million
Programs Served	• Medicaid, Medicare, CHIP and other government programs
Experience and Qualifications that Benefit West Virginia	• Extensive Medicaid experience currently serving ten states • Leading provider of healthcare management services; healthcare is its only business • Financial strength and corporate resources • Proven expertise in managed care cost management
Accreditations	• Excellent accreditation in Michigan, New Mexico, Utah and Washington • Commendable accreditation in California • New accreditation in Ohio and Texas • URAC: Nurse Advice Line

Molina's Medicaid managed care experience will be leveraged by the Molina West Virginia account management team for care management and fee-for-service managed care programs initiated by the BMS.

The Molina Healthcare plans administer services including preventive and primary care, disease management, case management, urgent care, dental services, long term care, care coordination, behavioral health, prenatal care, and care for children with special healthcare needs.

All of Molina's health plans eligible for quality accreditation are NCQA® accredited. In addition, Molina's nurse advice line call center is accredited by URAC. Molina's vigorous commitment to quality has yielded the following results:

- Molina Healthcare's seven NCQA accredited plans place Molina Healthcare among the national leaders in quality Medicaid accreditations.
- For six consecutive years, Molina Healthcare plans have been ranked among America's 100 top Medicaid plans by *U.S. News & World Report* and NCQA.
- *Fortune* magazine listed Molina Healthcare in its 2009 rankings of the 1,000 largest U.S. companies
- *Hispanic Business* magazine ranked Molina Healthcare as the nation's second-largest Hispanic owned company in 2009.

- Molina Healthcare was named among the 100 best corporate citizens by *Business Ethics* magazine.
- *Time* magazine recognized Dr. J. Mario Molina, CEO of Molina Healthcare, Inc., as one of the 25 most influential Hispanics in America.

3.4 Corporate Relevant Experience Summary Table

Molina lists its Medicaid contract experience for the past five years in **Figure 3.4-1**. Molina has been fortunate in establishing long term relationships with its clients, which are indicative of Molina's commitment to its customers and its ability to provide quality, cost effective services.

Figure 3.4-1: Molina Medicaid Solutions Experience in Medicaid

CORPORATE EXPERIENCE SUMMARY						
Scope of Work	**Idaho**	**Louisiana**	**Maine**	**New Jersey**	**West Virginia**	**Florida**
DDI	■		■		■	■*
Operations	■	■	■	■	■	■*
Claims Processing	■	■	■	■	■	
Provider Relations Services	■	■	■	■	■	
Prior Approval Services for Medical Necessity	■	■	■	■	■	
Enrollee Relations	■		■		■	
Enrollee Enrollment			■			
Drug Rebate Services		■	■		■	■
Pharmacy Benefits Management		■		■	■	
Point of Sale Processing and Support Services		■		■	■	
Eligibility Verification System Processing Services	■	■	■	■	■	
Provider Payment Issuance and Financial Management	■	■	■	■	■	
Third Party Liability Services	■	■	■	■	■	
Decision Support System/Data Warehouse		■	■	■		
Cost Reporting		■	■	■	■	
Auditing			■	■		
Program Integrity Services		■	■	■	■	

* As it relates to drug rebate processes and functionality

Molina Healthcare, Inc. also possesses vast Medicaid experience. Molina provides the following services to the Medicaid fiscal agent projects listed in **Figure 3.4-2**:

- Design, development and implementation
- Operations
- Claims processing
- Provider relations services
- Prior approval services for medical necessity
- Member relations
- Point of sale processing and support
- Eligibility verification system processing
- Provider payment issuance and financial management
- TPL services
- Decision support system/data warehouse
- Cost reporting

- Member enrollment
- Pharmacy benefits management
- Auditing
- Program integrity services.

Figure 3.4-2: Molina Healthcare, Inc. Medicaid and Medicare Projects

Molina Healthcare, Inc., Corporate Experience Summary		
Client	**Project**	**Contract Dates**
California Department of Health Care Services/MMCD	Medicaid Managed Care – Two Plans (Riverside and San Bernardino)	1985 to Present
California Department of Health Care Services/MMCD	Managed Risk Medical Insurance – Healthy Families and Access for Infants and Mothers	1985 to Present
Florida Agency for Health Care Administration	Molina healthcare of Florida (TANF, SSI)	2008 to Present
Michigan Department of Community Health	Medicaid Managed Care	1994 to Present
Missouri HealthNet Division	Medicaid Managed Care	2007 to Present
New Mexico Human Services Department – Medical Assistance Division	Medicaid and State Covered Insurance (SCI) Managed Care	2004 to Present
Ohio Department of Job and Family Services	Medicaid Managed Care (includes Eligible Aged, Blind and Disabled)	2005 to Present
Texas HHSC	Managed Care for CHIP STAR and STAR+PLUS (Harris Service Area, Houston); Aged, Blind and Disabled STAR+PLUS (Bexar Service Area, San Antonio)	2006 to Present
Texas HHSC	Managed Care for CHIP and CHIP Perinate Program (Webb Servcie Area, Laredo)	2006 to Present
Texas HHSC	Managed Care for CHIP and CHIP Perinate Program (Texas Rural Service Area, 174 Counties)	2006 to Present
Utah Department of Health	Managed Care for Medicaid and CHIP	1997 to Present
Washington Department of Social and Health Services	Medicaid (Basic Health Plus) and CHIP (Healthy Options) Managed Care and Maternity Benefits Program	1999 to Present
Washington State Health Care Authority	Medicaid (Basic Health Plan)	1999 to Present
Wisconsin Department of Health Services	Medicaid Managed Care via BadgerCare, Medicaid SSI, Childless Adult Population	2010 to Present
CMS Region VIII Office	Medicare Advantage Plans for California, Michigan, New Mexico, Ohio (Special Needs), Texas, Utah, and Washington	2006 to Present

Pages 3-18 through 3-19 contain confidential and proprietary information and have been redacted.

4.0 STAFF CAPACITY, QUALIFICATIONS AND EXPERIENCE [3.2.3, 4.1.8]

Pages 4-1 through 4-2 contain confidential and proprietary information and have been redacted.

Figure 4.2-1: Continuously Dedicated Staff

CONTINUOUSLY DEDICATED STAFF ROLES AND QUALIFICATIONS			
Position/Qualifications	**Phase 1: DDI**	**Phase 2: Operations**	**Phase 3: Turnover**
Role	Operations Manager.		
Data Conversion Specialist	**X**		
Qualifications and Experience	Bachelor of Arts/Science and three years of experience (can be replaced by seven years of relevant experience.) Minimum of 5 years experience managing data conversion for MMIS implementation or health care information system projects.		
Role	Manages data conversion for Medical, Dental, and POS.		
Interface Specialist	**X**		
Qualifications	Bachelor of Arts or Science and three years of experience (can be replaced by seven years of directly relevant experience.) Minimum of 3 years experience in systems integration, messaging components, and interface development for MMIS implementation projects or health care information systems.		
Role	Manage Medical, Dental, and POS interface development and implementation tasks.		

Molina provides all continuously dedicated staff as shown in our organization charts.

Molina acknowledges the following requirements related to CD staff:

- Once CD staffing levels have been agreed upon, those staffing levels will be maintained throughout the contract
- CD staff are 100 percent dedicated to the West Virginia project
- CD staff dedicated to West Virginia will not hold concurrent positions on any project
- CD staff may be located off site.

Support staff qualifications, experience, and roles are discussed in the next section.

4.3 Support and Other Staff [3.2.3.2]

Molina proposes the following positions as Support Staff for the West Virginia MMIS Re-procurement. Molina agrees to the requirements stated in the RFP related to Support staff. **Figure 4.3-1** provides the Support Staff position titles, qualifications, experience, and roles**.**

Figure 4.3-1: Support Staff

SUPPORT STAFF ROLES AND QUALIFICATIONS			
Position/Qualifications	**Phase 1: DDI**	**Phase 2: Operations**	**Phase 3: Turnover**
Trainer and Documentation Specialist	**X**	**X**	**X**
Qualifications and Experience	Bachelor of Arts or Science can be replaced by four additional years of directly relevant experience.) Two years experience in technical and/or user documentation development; one year in documentation version control and management		
Role	Develop training curricula and materials; facilitating training sessions; developing technical and/or user documentation for Medical/Dental and POS.		
Medical/Dental Ad Hoc Reporting Analysts (2)	**X**	**X**	**X**

SUPPORT STAFF ROLES AND QUALIFICATIONS			
Position/Qualifications	**Phase 1: DDI**	**Phase 2: Operations**	**Phase 3: Turnover**
Qualifications and Experience	Bachelor of Arts or Science and three years of experience (can be replaced by seven years of directly relevant experience.) Minimum of 2 years experience in the creation and production of technical and/or user documentation; at least 1 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.		
Role	Analyzes report data for trending purposes and reports variances to the BMS; gathers business requirements; develops reports; performs report QA and delivers reports for approval.		
POS Ad Hoc Reporting Analyst (1)	**X**	**X**	**X**
Qualifications and Experience	Bachelor of Arts/Science and three years of experience (can be replaced by seven years of directly relevant experience.) Minimum of three years experience supporting Medicaid or other health care programs data analysis and experience in the product being bid.		
Role	Analyzes report data for trending purposes and reports variances; gathers business requirements; develops reports; performs report QA and delivers reports for BMS' approval.		
Finance Report Analyst	**X**	**X**	**X**
Qualifications and Experience	Bachelor of Arts or Science and three years of experience (can be replaced by equivalent years of education and directly relevant experience.) Minimum of 3 years experience supporting data analysis for Medicaid or other health care programs and experience in the product being bid.		
Role	Analyzes report data for trending and reports variances to the BMS; gathers business requirements; develops reports; performs report QA; and delivers reports for BMS' approval.		
Drug Rebate Report Analyst	**X**	**X**	**X**
Qualifications and Experience	Bachelor of Arts or Science and three years of experience (can be replaced by equivalent years of education and directly relevant experience.) Minimum of 3 years experience supporting data analysis for Medicaid Drug Rebate or other health care programs and experience in the product being bid.		
Role	Analyzes report data for trending and reports variances to the BMS; gathers business requirements; develops reports; performs report QA; and delivers reports for BMS' approval.		

Molina provides all support staff as shown in our organization charts.

In addition to the support staff stated specifically in **Figure 4.3-1**, Molina agrees that the staff listed in **Figure 4.3-2** are also considered to be support staff. Molina agrees to maintain staffing levels for these classifications of personnel throughout the contract.

Figure 4.3-2: Additional Support Staff Classifications

ADDITIONAL SUPPORT STAFF CLASSIFICATIONS	
Support Staff Classification	**Requirements**
Systems Management Lead Staff	Molina's systems management lead staff will have a Bachelor's Degree and two years of experience in the assigned application, or equivalent experience on a year-for-year basis.
Systems Management Staff	Molina agrees to provide sufficient industry-qualified staff to perform version control, extracts, documentation maintenance, network and database management, release management, and other technical personnel required to maintain Health PAS.
Claims Lead	Molina's claims lead staff will have five years of experience in medical claims processing.
Claims Team	The Claims Team will include data input, claims resolution, and voids and adjustments staff.
Mail Room Lead	The Mailroom Lead will have at least two years of mailroom experience.
Mailroom Team	The Mailroom Team includes imaging and data capture, screening and data prep, mail processing and courier services.
Provider Enrollment	Molina's Provider Enrollment staff will have at least two years of healthcare billing or public relations experience.
Provider Field Representatives	Molina's Field Representatives will have at least two years of healthcare billing or public relations experience.
Provider Relations Representatives	The Provider Relations Representatives will have at least two years of health care billing or public relations experience.
QA Support Staff	The QA support staff will assist in QA activities. Molina's QA support staff will have a Bachelor's Degree and two years of Medicaid QA experience (or equivalent experience).
Systems/Business Analysts	System and Business Analyst staff will assist with modifications and enhancements to the West Virginia MMIS. This staff will have Bachelor's Degrees and three years of experience in analyzing business requirements for Medicaid or a large health payor.
Sterilization/Hysterectomy Staff	These staff will be responsible for reviewing and entering sterilization/hysterectomy information. One year of Medicaid or health care experience is required.
Member Services Staff	Molina will have sufficient staff to perform member services duties.
Member Payment Staff	Molina will maintain sufficient staff to perform member payment duties.
Pharmacy POS Clinical Staff	Molina will maintain staff to sufficiently support Pharmacy POS clinical programs. Qualifications include a registered pharmacist or other professional with five years of relevant experience.
Pharmacy POS Technical Staff	Molina will maintain sufficient staff to support technical programs for the Pharmacy POS. Staff qualifications are a Bachelor's Degree in Computer Science, IT or related field in addition to four years of relevant experience.
Pharmacy Benefit Technicians	Molina's Pharmacy Benefit Technicians will be registered with the West Virginia Board of Pharmacy and have two years experience in pharmacy operations.
Reporting Staff	Molina will maintain sufficient staff to develop and maintain reports for the West Virginia MMIS.

Molina provides all additional support staff classifications as shown in our organization charts.

Pages 4-6 through 4-26 contain confidential and proprietary information and have been redacted.

- Maintaining and retaining employees
- Training
- Succession planning, staff replacement, and staff backup
- Procedures for obtaining additional staffing support.

4.4.6 Transition of Essential Knowledge [3.2.3.3, #7]

Communication is the basic requirement for knowledge transfer. Molina defines communication as the transferring of thoughts, ideas, and knowledge with the intent of imparting understanding and information. Communication can occur in a number of ways, and Molina will use them in order to make best use of the training process. It is important to remember that communication is a “two-way street”. That is, Molina understands that the State of West Virginia contributes directly to the training process by elucidating wants, thoughts, ideas, and perspective. Communication techniques include:

- Listening
- Understanding the end user
- Obtaining feedback
- Being clear and direct in communications
- Consideration for the time and convenience of the audience.

Listening, on the surface might appear to be an easy activity, but in truth, active listening can take a lot of energy. It requires relinquishing control and the agenda for the interaction. Part of the activity of listening includes understanding the end user and obtaining feedback.

Communication can occur in two ways, written and verbal. Molina will use both techniques. Written communications for the user can be used either facilitated or self-paced, depending how the individual approaches the material. Written communication can take place by use of how to manuals, reference materials, context sensitive help “buttons”, email, and newsletters.

Verbal communication can take place by use of:

- Facilitated activities,
  - Class room settings (seminar)
  - Meetings, which allow a more relaxed “question and answer” environment
- Self paced independent
  - Telephone access of the user to the specialist (“tech support”)
  - Web enabled video demonstrations
  - LMS based training
  - Live use of the training system in a group setting.

All written training aids will be available on the Health PAS-InterComm, and eLearning videos will be available. The Health PAS-InterComm system is a SharePoint portal system that will be used by the BMS and Molina to facilitate training, document materials, and to track activities. This portal is designed to facilitate communications with the BMS stakeholders.

Since training and communication consists of the transfer of information back and forth between Molina and the BMS, these activities need to start at the beginning of the project. Therefore, Molina will hold training sessions from kick-off of the project through user acceptance and beyond. Molina will employ the techniques listed above as appropriate.

5.0 PROJECT APPROACH AND SOLUTION [4.1.9]

Molina Medicaid Solutions (Molina) offers the West Virginia Bureau for Medical Services (BMS) the technology and services that align with the BMS Medicaid Information Technology Architecture (MITA) alignment for the future. Molina's goal is to enable the Bureau to comply with mandatory changes, to introduce flexibility in program design to better manage costs and increase collaboration among intrastate agencies, and to facilitate the use of state and regional information exchange. Molina's Healthcare Payer Administration Solution (Health PAS), consisting of integrated, commercial off-the-shelf (COTS) components, and its associated business processes, aligned with MITA standards, can facilitate West Virginia's move into the future while meeting the goals and objectives of the MMIS project.

"The grave challenges that we face today cannot be solved by the same level of thinking that created them" – Albert Einstein

West Virginia, like all other states, faces unprecedented challenges in managing the Medicaid program. Molina offers the Bureau a new approach to manage the demand for improved programs and services that effectively respond to the regulatory requirements presented in the Deficit Reduction Act (DRA), the American Reinvestment and Recovery Act (ARRA) and "Meaningful Use", the HITECH Act, the Broadband Act, the Patient Protection and Affordable Care Act (PPACA), the Health Insurance Portability and Accountability Act (HIPAA) and Medicaid Information Technology Architecture (MITA), all of which have profound impact through 2015 and beyond.

"Molina is the only competitor in the MMIS Space which provides an off the shelf solution for MMIS where as EDS and ACS build out customized platforms for each state. Having a standardized platform allows Molina to complete the roll out phase faster than its competitors who have been running up to 13-15 months late on recent implementations and customized build outs."
Wedbush Equity Research, June 4, 2010

Molina Medicaid Solutions, a wholly owned subsidiary of Molina Healthcare, Inc., has developed an innovative and unique approach to managing MMIS requirements that allows it to provide a comprehensive and robust capability to administer and manage a Medicaid program in a dynamically changing environment. Molina's Health PAS integrates best-of-breed, COTS, functionally rich and rules-based components built on open systems architecture. Health PAS encompasses a comprehensive MMIS functionality that offers several distinct advantages to the Bureau during the DDI and Operations Phases:

- ***Health PAS is MITA-aligned.*** Health PAS was designed to align with MITA business processes and technical architecture, and is a "made-for-MITA" Medicaid fiscal payer system.
- ***Health PAS is built on best-of-breed COTS products*** whose vendors continue to independently upgrade their products to support changes and innovation in the market place. These enhancements can be leveraged by simply upgrading to the new releases covered by the included maintenance fees, and avoids the risk associated with traditional in-house system development practiced by legacy MMIS contractors. For example, HIPAA X12 5010 and ICD-10 functionality will be implemented by respective COTS vendors, allowing Molina customers to take advantage of this new functionality going forward through a COTS product upgrade. During ongoing operations, the COTS approach reduces the high cost of change orders to meet regulatory mandates since Molina customers will only have to cover the labor costs of the COTS upgrade to implement the new functionality.
- ***Health PAS provides a "work force multiplier" for Molina customers.*** Since Health PAS consists of COTS products from leading software vendors, the Health PAS solution brings

the expertise and support of the vendor functional and technical staff in support of West Virginia. For example, the vendor for QNXT, the primary claims processing engine of Health PAS-Administrator, has numerous functional and technical personnel reviewing upcoming Meaningful Use requirements and working to modify their COTS product to incorporate this new CMS mandate. West Virginia benefits from the expertise of these industry leading functional and technical personnel when the product release containing these updates becomes available. Additionally, the use of COTS products allows Molina to focus on West Virginia DDI activities while the vendors of the COTS components of Health PAS focus on incorporating requirements presented in the DRA, the ARRA and "Meaningful Use", the HITECH Act, the Broadband Act, the Patient Protection and Affordable Care Act, HIPAA and MITA.

- ***Health PAS consists of proven products.*** Health PAS consists of commercially or publically available products that have been tested and verified by their respective vendors prior to release, and proven in the market place. Health PAS provides the capability to process all West Virginia Medicaid claim types, while at the same time supporting coordination of benefits (COB), Federal and management reporting, and case management. Installation of product upgrades to Health PAS saves time, greatly limits system development and testing activities and dramatically reduces program risk.
- ***Health PAS is a configurable, rules-based solution.*** Health PAS typically requires configuration of system parameters by domain knowledgeable business analysts to meet specific requirements, avoiding high-risk system development activities by more expensive programming resources. This also allows many new requirements to be quickly implemented through simple configuration changes.
- ***Health PAS is extensible.*** Health PAS is built with open systems architecture, allowing the integration of new COTS components to provide added functionality. Integration of a new COTS component can significantly reduce the need for system development and associated costs.
- ***Health PAS is scalable.*** Health PAS is designed to allow the addition of hardware components in a scale up and scale out model to address evolving Medicaid program performance, throughput or volume requirements.

Health PAS reduces traditional system development activities, benefiting the State with decreased risk and reduced maintenance cost.

- ***Health PAS is designed to support technological currency using an evergreen model***. Health PAS provides continual modernization capabilities to support implementation of innovative technologies, allowing Health PAS to evolve as the healthcare market and technology evolve, thus allowing the Bureau to remain on the forefront of technology, functionality and performance.
- ***Health PAS is a multi-plan solution.*** Health PAS was built to provide multi-plan capabilities that can manage a variety of health care plans and benefit structures. This flexibility allows Health PAS to quickly adapt to changing program requirements. This capability also provides the Bureau with the opportunity to run multiple state plans under a single shared services model.
- ***The Health PAS relational database is easily extended.*** The Health PAS relational database is designed to allow new data elements to be easily added. New data elements can be defined and added to the database as attributes, and all attributes can be viewed online. This capability allows Health PAS to easily handle new data requirements as the Medicaid program evolves. Adding data elements to Health PAS does not require the massive "system recompiles" and master file expansions required by legacy applications, facilitating DDI activities to incorporate West Virginia-specific data elements.

Health PAS is an advanced solution that embodies an entirely new approach to providing a highly functional MMIS.

5.1 Statement of Understanding [4.1.9]

It is Molina's understanding that the purpose of the RFP issued by the Bureau is to solicit proposals for a vendor to provide fiscal agent services, a replacement MMIS system to include the design, development and implementation; CMS certification and on-going operations for the replacement system. The MMIS solution must provide at a minimum all components and functions that are detailed in the RFP (pp. 6-8) as well as defined in the business and technical requirements of the RFP (Appendix E). These services will be provided in three phases:

- Phase 1: MMIS Replacement, DDI and Certification Planning;
- Phase 2: Fiscal Agent Responsibilities;
- Phase 3: Turnover and Closeout.

The BMS desires the proposed solution to be aligned based on MITA business areas, including:

- Member Management
- Provider Management
- Operations Management
- Program Management
- Care Management
- Program Integrity Management

In addition, the BMS is seeking Pharmacy Point-of-Sale (POS), general technical and general operational requirements to be met.

The proposed Molina West Virginia Replacement MMIS approach and solution is in perfect alignment with MITA principles and will complement the Bureau's business area goals and objectives for the State Medicaid program. This alignment is further clarified in Section 6.2, MITA Alignment.

At the highest level, the BMS is looking for a MMIS that is flexible and can quickly respond to changes in the State program, is able to effectively address new regulatory requirements, and can remediate deficiencies in an efficient manner. This replacement system will align with MITA principles and use an open and service-oriented architecture. The system will achieve the goals and objectives of Medicaid as well as obtain the "To Be" capabilities that were identified by the BMS in the MITA State Self-Assessment. This configurable and highly flexible solution will offer the BMS the technical solution to match services to their member and provider communities.

The BMS expects that the fiscal agent provides the technology, service delivery and management that meet their stated objectives. Molina has categorized the objectives as it understands them into four key areas: Administrative, Tailored Services, Care Coordination and Improved Technology. Each of these areas is addressed in the following paragraphs.

- **Administrative** – The BMS knows that a successful fiscal agent must provide much more than simply claims administration. The fiscal agent must:
  - Be accessible
  - Be accountable
  - Solely focus on the BMS' defined objectives
  - Utilize project management oversight to ensure that schedules and deliverables are met timely, within budget and defect free
  - Emphasize quality in services and technology
  - Provide leadership grounded in experience and best practices
  - Be a partner

Molina has strengthened the management and support teams to deliver these services with confidence.

- **Tailored Services** – The BMS wants a partner that can facilitate them meeting the many challenges in today's health care industry. The BMS must meet Federal, State and Legislative mandates as well as the needs of Providers and most importantly, the Medicaid member population. The BMS desires to maintain traditional services in a non traditional approach and also introduce new services or benefits through the use of waivers and grants. The fiscal agent must have the technology to:
  - Allow the BMS flexibility to arrange benefit plans by member, provider, or both
  - Assess change prior to its implementation, and
  - Provide the outcomes and measurements so that the BMS can manage the changes.

  Molina not only provides the advanced technology to facilitate the implementation of tailored services but also provides tools to measure their success.

- **Care Coordination** – Molina understands that the BMS desires that their members become more involved in their health and health care through having the advantage of a fiscal agent that provides:
  - Best practices in care coordination in both FFS and Medicaid managed care
  - Technology that is service oriented based on the needs and requirements of the changing population
  - Practices and processes that improve the health care delivery, especially to the chronically ill
  - Strategies that assist the BMS in maximizing how their dollars are spent, and
  - A solution that engages their members.

  Molina understands the concept of Care Coordination as Molina was built on a managed care foundation.

- **Technology** – The BMS relies on the technology solution to facilitate the many decisions that must be made as policies, procedures and benefits are reviewed and revised to better meet the needs for the Medicaid program. The BMS requires technology that:
  - Is easily maintained and modified to address their evolution of the Medicaid program
  - Is based on best practices, approach and methodologies
  - Has the capability for growth
  - Is based on open architecture and meets Federal requirements
  - Provides tools and information that assist the members in their health decisions and outcomes
  - Provides the BMS and other stakeholders with data that are reliable and facilitates decision making and reporting

  Molina's replacement MMIS solution is the only COTS certified MMIS in the Medicaid industry.

Finally, the BMS wants a highly skilled, flexible and dependable partner to provide the highest quality fiscal agent services to the Medicaid members of West Virginia.

Molina agrees that the 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 will be provided only for the life of the contract. Molina also agrees to place the third-party escrow arrangement as itemized in RFP requirement 3.1.39.

Page 5-5 contains confidential and proprietary information and has been redacted.

In **Figure 5.2-2** Molina provides the list of Milestones by project phase for the West Virginia MMIS project.

Figure 5.2-2: Project Milestones

Project Phase	Milestone
Phase 1a – Start Up	Contract Execution
	Project Site Facility Established
	Completion and BMS Approval of Phase 1a
Phase 1b – Analysis and Design	Completion and BMS Approval of Phase 1b
Phase 1c – Development, Testing, Data Conversion and Training	Completion and BMS Approval of Unit Testing
	Completion and BMS Approval of Standard Output Reports
	Completion and BMS Approval of BMS-Specific Reports
	Completion and BMS Approval of System Integration Testing
	Completion and BMS Approval of Regression Testing
	Completion and BMS Approval of Load/Stress Testing
	Completion and BMS Approval of User Acceptance Testing
	Completion and BMS Approval of Operational Readiness Testing
	Completion and BMS Approval of Data Conversion and Reconciliation for Implementation
	Completion and BMS Approval of User Acceptance Testing
	Completion and BMS Approval of Provider Training
	Completion and BMS Approval of Pre-Implementation System User Training
	Completion and BMS Approval of Phase 1c
Phase 1d – Implementation	Completion and BMS Approval of Provider Re-enrollment
	Completion and BMS Approval of Phase 1d (Replacement MMIS becomes the system of record)
Phase 1e – CMS Certification Planning	Completion and BMS Approval of Phase 1e
Phase 2a – Routine Operations	
Phase 2b – CMS Certification	Completion and BMS Approval of Certification Readiness Planning Meetings
	Pre-Certification Meeting and/or CMS Call
	CMS Certification (This is considered the final deliverable for DDI)
Phase 2c – MMIS Modifications and Enhancements	
Phase 3 – Turnover and Closeout	Completion and BMS Approval of Turnover Training
	Completion and BMS Approval of Turnover and Contract Close-out

Molina provides a comprehensive list of project milestones.

Molina provides the preliminary project work plan in **Section D03**. The work plan includes the planned dates for all project deliverables and milestones.

5.3 Requirements Checklist [4.1.9, 4.1.14, Attachment II]

Molina provides a completed RFP Requirements Checklist in **Section 10** to this proposal response. The reader is referred to Section 10 for the completed checklist.

5.4 Approach to Project Phases [3.2.5]

The work that Molina performs under the scope of work for the West Virginia Replacement MMIS project and fiscal agent services is organized under three major phases. **Figure 5.4-1** provides an overview of the West Virginia MMIS project phases, and indicates in which section of this proposal response a discussion of the phase may be found.

Figure 5.4-1: Section Roadmap

Phase	Where Addressed	Synopsis of Contents
Phase 1: MMIS Replacement DDI and CMS Certification Planning	Section 5.5.1	This section provides an overview of the DDI Phase, including Molina's release-based approach to DDI and the overall structure of the Project Work Plan. The contents of the planned four (4) releases are discussed, along with the MITA business processes contained in each release.
Phase 1a: Start-Up	Section 5.5.2.1	This section addresses the initiation of project activities, including: • Conducting the project kick-off meeting • Conducting project expectations meetings • Updating the project work plan • Developing key project plans and deliverables • Upgrading the Charleston facility/infrastructure for new contract operations • Implementing/upgrading the project portal
Phase 1b: Analysis and Design	Section 5.5.2.2	In this section Molina discusses the COTS-based approach, which includes Requirements to COTS Specification (RCS) workshops based on MITA end-to-end Business Processes, as well as the development of the General System Design, the Detailed System Design and the Requirements Traceability Matrix.
Phase 1c: Development, Testing, Data Conversion, and Training	Section 5.5.2.3	In this section Molina discusses the importance of clearly understanding the West Virginia business rules and being able to configure Health PAS to meet West Virginia requirements. Molina will develop and deliver Health PAS in four (4) releases, with each release being built incrementally using an agile-driven approach. Molina also discusses: • Its approach to testing each release increment, each release, and the overall solution. • Its overall data conversion process, and the approach of converting data aligned with the requirements of each Health PAS release. Deliverables such as the Conversion Plan are also discussed. • The approach to training, including training the BMS and Molina staff on the new capabilities offered in the upgraded version of the COTS components of Health PAS. Provider training activities are also addressed.

Page 5-8 contains confidential and proprietary information and has been redacted.

5.5 DDI, Operations, Turnover and Close-Out

Pages 5-9 through 5-13 contain confidential and proprietary information and have been redacted.

changing program requirements. This capability also provides the Bureau with the opportunity to run multiple state plans under a single shared services model. Unlike other solutions, Health PAS does not require multiple images or instances of the solution to handle multiple plans. Health PAS makes efficient and streamlined use of resources for West Virginia.

Incorporation of Future Requirements [3.1.19]

Molina agrees to incorporate all applicable 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. This includes, but is not limited to, ICD-10, HIPAA v5010, NCPDP Claims Processing Standards D.0, the Patient Protection and Access to Care Act (PPACA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Health PAS is built on best-of-breed COTS products whose vendors continue to independently upgrade their products to support applicable coding standards that impact the market place. These enhancements can be leveraged by simply upgrading to the new releases covered by the included maintenance fees, and avoids the risk associated with traditional in-house system development practiced by legacy MMIS contractors.

Health PAS COTS component vendors upgrade their products continuously to stay aligned with current coding standards.

NCPDP Standards [3.1.20]

Health PAS will adhere to the current National Council on Prescription Drug Programs (NCPDP) version standards, or the most current HIPAA required version for single drug claims and compound prescriptions. Specific NCPDP transaction types include:

- NCPDP D.0 pharmacy claim transactions will be consistent with the transactions currently offered in the 5.1 standard. These transactions consist of the B1 (billing) and B2 (reversal) claim types.
- Coordination of benefits segment as defined in the NCPDP D.0 standard.
- NCPDP D.0 transactions for retail pharmacy supplies, and the adjudication application can also be modified to accept professional services transactions.
- NCPDP D.0 E1 eligibility transactions for eligibility inquiry and response.
- NCPDP D.0 transactions for referral certification and authorization as state policy will require certification for drugs to be dispensed, and Health PAS-Rx can be configured to accept the authorization on the incoming transaction.
- NCPDP 5.1 transactions until December 31, 2011 for retail pharmacy drug claims; and on and after January1, 2012, Health PAS-Rx will accept and send NCPDP D.0 transactions for retail pharmacy drug claims.
- NCPDP 3.0 transactions for Medicaid subrogation with the guidance of the Bureau.

A true COTS solution approach reduces the high cost of change orders to meet regulatory mandates. Additionally, the ability to integrate new COTS components can significantly reduce the need for system development and its associated risks and costs.

As a COTS-based solution, Health PAS evolves as market requirements evolve. As new national standards or transactions are mandated, the vendors of the COTS components of Health PAS upgrade their products to accommodate the new requirements. Simple installation of a product upgrade for West Virginia makes Health PAS compliant with the new requirement.

Pages 5-15 through 5-32 contain confidential and proprietary information and have been redacted.

Molina works closely with each subcontractor to make sure they are specifically trained and grounded in all project standards and quality control processes established at project initiation. All SOWs provided for subcontractors include expected quality assurance activities, the method for reviewing these activities, the acceptance criteria, and a definition of the process for Molina's preventive and corrective action program. All subcontractor work is subject to Quality Assurance reviews by Molina Quality Assurance staff, and must meet all project quality standards.

Molina creates and maintains cooperative and productive working relations and open communications with subcontractors. Each subcontractor Project Manager reports to an appropriate Molina manager and is responsible for status reporting, issue resolution, and all other leadership tasks associated with their position. Each subcontractor is a member of the overall Molina team, and Molina's goal is to enable the transparency of all subcontractor relationships to the State. Molina believes this approach underlies an active and positive attitude throughout the West Virginia organization in addressing project requirements, fulfilling the scope of work, and promoting client satisfaction.

5.5.1.1.7 Minimizing Risk to the BMS [3.2.1.1(9)]

Health PAS consists of configurable, commercially available COTS components which are extensively tested by the respective vendors and have been proven across a national customer base. Health PAS requires configuration to satisfy West Virginia business requirements, but actual system development activities are kept to a minimum. This greatly reduces the risk associated with developing and implementing a new MMIS.

With Health PAS, system development activities are kept to a minimum, reducing overall project risk.

Molina is also the incumbent fiscal agent for West Virginia; and as such, operates the existing MMIS. This will simplify data conversion and system configuration activities reducing project risk.

Molina's agile-driven, incremental approach to DDI reduces DDI activities to small, more manageable efforts. This incremental approach to delivery also reduces risk associated with the implementation of a new MMIS. This approach avoids the "big bang" approach too often seen in the Medicaid arena, where all of the system is developed and delivered at once.

5.5.1.1.8 Parallel Development of POS and Medical/Dental Systems [3.2.1.1(10)]

As the incumbent Fiscal Agent for West Virginia, Molina is well positioned to implement Health PAS-Rx in parallel with the rest of the Health PAS solution. Molina has a separate support team that specializes in the pharmacy components of Health PAS who will be responsible for configuring and implementing Health PAS-Rx. Use of this team avoids conflict of resources that are implementing the Medical/Dental Health PAS components, allowing parallel development of Health PAS-Rx and the rest of the Health PAS solution components.

5.5.1.1.9 Caveats and Constraints [3.2.1.1(11)]

While there are many advantages to using a COTS-based solution, there are also some aspects to this approach of which all parties should be aware. Since Health PAS consists of COTS components, the upfront costs of the solution can be higher than experienced with legacy MMIS applications or contractor-developed applications tailored as a "one off" on a state-by-state basis. This is due to upfront license and maintenance fees. However, this additional upfront cost is more than offset by reduced ongoing costs for the design, development and implementation of major program initiatives, such as HIPAA X12 5010 and ICD-10 functionality. The vendors of

the COTS components of Health PAS independently upgrade their products to comply with new CMS mandates and innovation in the marketplace. The Bureau can take advantage of this by simply upgrading to a new release of the respective COTS components. During ongoing operations, the COTS approach reduces the high cost of major change orders to meet regulatory mandates since Molina customers will only have to cover the labor costs, mainly in the form of regression and acceptance testing, of the service pack or COTS upgrade to implement the new functionality. The West Virginia customer will review the service pack's new or changed functionality in order to decide whether to have that service pack installed or wait until the next COTS release/upgrade to implement the change. Additionally, most ongoing maintenance changes and state initiatives can be handled through a configuration update to the solution versus the custom code development experienced with legacy applications. For instance, a new benefit program can be quickly accommodated through configuration updates to the solution.

In order for the COTS approach to remain effective over the term of the contract, it is important that the Bureau review and provide direction about upgrades to new releases of COTS components when they become available. Molina will provide the Bureau with needed data points to make an informed decision. As with any COTS product, the vendor may no longer support a version of the product older than the two most current releases, or provide upgrade support. This can significantly increase the costs associated with a product upgrade. Additionally, vendors provide support in installing new releases if file formats or database structures are impacted, often providing conversion programs to facilitate the upgrade process. This provides incentive for both the Bureau and Molina to make certain new releases are installed when available and shown as stable in the vendor's customer base.

5.5.2 Phase 1: Approach to DDI Tasks [3.2.6]

Molina's Design, Development and Implementation (DDI) approach focuses on capturing the business requirements and configuring Health PAS to meet those requirements. As a COTS-based solution, Health PAS is already designed and developed, greatly reducing the need for software design and development, reducing overall project risk.

Health PAS requires a new way of thinking about MMIS solutions and implementation of those solutions. Traditional waterfall methodology to develop and implement an entire MMIS at once has proven to be a high risk approach for a timely implementation of a certifiable, maintainable, new MMIS. A different, business-requirements driven approach is effective in deploying a COTS-based Medicaid system into a dynamic and complex Medicaid environment such as the West Virginia Medicaid program. The Molina solution utilizes highly configurable, industry proven, regularly updated, COTS products that, when compared to customized legacy systems, provide significant advantages in speed and reduction of cost of applying changes and mandated updates. Molina's solution will provide the flexibility, adaptability and speed-to-market required to meet the demands of today's Medicaid systems.

Molina uses three (3) innovative approaches to accomplish the Health PAS implementation in both a timely and a quality manner:

Requirements to COTS Specification Workshops – Molina has developed an innovative approach to the requirements analysis process called Requirements to COTS Specification (RCS) workshops. These are the detailed requirements gathering meetings between the BMS and Molina. Molina organizes the RCS workshops by relevant MITA Business Area, or by aggregates of MITA business process areas**.** This approach facilitates effective requirements clarification, understanding and traceability. Molina schedules the RCS workshops to most efficiently utilize resources. The Molina solution and its implementation approach are aligned with MITA Business Processes.

The RCS workshops include MITA business process artifacts, MITA business process modeling verification and Health PAS demonstrations following the applicable MITA business area structure. These workshops allow the BMS to experience firsthand how each applicable MITA business process will operate using Health PAS. At the completion of each RCS workshop, Molina business analysts prepare a complete and accurate RCS document covering the workshop's MITA business processes. Molina reviews each completed RCS document internally, and the completed version is delivered to the BMS for review and approval. Once approved, the RCS document is placed under configuration management control so that subsequent changes must be approved by appropriate BMS and Molina management. Each RCS workshop is considered complete upon the BMS approval of its RCS document. The RCS document replaces the traditional Requirements Specification Document (RSD), and the work required to complete the RCS is more streamlined because it is COTS-based.

The RCS workshops provide a streamlined method of validating West Virginia requirements, and modeling those requirements based on MITA business area. The RCS workshops outputs provide documentation on West Virginia business processes aligned with MITA.

Business Process Modeling – Molina uses its innovative patent-pending MITA-business process modeling tailored according to West Virginia's requirements to represent West Virginia's "to be" MMIS model. The Molina business process modeling approach facilitates requirements traceability and provides a visible model across the business and technical architecture to trace requirements. Business process modeling refers both to a collection of interconnected business models, as depicted in **Figure 5.5.2-1**, and to the methods by which those models are developed and used. Since Molina is implementing a COTS-based solution,

Pages 5-36 through 5-37 contain confidential and proprietary information and have been redacted.

Release #	MITA Process Area	MITA Business Processes
		PG03 Manage Rate Setting PG18 Maintain Benefits-Reference Information
2	**Member Management**	ME01 Manage Member Information ME02 Manage Applicant and Member Communication ME03 Perform Population and Member Outreach
	Provider Management	PM01 Manage Provider Information PM04 Enroll Provider PM05 Inquire Provider Information PM06 Disenroll Provider
	Operations Management	OM07 Edit Claim-Encounter OM11 Prepare Home and Community Services Payment OM13 Prepare Provider EFT-Check OM14 Prepare Remittance Advice-Encounter Report OM15 Prepare Capitation Premium Payment OM18 Inquire Payment Status OM20 Calculate Spend-Down Amount OM21 Prepare Member Premium Invoice
3	**Member Management**	ME05 Enroll Member ME07 Disenroll Member
	Operations Management	OM01 Authorize Referral OM02 Authorize Service OM03 Authorize Treatment Plan OM04 Apply Attachment OM05 Apply Mass Adjustment OM06 Audit Claim-Encounter OM08 Price Claim-Value Encounter OM09 Prepare COB OM10 Prepare EOB OM17 Prepare Medicare Premium Payment
	Care Management	CM01 Establish Case CM02 Manage Case
4	**Provider Management**	PM02 Manage Provider Communication PM03 Perform Provider Outreach
	Operations Management	OM12 Prepare Premium EFT OM16 Prepare Health Insurance Premium Payment OM19 Manage Payment Information OM22 Manage Drug Rebate OM23 Manage Estate Recovery OM24 Manage Recoupment OM25 Manage Cost Settlement OM26 Manage TPL Recovery
	Program Management	PG01 Designate Approved Services and Drug Formulary PG08 Manage FFP for MMIS[1] PG13 Manage 1099s

Pages 5-39 through 5-40 contain confidential and proprietary information and have been redacted.

configuration during the User Acceptance Test (UAT). With the completion of the final release, which includes regression testing of the overall solution, the entire MMIS will be ready for UAT.

5.5.2.1 Phase 1a, Start-Up [3.2.6.1, 3.2.6.1.1]

Molina's general approach to the Start Up Phase will be to establish a common framework and understanding of what will be accomplished on the West Virginia MMIS project. This includes identification of the key players at the BMS and at Molina; roles and responsibilities; deliverables; deliverable content; acceptance criteria; review and approval processes; and project control processes and procedures for addressing potential increases in project scope. During the Start Up Phase, Molina will initiate a number of key activities that affect the course of subsequent project phases. They include the following:

- **Conducting the Project Kickoff Meeting.** Molina will prepare materials for and conduct a project kickoff meeting with the BMS. During the kickoff meeting, key members of the Bureau and Molina will be introduced and Molina will present an overview of its approach for implementation of Health PAS and assumption of fiscal agent operations under the new contract.
- **Conducting Expectations Meetings.** Molina prepares materials for and conducts a series of project Expectations Meetings. The purpose of these meetings is to meet with various West Virginia stakeholders to review Molina processes and to set the level of expectations for deliverables and other items that will be presented to the Bureau. This helps avoid confusion later in the project by making sure everyone has the same frame of reference for project activities and deliverables.
- **Updating the Project Work Plan (PWP).** Molina provides its preliminary PWP in Proposal **Section D03**. During the Start Up Phase, Molina will update this plan based on actual contract signing dates and adjust the plan as necessary based on contract negotiations. The updated plan will be presented to the BMS for review and approval. Once approved, the work plan will be baselined and placed under configuration management control. Subsequent changes to the baseline plan will require the BMS and Molina management approval.
- **Developing Key Project Plans and Deliverables.** Within 45 days of contract award, Molina will submit for the BMS approval the Project Management Plans, prepared in accordance with Project Management Body of Knowledge (PMBOK) principles and the Molina project management methodology, and other Deliverables.
- **Establishing/Updating the Charleston Office.** As the incumbent fiscal agent, Molina has an existing office already established in Charleston. Molina's internal real estate group is responsible for real estate and facilities services—including brokerage, construction, and project management—and facilities management for locations in the United States. Molina's internal real estate group will be responsible for any updates required to the existing facility. Once office modifications are identified, Molina will begin building out the facility to meet new contract requirements.
- **Establishing the Molina Project Management Office (PMO).** Molina will identify/assign members of the West Virginia team as members of the PMO. Molina's PMO structure is designed to be flexible—the Molina leadership team can add or remove positions within the PMO to adjust to the evolving needs of the project.
- **Implementing the Project Portal.** Health PAS-InterComm is the Molina solution for a project portal. Built using Microsoft SharePoint technology, Molina will establish an initial configuration of the updated Health PAS-InterComm within 30 days of contract award for the

sharing of information and as a repository for key project artifacts. As the project progresses, the BMS and Molina can easily update the portal to provide the most effective means of communication sharing.

Work that Molina completes for the West Virginia engagement will be performed within the continental United States, unless Molina obtains prior approval from the Bureau to locate functions more cost effectively elsewhere.

5.5.2.1.1 Start-Up Deliverables and Milestones [3.2.6.1.1(1), 3.1.24, 3.1.45]

The required Start Up Phase deliverables are defined in **Section D02**. Molina prepares and submits all required Start Up Phase deliverables and attains all phase milestones.

Please note that Molina has added a Project Management task to its work plan which encompasses activities that impact all project phases. This includes project management and infrastructure services activities. Some of the common deliverables required by project phase, such as weekly and monthly status reports, have been included under the Project Management task. Otherwise, the Molina work plan aligns with RFP phase requirements.

Each project plan or other deliverable will be submitted to the Bureau separately for review and approval. Once approved, each item will be placed under configuration management control and subsequent changes to each item will require the BMS and Molina management approval.

As the incumbent fiscal agent, Molina has some project plans in place, and will leverage/update these plans to meet the new contract requirements. This will facilitate the plan submission and approval process for the Start Up Phase.

There are three required milestones for the Start Up Phase:

- Contract Execution – This is the start of the new contract and the beginning of Start Up Phase activities.
- Project Site Facility Established – As the incumbent fiscal agent, Molina already has a Charleston office established. This office will be upgraded as necessary for new contract operations.
- Completion and the BMS Approval of Phase 1a – This is the official end of the Start Up Phase with the BMS formal approval of phase completion.

Molina will work with the State to complete all Start Up Phase deliverables and attain all Start Up Phase milestones on the approved work plan schedule.

Molina provides a comprehensive security, privacy and confidentiality approach as discussed earlier in **Section 5.5.1.1.1**. Molina also provides an initial version of the required Security, Privacy and Confidentiality Plan in **Section E01**.

5.5.2.1.2 Completion of Phase 1a, Start-Up [3.2.6.1.1(2)]

As noted above, there are three required Start Up Phase milestones:

- Contract Execution – The acceptance criteria for this milestone will be the signing and execution of the formal contract between the State and Molina to provide the MMIS and fiscal agent services.
- Project Site Facility Established – The acceptance criteria for this milestone will be the establishment of the Charleston office. Since Molina is the incumbent fiscal agent, the site office is already established but will be upgraded as necessary for new contract operations.
- Completion and the BMS Approval of Phase 1a – The acceptance criteria for this milestone will be the BMS approval of all required Start Up Phase deliverables and approval that all other Start Up Phase milestones have been attained.

Molina submits all required deliverables to the State for review and approval. The Bureau or Molina may request that a deliverable review walkthrough be scheduled soon after the deliverable is submitted. Molina generally schedules a deliverable walkthrough for more complex deliverables. Either the BMS or Molina may request a post-submission review be scheduled depending on the complexity of the deliverable.

The Bureau will perform an initial review of the deliverable. Ten (10) days are scheduled for State review. At that time the State Project Manager will determine if an expanded review cycle is appropriate based on the importance, complexity, and/or scope of the deliverable. The expanded time for review is communicated to the Molina Project Manager so that the Project Work Plan can be updated. Expanded time for review may impact the project schedule.

The State Project Manager will send the deliverable to the BMS reviewers with a review deadline. The State reviewers will read and assess the deliverable and record their comments and severity of the comment on the Deliverable Review Tracking Log. All comments will be returned to the State Project Manager or delegate via the Deliverable Review Tracking Log. The State will consolidate the review comments into a single Deliverable Review Tracking Log, remove duplicated comments, and verify the applicability of the comments.

State comments and Molina responses relating to each deliverable are recorded and tracked to completion using the Deliverable Review Tracking Log, a draft of which is provided in **Figure 5.5.2.1.2-1**. This draft Tracking Log will be included in the Deliverable Acceptance Process artifact that is reviewed with the State during the initial period of the DDI Phase. Any feedback from the State is incorporated into the final Tracking Log used throughout the DDI Phase.

Figure 5.5.2.1.2-1: Draft Deliverable Review Tracking Log

DELIVERABLE REVIEW TRACKING LOG								
DELIVERABLE or ARTIFACT			[Deliverable OR Artifact Identification Number and Name]					
West Virginia BMS Reviewer Comments						Molina	Bureau 2d Review	Molina
Document: - Artifact - Expectation - Draft (+ version #) - Final	Comment #	Reference in Deliverable (Section #)	Initial DPHHS reviewer comments	Severity (Major or Minor)	Status (Open or Closed)	Response (Brief comment related to BMS comments and resultant Deliverable update)	Comments (Based on Molina's response and/or updates to Deliverable)	Response (Brief comment related to BMS comments and resultant Deliverable update)

The Deliverable Review Tracking Log provides an audit trail of all Bureau comments and Molina responses.

A blank Deliverable Review Tracking Log will be included with the submission of each deliverable, including the Deliverable's Expectation Document and artifact. Molina will use the State-completed log to make the necessary updates to the deliverable and, when needed, contact the State for further clarification of a comment. The Deliverable Review Tracking Log will also be used as the guide to record comments during Molina reviews and walkthroughs of the deliverable with the State after the initial submission.

The Health PAS-InterComm Project portal will provide a central repository of contract-required Deliverables. Molina has structured the work plan based on the State's conducting one comprehensive review of draft Deliverables and, after the incorporation of State comments, the Deliverable's being resubmitted for approval and finalized. This will avoid project delays from repeated rounds of submission, review and comment, incorporation of comments, and resubmission. This will require the State to verify that stakeholders for a Deliverable are included in the review process of the draft Deliverable.

5.5.2.1.3 Start-Up Risk Assessment and Mitigation [3.2.6.1.1(3)]

Molina provides its initial Risk Management Plan in **Section D15**. The Risk Management Plan will be updated during the Start Up Phase and submitted to the BMS for review and approval. Once approved, Molina will utilize the processes and procedures defined in this plan to guide all risk assessment and risk mitigation activities through all project phases.

5.5.2.1.4 Start-Up Required Project Plans [3.2.6.1.1(4 - 8)]

In **Tab E** Molina provides the following plans and their components:

- Comprehensive, initial Security, Privacy, and Confidentiality Plan (**Section E01**)
- Comprehensive, initial Configuration Management Plan (**Section E02**)
- Comprehensive, initial Data Conversion Plan (**Section E03**)
- Comprehensive, initial Disaster Recovery and Business Continuity Plan (**Section E04**)
- Comprehensive, initial Data and Records Retention Plan (**Section E05**).

Each plan incorporates within the plan the components required by the RFP.

5.5.2.2 Phase 1b, Analysis and Design [3.2.6.2, 3.2.6.2.1]

Molina's primary tool for analysis of West Virginia Replacement MMIS requirements is the Requirements to COTS (RCS) workshops. These are the detailed requirements gathering meetings between the BMS and Molina. Molina organizes the RCS workshops by relevant MITA business area or by aggregates of MITA business process areas**.** This approach facilitates effective requirements clarification, understanding and traceability.

The RCS workshops include MITA business process artifacts, MITA business process modeling verification and Health PAS demonstrations following the applicable MITA business area structure. These workshops allow the BMS to experience firsthand how each applicable MITA business process will operate using the replacement Health PAS MMIS. At the completion of each RCS workshop, Molina business analysts prepare a complete and accurate RCS document covering the workshop's MITA business processes. Molina reviews each completed RCS document internally, and the completed version is delivered to the BMS for review and approval. Once approved, the RCS document is placed under configuration management control so that subsequent changes must be approved by appropriate BMS and Molina management. Each RCS workshop is considered complete upon the BMS approval of its RCS document. The RCS document replaces the traditional Requirements Specification Document (RSD), and the work required to complete the RCS is more streamlined because it is COTS-based.

Molina is offering a COTS-based MMIS solution. As such, Health PAS is already "designed" and "developed". During the Analysis and Design Phase, Molina focuses on understanding West Virginia business requirements and determining how best to configure Health PAS to meet those requirements. Molina's significant experience with Health PAS in West Virginia will facilitate the system configuration activities for the Health PAS replacement system.

The business architecture of the Molina COTS-based solution to satisfy the to-be MITA business process capability for West Virginia is already baselined. During the RCS workshops, updates to the Business Architecture models will be captured to depict West Virginia's business strategy and processes. Resolution of identified functionality gaps may require some minimal changes in a small subset of the technical architecture, but overall the technical architecture of Molina's COTS-based solution is already established.

Pages 5-45 through 5-53 contain confidential and proprietary information and have been redacted.

All database components developed by Molina for integrating COTS applications or fulfilling specialized customer requirements for which no corresponding structures exist in the COTS databases are placed in a custom database. During the Analysis and Design Phase, Molina will create logical and physical data models for the custom database based on application requirements. Molina will validate the data models, including ensuring that:

- All data elements required by the application are present
- Database standards and naming conventions are followed
- Column names and data types are consistent
- Each table contains a primary key, which is a column or group of columns that can be used to uniquely identify each row of the table, and
- Relationships between tables are defined correctly.

Once validated, the data models will be published for use during the development phase and subsequent phases, and the physical data model will be used to create the custom database.

5.5.2.3 Phase 1c, Development, Testing, Data Conversion and Training [3.2.6.3, 3.2.6.3.1]

Molina offers an integrated, configurable, web-based COTS solution that greatly reduces system development activities. The COTS components of Health PAS work out-of-the-box and are configured to meet West Virginia requirements. The Bureau benefits from reduced risk and less reliance on highly skilled technical resources to implement change. The Molina MMIS approach provides the Bureau with concrete value in solution sustainability, minimized risks and costs, and project quality that directly relate to the State's return on investment.

Molina understands and agrees that the Development, Testing, Data Conversion and Training phase will commence upon the BMS's issuance of a Formal Notice to Proceed. As a configurable, COTS-based solution, Health PAS limits system development activities to data conversion processes, electronic interfaces specific to West Virginia requirements and resolution of specific functionality gaps. Molina has successfully implemented Health PAS in three states, so system integration processes for Health PAS COTS components are already completed, reducing the high-level of risk associated with implementing a new MMIS. Additionally, since Molina is the incumbent in West Virginia, Molina has already developed the West Virginia specific electronic interfaces and resolved functionality gaps identified for the existing contract. This reduces the overall development effort further. Finally, data conversion activities will be less effort that converting data from a legacy-based MMIS.

5.5.2.3.1 Development Task [3.2.6.3.1.1]

Historically, design and development for MMIS solutions have been accomplished with what is known as the waterfall approach. Requirements for the entire solution are gathered and approved. Those requirements are converted into system and detailed design documents for the entire solution. After these design documents are approved, development for the entire system begins. When development and unit testing is complete, the entire solution goes through system testing. System testing is followed by a series of subsequent steps, such as User Acceptance Testing (UAT), training, implementation, and site support. The risky aspects to this approach are that each step involves every facet of the overall solution, and no phase starts before the previous phase is complete. System testing and UAT are executed only at the end of the effort, leaving little to no room for errors or issues to arise or for changes to be implemented. With key approvals and testing lumped into the final project phases, the waterfall development

Pages 5-55 through 5-57 contain confidential and proprietary information and have been redacted.

Inspect

In the Inspect step, Molina delivers a list of features included in the increment to the BMS, demonstrates the included business functionality, and turns it over to the BMS for a period of hands-on verification and testing. This hands-on inspection by the BMS is very important, providing the opportunity for feedback that cannot occur in the space of a controlled demonstration meeting. This step also provides the opportunity for the BMS test personnel to develop and refine their test case scenarios for User Acceptance Test (UAT). Any identified issues from this inspection are documented and provided to the configuration analysts or the development team for resolution. Once all issues have been resolved, the end-to-end business process resides in the systems integration test (SIT) environment to await final SIT of the entire solution.

5.5.2.3.1.1 Development Task Deliverables and Milestones [3.2.6.3.1.1(1), 3.1.24]

The required Development Task deliverables are defined in **Section D02**. Molina prepares and submits all required Development Task deliverables and attains all task milestones.

Please note that Molina has added a Project Management task to its work plan which encompasses activities that impact all project phases. This includes project management and infrastructure services activities. Some of the common deliverables required by project phase, such as weekly and monthly status reports, have been included under the Project Management task. Otherwise, the Molina work plan aligns with RFP phase requirements.

Each deliverable will be submitted to the Bureau separately for review and approval. Once approved, each item will be placed under configuration management control and subsequent changes to each item will require the BMS and Molina management approval. Molina maintains a Revision History on all deliverables that indicates when a deliverable is updated, who made the update, and a summary of the changes that were made. This helps maintain an audit trail of deliverable changes over the life of the contract.

There are three required milestones for the Development Task:

- Completion and the BMS Approval of Unit Testing – Molina will be delivering the functionality of Health PAS on an incremental basis. This will facilitate the BMS approval of unit testing for each release/increment.
- Completion and the BMS Approval of Standard Output Reports – As the incumbent fiscal agent, Molina has developed or provided Standard Output Reports that have been approved by the BMS. Molina will leverage these in-place reports to facilitate the approval process for the Standard Output Reports.
- Completion and the BMS Approval of BMS-specific Reports – As the incumbent fiscal agent, Molina has developed or provided many BMS-Specific Reports that have been approved by the BMS. Molina will leverage these in-place reports to facilitate the approval process for the BMS-Specific Reports.

Molina will work with the State to complete all Development Task deliverables and attain all Development Task milestones on the approved work plan schedule.

5.5.2.3.1.2 Completion of Phase 1c [3.2.6.3.1.1(2)]

Completion of Phase 1c, Development, Testing, Data Conversion and Training, requires the BMS approval of all required phase deliverables and completion of all project plan tasks identified. Molina will develop and submit all required phase deliverables for the BMS review and approval. Once all deliverables have been approved by the Bureau, the Molina account

manager will work with the Bureau's project manager to obtain sign-off that the phase has been successfully completed. If all deliverables have been approved but there are still outstanding Development, Testing, Data Conversion and Training Phase tasks that have not been completed, Molina will wait until the tasks are complete before seeking phase completion approval.

5.5.2.3.1.3 Software/Hardware Configuration [3.2.6.3.1.1(3)]

Health PAS is designed to accommodate both current and future needs of the West Virginia Medicaid program. Features of Health PAS important in this aspect include:

- ***Health PAS is built on best-of-breed COTS products*** whose vendors continue to independently upgrade their products to support changes and innovation in the market place. These enhancements can be leveraged by simply upgrading to the new releases covered by the included maintenance fees, and avoids the risk associated with traditional in-house system development practiced by legacy MMIS contractors. For example, HIPAA X12 5010 and ICD-10 functionality will be implemented by respective COTS vendors, allowing Molina customers to take advantage of this new functionality going forward through a COTS product upgrade. During ongoing operations, the COTS approach reduces the high cost of change orders to meet regulatory mandates since Molina customers will only have to cover the labor costs of the COTS upgrade to implement the new functionality.
- ***Health PAS is a configurable, rules-based solution.*** Health PAS typically requires configuration of system parameters by domain knowledgeable business analysts to meet specific requirements, avoiding high-risk system development activities by more expensive programming resources. This also allows many new requirements to be quickly implemented through simple configuration changes.
- ***Health PAS is extensible.*** Health PAS is built with open systems architecture, allowing the integration of new COTS components to provide added functionality. Integration of a new COTS component can significantly reduce the need for system development.
- ***Health PAS is scalable.*** Health PAS is designed to allow the addition of hardware components in a scale up and scale out model to address evolving Medicaid program performance, throughput or volume requirements.
- ***Health PAS is designed to support technological currency using an evergreen model***. Health PAS provides continual modernization capabilities to support implementation of innovative technologies, allowing Health PAS to evolve as the healthcare market and technology evolve, thus allowing the Bureau to remain on the forefront of technology, functionality and performance.
- ***Health PAS is a multi-plan solution.*** Health PAS was built to provide multi-plan capabilities that can manage a variety of health care plans and benefit structures. This flexibility allows Health PAS to quickly adapt to changing program requirements. This capability also provides the Bureau with the opportunity to run multiple state plans under a single shared services model.
- ***The Health PAS relational database is easily extended.*** The Health PAS relational database is designed to allow new data elements to be easily added. New data elements can be defined and added to the database as attributes, and all attributes can be viewed online. This capability allows Health PAS to easily handle new data requirements as the Medicaid program evolves. Adding data elements to Health PAS does not require the massive "system recompiles" and master file expansions required by legacy applications, facilitating DDI activities to incorporate West Virginia-specific data elements.

These features of Health PAS allow Molina to support changes in the Program, changes in standards and transactions, and increased transaction volumes.

Pages 5-60 through 5-71 contain confidential and proprietary information and have been redacted.

- Assign (business) priority and severity to defects, discuss the expected turnaround time from the support teams
- Help prioritize defect fixes for Environment Build-out teams, Application Development teams and other teams involved
- Monitor and review the progress of defect fixes that are due or overdue as of current date
- Determine whether a defect is due to gap in business design, and to agree upon a reasonable turnaround time for delivering the fix/ enhancement
- Determine the extent of retesting required due to a fix/ enhancement
- Escalate defects/ issues to senior management when a quick resolution is required, or in case of a deadlock on resolution of defects/ issues

Use of modern testing tools and processes will facilitate the testing of Health PAS for the West Virginia environment.

5.5.2.3.2.1 Testing Task Deliverables and Milestones [3.2.6.3.2.1(1), 3.1.24]

The required Testing Task deliverables are defined in **Section D02**. Molina prepares and submits all required Testing Task deliverables and attains all task milestones.

Please note that Molina has added a Project Management task to its work plan which encompasses activities that impact all project phases. This includes project management and infrastructure services activities. Some of the common deliverables required by project phase, such as weekly and monthly status reports, have been included under the Project Management task. Otherwise, the Molina work plan aligns with RFP phase requirements.

Each deliverable will be submitted to the Bureau separately for review and approval. Once approved, each item will be placed under configuration management control and subsequent changes to each item will require the BMS and Molina management approval. Molina maintains a Revision History on all deliverables that indicates when a deliverable is updated, who made the update, and a summary of the changes that were made. This helps maintain an audit trail of deliverable changes over the life of the contract.

There are five required milestones for the testing task:

1. Completion and the BMS Approval of System Integration Testing
2. Completion and the BMS Approval of Regression Testing
3. Completion and the BMS Approval of Load/Stress Testing
4. Completion and the BMS Approval of User Acceptance Testing
5. Completion and the BMS Approval of Operational Readiness Testing.

Molina will work with the State to complete all testing task deliverables and attain all testing task milestones on the approved work plan schedule.

5.5.2.3.2.2 Completion of Testing Task [3.2.6.3.2.1(2)]

Completion of the testing task requires the BMS review and approval of all required task deliverables and completion of all project plan activities identified for the task. Molina will develop and submit all required deliverables, listed above in **Figure 5.5.2.3.2.1-1**, for the BMS review and approval. Once all deliverables have been approved by the Bureau, the Molina account manager will work with the Bureau's project manager to obtain sign-off that the testing task has been successfully completed. If all deliverables have been approved but there are still outstanding testing activities that have not been completed, Molina will wait until the activities are complete before seeking the BMS approval for testing task completion.

Pages 5-73 through 5-98 contain confidential and proprietary information and have been redacted.

During contract startup, the Molina Training Team will meet with designated BMS staff to obtain a clear picture of the current organization's culture and training practices. Training Team members will also attend requirements analysis meetings of the State and Molina with two objectives in mind:

- To become better acquainted with West Virginia business processes that use the current legacy MMIS. This will help them assess the gap between the old way and new way of doing things with Health PAS and will ensure Molina provides excellent end-to-end training on processes.
- To build relationships with key BMS staff (as designated by the BMS) whose input will be instrumental in helping Molina design effective learning experiences.

5.5.2.3.4.1 Training Task Deliverables and Milestones [3.2.6.3.4.1(1), 3.1.24]

The required Training Task deliverables are defined in **Section D02**. Molina prepares and submits all required Training Task deliverables and attains all task milestones.

Please note that Molina has added a Project Management task to its work plan which encompasses activities that impact all project phases. This includes project management and infrastructure services activities. Some of the common deliverables required by project phase, such as weekly and monthly status reports, have been included under the Project Management task. Otherwise, the Molina work plan aligns with RFP phase requirements.

Each deliverable will be submitted to the Bureau separately for review and approval. Once approved, each item will be placed under configuration management control and subsequent changes to each item will require BMS and Molina management approval. Molina maintains a Revision History on all deliverables that indicates when a deliverable is updated, who made the update, and a summary of the changes that were made. This helps maintain an audit trail of deliverable changes over the life of the contract.

There are three required milestones for the Training Task:

- Completion and the BMS Approval of Provider Training
- Completion and the BMS Approval of Pre-Implementation System User Training
- Completion and the BMS Approval of Phase 1c

As the incumbent fiscal agent with training staff already in place in Charleston, Molina is well positioned to conduct training activities and to attain all Training Task milestones. Additionally, Molina's provider relations staff are knowledgeable in the training needs of the West Virginia provider community and have established relationships within that community. Molina training staff will update existing training materials prior to conducting training. Molina central support training staff will assist in the process.

Molina will work with the State to complete all Training Task deliverables and attain all Training Task milestones on the approved work plan schedule.

5.5.2.3.4.2 Training Task Completion [3.2.6.3.4.1(2)]

Completion of the Training Task requires the BMS review and approval of all required task deliverables and completion of all project plan activities identified for the task. Molina will develop and submit all required deliverables, listed above in **Figure 5.5.2.3.4.1-1**, for the BMS review and approval. Once all deliverables have been approved by the Bureau, the Molina account manager will work with the Bureau's project manager to obtain sign-off that the Training Task has been successfully completed. If all deliverables have been approved but there are still

outstanding training activities that have not been completed, Molina will wait until the activities are complete before seeking the BMS approval for Training Task completion.

5.5.2.3.4.3 Training Plan Approach [3.2.6.3.4.1(3)]

Molina will initially use training plans covering their baseline train-the-trainer and will enhance them to include any newly developed state-specific training. Training personnel on site in Charleston will create, maintain, and update annual approved training plans for the West Virginia MMIS project. As the Molina Team becomes acquainted with each business group during the development of pre-implementation training, Molina will also make recommendations for the best process to train new hires and to deliver updated and remedial training designed for existing staff. This information will be included in the training plan and be subject to the BMS approval. The training plan will include the proposed curricula, both for online and facilitated sessions.

Molina's final training plans will:

- Provide an overview of the training methodology for a security/role-based MMIS environment and training objectives for the Health PAS users
- Identify the training courses and associated course objectives, including the format of training material to be developed
- Identify the training presentation style
- Identify the number of role based training sessions necessary to train the identified staff per designated levels
- Identify the number of users to be trained by type of training
- Identify the length of each training course
- Describe the online real-time training on electronic communications and claims and other documentation
- Define procedures for implementing and maintaining a training database
- Provide for evaluation of training sessions and feedback to the State
- Provide milestones for training.

Molina uses a variety of training venues to more effectively meet the requirements of the West Virginia Medicaid program. This includes instructor-led training, computer-based training (CBT) eLearning videos, webinars / live meetings, and other venues as appropriate. These multiple venues allow Molina to tailor training plans to provide the most effective training for specific audiences.

Assessment of Training Needs

As the incumbent fiscal agent, Molina has in place training staff in Charleston that have been working with the Bureau for many years in understanding West Virginia training needs and in developing and delivering training that meets those needs. The Molina training team will work with the BMS to define and agree upon the West Virginia learning objectives. Molina will then establish the baseline curriculum to accomplish the learning objectives, and the Molina training team will tailor Health PAS training material in the form of participant user guides, PowerPoint presentations, self-paced Web-based video modules, live web-based collaborative LiveMeeting events, online tests and evaluation forms, and other web-based links to related reference materials. Materials will be developed to be consistent, whether training is classroom-based or web-based. COTs user guides will be made available as applicable. The Molina training team will develop appropriate training plans, training e-documentation and training materials.

User Training

Molina understands how crucial it is to enable the BMS staff and Molina's designated business partners to be trained in using Health PAS. Molina's approach to training the BMS staff will parallel the approach to training Molina staff. Molina's corporate Training Manager will work with trainers in the Charleston office to confirm that the BMS and Molina staff are properly trained. Molina realizes that a successful implementation hinges on the ability of staff to navigate the new system and view and interpret the appropriate modules and subsequent windows. Molina Training Team will provide training to State personnel who have varying computer skills and who perform different functions in their organizations. Molina will use various training venues, including classroom style of instruction with job aids for each MMIS job function. Since the BMS users are already familiar with Health PAS, training will be facilitated and the learning curves on the new system capabilities should be minimal.

Training for the BMS staff will be developed with the ISD methodology described earlier and be subject to the BMS approval at every step, including the training material, plans, and user guides. Instruction will be tailored to the needs of each business unit and organized by function and role, will align with MITA business areas and will include training on applicable Health PAS components. The decision to use instructor-led or online training as the delivery method of choice will be made with the BMS input, taking into account the specific and approved learning objectives, as well as business unit characteristics (such as number of staff and location). The length of training will vary depending on the subject matter—for example, instructing staff on how to access the Call Tracking system to log a call may be shorter than a class on Benefit Administration, which involves creating benefit plans and using the Health PAS rules engine to set a hierarchy of client enrollment. Whatever the topic, Molina Training Team will provide and execute a plan around specific and approved learning outcomes and deliver training in the most practical format for participants, supporting it with the necessary training material, including online Help windows and step by step user documentation.

Molina offers the Learning Management System (LMS) repository for eLearning videos that can be used by Bureau personnel, Molina staff, and providers. Specific training is available targeted for providers, Bureau staff, and Molina Fiscal Intermediary staff. Links to the training are provided through Health PAS-OnLine (providers) and through Health PAS-InterComm (Bureau and Molina personnel). Training comprises interactive videos and/or PowerPoint presentations, with courses targeted toward specific audiences. For example, a new provider can go to Health PAS-OnLine and take a general course on provider enrollment. Once enrolled, providers can use their secure login to Health PAS-OnLine and will be able to access additional training regarding features available to them. Once a course is completed, users will be asked to complete an evaluation form indicating the effectiveness of the training. Providers, the BMS personnel, and Molina personnel can access the LMS to see a list of available courses and a list of courses successfully completed.

Molina has more than 30 years of experience in implementing systems for contracts in several States. This experience has honed Molina's ability to prepare users to quickly and effectively access data found in new systems.

Scheduling training for staff in multiple departments will obviously require many training sessions. Functional workgroups will be defined and schedules will be developed in collaboration with the State, taking into account staff workloads and system readiness issues.

Depending on the number of individuals in a business unit and the complexity of the curriculum, sessions may be held on site at a Molina training facility, at local venues, or even at the team's workplace, when possible and approved by the State. State staff training will be role based, structured to support the system security levels for MMIS business processes.

Molina's proven instructional design approach, in combination with the Learning Management System (LMS) solution and Health PAS-InterComm information collaboration technology, will allow the Molina Training Team to deliver effective system training. Molina recommends a State staff be present during instructor-led courses to answer State business questions. In coordination with the BMS, Molina will create a complete learning experience that enables staff to be comfortable with Health PAS and ready to make the transition by implementation.

As a supplement to training, one of the outstanding features of Molina's solution is that Health PAS-Administrator incorporates context sensitive online Help and documentation for every aspect of the system. Online Help will contain detailed descriptions and step-by-step procedures of system features. Online Help can be accessed by simply clicking on the question mark that appears on each window. The Help function will comprise three components: contents, index, and search. The contents tab will contain folders defining major tasks that can be performed in the selected module. To locate information pertaining to a specific function or question, users will double click on that folder.

The Help function for windows in Health PAS Administrator can also be immediately accessed from that window by clicking on the Help button. If users are at a Benefits window, the Help button automatically takes them to the Help function for Benefits. The intuitive, easy-to-use Help function will provide ready assistance to systems users.

Because Health PAS Administrator is a configurable solution, much of the content of the Help function is customizable by the BMS. For example, a State policy can be loaded in the system where it can be easily accessed using the Help function to assist claims examiners in resolving a suspense issue with a claim. Using this feature, online assistance is readily available.

Provider Training

At the provider service level, Molina will furnish an array of services supporting providers. From field representatives and trainers, to telephone support staff and the Health PAS-OnLine web portal, providers will have access to web-based technology and subject matter expertise that they require to quickly and efficiently process Medicaid transactions through the Health PAS-OnLine web portal.

Molina realizes that provider training needs vary widely, depending on specialty, location, and whether they are veterans or new to Medicaid. Using the Health PAS-OnLine portal, Molina will promote one web portal to address provider needs. To gain a realistic understanding of the learning gaps to be addressed, Molina will rely on the input of people who are in regular contact with the West Virginia provider population. Molina's field representatives will work closely with State staff to understand and define training needs in their region. One way that Molina will accomplish this is by conducting focus groups with physician practices and provider associations, which will provide valuable insight into the problems and/or topics that may be of interest to providers.

Molina will also recommend the formation of a Training Oversight Council comprising representatives of the State Medicaid program office, the Molina Provider Services Group, and Molina Training Team staff. This council will define the goals and criteria for the annual provider training plan that will guide the Molina Training Team in developing the details of the plan—including the provider types to be trained, topics, methods, schedule, and evaluation methods. The plan will be reviewed and approved by the council and then forwarded to the BMS for formal approval. The approval process will entail a review by the state of the written and visual products, including a critique of the dry run presentation of the proposed materials.

Deployment will begin with train-the-trainer sessions for Molina provider field staff, who will instruct providers on changes in policies, procedures, and system enhancements. During these

sessions, the boundary between the topics and questions that field staff and area office staff are best qualified to address will be clearly defined, so that providers consistently receive accurate information on matters such as Medicaid policy and eligibility. As regional training events are planned and scheduled, they will be announced through a variety of methods, including newsletters, remittance banner page messages, web portal event calendars, and postal mail. From the preparatory phase to actual live training, the Molina Training Team will be available to support field staff by logistically coordinating scheduling, registration, facilities, and other activities. Upon completion of training, the council will evaluate the training session's effectiveness by reviewing evaluations completed by participants and staff. This feedback information will become input for the following year's training plan.

Health PAS-OnLine Internet Portal

A key feature for providers under the new contract will be implementation of the Health PAS-OnLine Internet portal for provider access, enrollment, training, claims submission, eligibility verification, claims status, electronic remittance advices, and distribution of provider communication like bulletins and advisories. This centralized web portal will be accessible with secure access mechanisms, such as restricted login IDs and passwords provided to the appropriately authorized providers.

Initial Training

Initial training for providers will be a fluid, ongoing process because training is optional for them. Although Molina will be taking the initiative to schedule facilitated workshops along with providing online training, Molina expects that providers will initiate a portion of training. Molina will respond to the individual requests received through the provider support line and field representatives in a timeframe approved by the BMS, using a variety of resources to expedite information transfer. Resources such as email, eFax, e-newsletters, and telephone calls and formal correspondence will be used to educate and share vital provider updates with providers.

As the incumbent fiscal agent, Molina has in place provider relations staff who have developed positive relationships with the West Virginia provider community. Molina's in place training staff and working relationships with the provider community will facilitate the provider training effort.

Understanding the criticality of provider readiness to adopt the Health PAS-OnLine Internet portal as a primary tool for electronic transactions, Molina will address initial training for providers who are ready by providing explicit online instructions defining the process to register as a new trading partner before implementation. Providers will receive formal notification that the Health PAS-OnLine Internet portal is available, along with instructions on what they must do to become connected and how to access training on line.

Online provider training will cover the changes associated with the use of the new Health PAS-OnLine provider portal, including new e-processes for provider payment and adjustments, explanation of remittance vouchers, and web-based inquiry on payment status.

Providers can call provider support at their convenience for individual guidance, or request an onsite visit from a field representative to help address their issues. Molina will remind providers that there is an FAQ link at the portal designed to answer frequently asked questions that Molina regularly updates as new issues and questions arise.

Ongoing Support

Ongoing provider support will be available as soon as telephone support is operational and providers begin receiving visits from field representatives. Providers will have access to help on matters that include using the Health PAS-OnLine provider portal. Based on input gathered from field representatives, providers, and the BMS, topics will be forwarded to the Training Oversight Council, which will determine the direction of training. Topics will include the use of the Health

PAS-OnLine Internet portal and the transition to using the NPI number. Area provider seminars will then be scheduled and submitted to the State for approval.

Professional training material, both web-based and facilitated, will be designed following the ISD process, with the BMS input at various stages of development. Upon completion, this material will be submitted for approval; the BMS will be provided with both hardcopy and electronic versions of the final products. Materials will include a formal PowerPoint presentation and a Health PAS-OnLine Internet portal demonstration, complete with hardcopies of step by step windows and flowcharts captured for distribution to participants. Molina will upload online versions of the seminar to a special archival document library whose link will be available through the Health PAS-OnLine portal. These presentation and training materials will be provided to area Medicaid staff who deliver training seminars, and will also be used by field representatives when they are required to conduct training sessions with providers. As policy, system, or procedural changes dictate, training materials will be updated and submitted to the BMS for approval.

Field representatives responsible for training and assisting providers with claims and other Medicaid issues will be assigned to locations designated by the BMS. Molina agrees that the BMS must approve changes to that assignment. In preparation for their new role and on an ongoing basis, field representatives will attend Medicaid headquarters in-service training and participate in Statewide meetings with Medicaid headquarters and area staff to determine the subjects on which providers must be trained and the types of training materials that must be developed. This information will be relayed to the Molina Training Team to update or develop new material as required.

Field representatives will be available to:

- Present training seminars to providers together with the area Medicaid staff, as requested
- Provide special training on policy changes affecting specific providers before implementation of new policies and services
- Offer training to new providers and billing clerks who will be submitting claims for the new provider
- Conduct onsite visits to providers for assistance with the resolution of claims.

Field representatives may also initiate onsite visits to providers whom Provider Services has identified as possibly benefiting from extra coaching because of billing error frequency or other claims-related problems. Equipped with a laptop computer with access to the Health PAS-OnLine Internet portal, field staff can assist a provider on site with individual training and the claims resolution process. The laptop will enable the representative to query the MMIS while in the provider's office, providing the detailed assistance necessary to avoid the problem in the future. Backup support will be available to assist field representatives in researching issues that cannot be resolved in the field. After the visit, the representative will document the encounter with a BMS approved Provider Field Visit Report covering the details of the encounter, including specific training issues that were addressed.

Field representative contacts with providers, both field visits and seminars, will be tracked and reported. Both data and statistics describing those encounters, as well as participation by providers in online learning sessions, will be available for viewing by the BMS staff.

Molina values the experience of staff who experience daily face-to-face contact with providers. The wisdom gleaned in scheduled field staff meetings, Provider Field Visit reports and ad hoc verbal reports will be conveyed in lessons learned sessions to onsite Provider Services staff as part of ongoing training. The training format will depend on the type of information to be shared. Field representatives may present information individually in a brief session or as a part of a

broader training event. This dynamic exchange will broaden Provider Services' understanding of the West Virginia provider environment and daily activities, thereby further enhancing the quality of services offered to callers.

New Provider Training

As new enrollments are processed, providers will be sent a packet containing such items as a provider guide, a forms billing guide, and information on how to submit claims electronically. The notice will include instructions on accessing an online tutorial designed specifically for the new provider, and a reminder that a field representative is available to assist the provider personally if needed. New provider training, whether it takes place on line, at a seminar, or during office visits, will be tracked in LMS, and reports will be available for viewing.

Molina has a long and successful record working with many State Medicaid providers. Molina will leverage this experience in the phases of the West Virginia MMIS project, being responsive to provider needs through the web-based Health PAS system and through the unique human resource of field representatives at Provider Services headquarters.

Ongoing Training

Molina will maintain a staff of trainers onsite in Charleston that will be responsible for meeting the training needs of the program during ongoing operations. Ongoing provider training support will be provided through the Health PAS-OnLine portal and by Molina provider field representatives. Molina will maintain the staff required to effectively meet all training requirements for the term of the contract.

Online Tutorials

Molina offers the Learning Management System (LMS) online training tool that can be used by Bureau personnel, Molina staff, and providers. Specific training is available targeted for providers, Bureau staff, and Molina staff. Links to the training are provided through Health PAS-OnLine (providers) and through Health PAS-InterComm (Bureau and Molina personnel). Training comprises interactive videos and/or PowerPoint presentations, with courses targeted toward specific audiences. For example, a new provider can go to Health PAS-OnLine and take a general course on provider enrollment. Once enrolled, providers can use their secure login to Health PAS-OnLine and will be able to access training. Once a course is completed, users will be asked to complete an evaluation form indicating the effectiveness of the training. Providers, the BMS personnel, and Molina personnel can access the LMS to see a list of available courses and a list of courses successfully completed.

LMS provides a repository of training information. For training through LMS the following information may be tracked:

- Name , address, telephone number, e-mail address, organization and role in organization
- Date and location of training
- Training component attended
- Training completed results

Molina will work with the State to provide online tutorials that best meet the needs of State users. Tutorials may cover topics such as the following:

- Mass adjustment processing
- Financial transaction processing
- PA
- Benefit packages
- Edits and audits
- Rules-based engine
- Reporting
- Web portal application
- Drug rebate processing.

Molina training personnel will be able to generate reports from the LMS. This will allow authorized training personnel to see who took what courses, how they did on the courses, and to review course evaluation feedback. LMS provides an always available training tool to facilitate training of West Virginia Medicaid constituents.

Molina will continuously provide MMIS staff access to course and course information online through LMS or through the Health PAS-InterComm portal. Through Health PAS-InterComm's customized document libraries, the BMS may access project artifacts, including user guides, user manuals, instruction sheets, and related resource materials, as well a project data/documentation, program reference information, work plans, news, reports, and workflows. InterComm will enable the BMS to interact electronically 24x7 with Molina project staff in a secure environment.

As is practical, in addition to classroom and self-paced online instruction, Molina will use web conferencing as a group virtual training medium to develop the proficiency of the BMS staff in the use of Health PAS. Molina has found LiveMeeting to be useful in promoting professional development opportunities that are continuously available to virtual groups of personnel.

Molina will provide an online eLearning tutorial capability for the major functions in the MMIS system. The tutorial will provide basic data and allow users to enter or modify information to simulate actual use of the system. The tutorial will be used for training and made part of the final MMIS system, so that new users accessing MMIS will have an online tutorial to assist in learning the system's functionality. The eLearning tutorials are available 24X7.

Provider Online Training

Molina will provide Web seminar and video-based training for providers. As noted earlier, Molina offers the Learning Management System (LMS) online training tool that can be used by Bureau personnel, Molina staff, and providers. Specific training is available targeted for providers, Bureau staff, and Molina staff. Links to the training are provided through Health PAS-OnLine (providers) and through Health PAS-InterComm (Bureau and Molina personnel). Training comprises interactive videos and/or PowerPoint presentations, with courses targeted toward specific audiences. For example, a new provider can go to Health PAS-OnLine and take a general course on provider enrollment. Once enrolled, providers can use their secure login to Health PAS-OnLine and will be able to access training. Once a course is completed, users will be asked to complete an evaluation form indicating the effectiveness of the training. Providers, the BMS personnel, and Molina personnel can access the LMS to see a list of available courses and a list of courses successfully completed.

Version Control

All training documentation will go through a Bureau review and approval process. Once approved, documentation is place under configuration management control so that subsequent updates to the documentation requires appropriate levels of the BMS and Molina management approval. Molina maintains a Revision History on all deliverables that indicates when a deliverable is updated, who made the update, and a summary of the changes that were made. This helps maintain an audit trail of deliverable changes over the life of the contract.

Molina's ISD methodology works in tandem with the system development team process that produces business process models. These models are used in developing training labs emphasizing task-based, hands-on simulated scenarios. They provide the basis for both classroom and online instructional formats. Once the curriculum is defined and approved by the BMS, the Molina Training Team has a baseline set of training material in the form of participant user guides, PowerPoint presentations, self-paced eLearning video modules, live web-based collaborative LiveMeeting events, online tests and evaluation forms, and web-based links to

related reference materials for the components of Health PAS and will work with the State to enhance this to include State specific topics. The Molina Training Team will develop and update training e-documentation, manuals, materials, training guides, and course curricula (including training objectives and outcomes). The materials, once approved, are placed under configuration management control; subsequent updates to training materials must go through a formal review and approval process before in can replace the earlier version.

Training Evaluation

The Molina Training Plan will specify expected performance and outcomes of each type of training. Once a training event is completed, a key component of the overall training effort is to ask participants to share their opinions on aspects of their training experience. The Molina Training Team provides an evaluation survey for most training events to determine if the training was effective and produced the expected results. The evaluation will ask participants to rate such things as:

- Content (relevance and level of detail)
- For seminars, the instructor's effectiveness (clear explanations, responsiveness to questions, and credibility)
- Format and delivery method (exercises and supporting materials)
- Facility logistics (comfort, registration process, etc.)
- Suggestions for improvement, future topics, or both.

The State may use these same evaluation forms during regional provider training if they choose to do so. Feedback from evaluations will be used to produce reports for review by both the BMS and Molina Training Team. Finally, in accordance with participant and instructor evaluations, as well as feedback from other sources as approved by the State, the training curriculum and materials will be revised to include the requested changes. This revised training will then be available for use with new hires and in refresher courses for existing staff.

Depending on the training, tests may be administered during the training session to ascertain the level of comprehension of the trainees. These tests will provide another mechanism to judge the effectiveness of the training and identify areas of weakness where the training must be strengthened.

Training Results Reporting

As part of the training process, Molina's onsite Training Team will prepare training reports that document training results. Information such as the number of training sessions, the types and locations of training, and the number of people being trained is included in the report. Additionally, Molina will conduct an evaluation after most training events, providing trainees with the opportunity to provide feedback on the effectiveness of the training and training content. The results of the training evaluations will be compiled and then summarized in the Training Report. The evaluation feedback will provide a valuable mechanism to identify areas of strength and areas of concern, allowing Molina to adjust training when required to better meet the needs of West Virginia Medicaid constituents. Molina's training staff may include recommendations for follow up training if they believe that it is required.

5.5.2.4 Phase 1d, Implementation Readiness [3.2.6.4, 3.2.6.4.1]

Implementation is the culmination of the DDI Phase and results in the transition to a production operations mode for the new Health PAS Replacement MMIS. Molina can leverage the lessons learned from two recent implementations to facilitate DDI activities for West Virginia.

During the Implementation Phase, Molina will complete all activities required to implement the Health PAS Replacement MMIS and assume all functions required for Operations. Molina activities include, but are not limited to:

- Conversion of the existing MMIS data to the Replacement MMIS – the Molina conversion team will perform the final file conversions from the Legacy MMIS to the Replacement MMIS. Bureau approval of conversion results from the UAT Task will be the predecessor for beginning final file conversions.
- Contingency planning – Molina develops and submits the Contingency Plan for Bureau review and approval. The Contingency Plan establishes procedures to follow should any of the components of Health PAS not perform as expected once implemented. The Contingency Plan will also address the worst case scenario of not being able to pay providers and how providers can be paid on an interim basis until the identified issues are corrected.
- Implementing the Health PAS Replacement MMIS and operational procedures – With Bureau approval, Molina will implement the Health PAS Replacement MMIS. Processing all claim types will be implemented simultaneously unless otherwise agreed to by the Bureau.

During the MMIS Implementation Phase, the primary Molina objective will be to perform all activities necessary to transition into production operations. Molina will also re-enroll all existing providers. Molina will implement the capabilities of Health PAS-Administrator, Health PAS-Document Manager, Health PAS-Process Manager and Health PAS-OnLine early in order to facilitate the provider enrollment process.

5.5.2.4.1 Implementation Readiness Deliverables and Milestones [3.2.6.4.1(1), 3.1.24]

The required Implementation Readiness Phase deliverables are defined in **Section D02**. Molina prepares and submits all required Implementation Readiness Phase deliverables and attains all task milestones.

Please note that Molina has added a Project Management task to its work plan which encompasses activities that impact all project phases. This includes project management and infrastructure services activities. Some of the common deliverables required by project phase, such as weekly and monthly status reports, have been included under the Project Management task. Otherwise, the Molina work plan aligns with RFP phase requirements.

Each deliverable will be submitted to the Bureau separately for review and approval. Once approved, each item will be placed under configuration management control and subsequent changes to each item will require the BMS and Molina management approval. Molina maintains a Revision History on all deliverables that indicates when a deliverable is updated, who made the update, and a summary of the changes that were made. This helps maintain an audit trail of deliverable changes over the life of the contract.

There are two required milestones for the Implementation Readiness Phase:

- Completion and the BMS Approval of Provider Re-enrollment – As the incumbent fiscal agent, Molina is well positioned to accomplish the provider re-enrollment task. Molina has an in-place provider services group as well as in-place provider enrollment processes that can be leveraged to facilitate completion of this task.
- Completion and the BMS Approval of Phase 1d – This is the official end of the Implementation Readiness Phase with the BMS formal approval of phase completion.

Molina will work with the State to complete all Implementation Readiness deliverables and attain all Implementation Readiness milestones on the approved work plan schedule.

5.5.2.4.2 Completion of Phase 1d, Implementation Readiness [3.2.6.4.1(2)]

Completion of the Implementation Readiness Phase requires the BMS review and approval of all required phase deliverables and completion of all project plan tasks identified for the phase. Molina will develop and submit all required deliverables, listed above in **Figure 5.5.2.4.1-1**, for the BMS review and approval. Once all deliverables have been approved by the Bureau, the Molina account manager will work with the Bureau's project manager to obtain sign-off that the Implementation Readiness Phase has been successfully completed. If all deliverables have been approved but there are still outstanding tasks that have not been completed, Molina will wait until the tasks are complete before seeking the BMS approval for Implementation Readiness Phase completion.

Additionally, the BMS is requiring the re-enrollment of all West Virginia providers. As the incumbent fiscal agent, Molina has successfully administered the provider enrollment administration functions for West Virginia, performing all facets of provider enrollment. Molina has developed material, verified certification, enrolled, re-enrolled, and disenrolled providers according to the BMS rules and procedures. With its knowledgeable provider relations staff and the functionality of Health PAS, Molina will fully enroll and activate providers for the West Virginia Replacement MMIS. Molina will use Health PAS-Administrator, Health PAS-OnLine, Health PAS-Document Manager and Health PAS-Process Manager to support the provider re-enrollment function:

- **Health PAS-OnLine** will allow providers to obtain relevant enrollment information and forms, or enter enrollment applications/information online through the web
- **Health PAS-Process Manager** will be used to manage provider enrollment workflow tracking and routing for both manual on online entered applications
- **Health PAS-Document Manager** will be used to capture electronic images of paper application forms/information received from providers
- **Health PAS-Administrator** is used to enter relevant provider information to the Health PAS unified relational database

Provider re-enrollment incorporates the file maintenance activities involved in establishing the rules and classifications for enrollment of Medicaid providers.

Once all required Implementation Readiness deliverables have been approved by the BMS, and the provider enrollment task has been completed and approved by the BMS, the project is positioned for the BMS approval of the completion of Phase 1d – Implementation Readiness Phase.

5.5.2.4.3 Implementation Plan Development and Deployment [3.2.6.4.1(3)]

Molina will confirm that the new Health PAS system is ready to be implemented and the BMS approvals have been obtained to begin operations of the new replacement MMIS. The West Virginia Project Manager will be responsible for producing a certification letter to the State indicating that functional, system, and infrastructure components of Health PAS are ready to support the West Virginia Medicaid program. Molina will then seek written approval from the BMS to implement Health PAS and begin production operations. In the Implementation Plan, written approval from the State will be a precondition to execution of the Implementation Plan.

To be ready for implementation, Molina's staff and Health PAS must satisfy the functional and technological requirements specified in the RFP and documented during the requirements analysis and systems design activities. Through the use of automated tools, such as Rational RequisitePro, Molina will be able to track requirements from initial capture through implementation, providing complete requirements traceability.

Pages 5-110 through 5-112 contain confidential and proprietary information and have been redacted.

Satisfying West Virginia Requirements

Molina will demonstrate that the new Health PAS replacement MMIS satisfies requirements specified in the RFP (including all Appendices) and all requirements documented during the requirements analysis and systems design activities. Beginning with the preparation of the Molina proposal response to the West Virginia RFP, Molina has captured West Virginia requirements in IBM Rational RequisitePro. This includes the West Virginia requirements included in the RFP appendices. Molina uses RequisitePro to capture and track all requirements. RequisitePro provides the central repository of requirements and is used to manage the generation and maintenance of requirements and the traceability matrix to allow developers, engineers, and users to easily write, communicate, and change necessary information throughout the project's lifecycle. The RequisitePro automated tool helps keep project work products, such as design documents, project plans, and test plans, in step with project requirements. This information is integral to designing and developing applications that meet the requirements from the end-user's perspective.

Molina DDI staff are responsible for tracing requirements through all related requirements analysis, design, development, and test artifacts. Molina will maintain requirements traceability between the technical design documents and their business requirements and their related requirements analysis documents in Rational RequisitePro and associated Rational tools, such as ClearCase, ClearQuest and TestManager. Molina archives these artifacts in a Sharepoint portal setting that provides easy access to and traceability of various Microsoft Word documents, Microsoft Excel, business process models, design models, and test case documents in an organized and easily navigable environment. Requirements are traced through inception, design, development, and testing. Use of an integrated requirements capture and tracking process allows Molina to verify that all requirements have been met. The BMS will have access to this requirements traceability information throughout the DDI Phase.

Integrated Test Environment

Molina will establish multiple environments for development, testing and training purposes. These environments were discussed earlier in **Section 5.5.2.3.2.5** and illustrated in **Figure 5.5.2.3.2.5-1**. This included the Integrated Test Environment.

System Access

The BMS users will be able to access the new West Virginia Health PAS MMIS according to the established system accessibility and performance requirements. The BMS users currently access Health PAS according to the security settings and role definitions established for each individual. These settings will be carried over to the new system and modified, if needed, based on the BMS requirements.

Health PAS is scalable, designed to allow the addition of hardware components to address performance, throughput, or volume requirements. As the needs of the West Virginia Medicaid program evolve, the solution can evolve. Additionally, Health PAS is extensible, built using open systems architecture, allowing new COTS components providing added functionality to be easily integrated with the solution. These features allow Health PAS to be architected to meet the performance requirements specified in the West Virginia system design specification document.

Performance issues may be identified in volume/stress testing, using automated testing tools. Molina's technicians will address any performance problems encountered and will bring the performance in line to defined standards. Performance tuning will be planned and completed using tier-by-tier and end to end methodologies. Molina's technical staff will monitor system performance on an ongoing basis and may make changes to system settings to improve performance. These changes will be transparent to the State and allow Molina to maintain

required performance levels. Molina will document its performance tuning approach in a performance tuning document.

Transparent Cutover

Molina will make certain the cutover to the new Health PAS MMIS is transparent as possible to the member and provider communities. Molina is uniquely positioned to support a transparent cutover in moving to the Health PAS replacement system. Use of the same base system will facilitate the cutover process and avoid West Virginia Medicaid constituents having to learn an entirely new system with entirely different ways of accomplishing tasks. This will reduce the overall implementation risk.

System Walkthroughs

Molina will conduct system walkthroughs and system demonstrations for the BMS and designated staff. Beginning during the Start Up Phase, Molina conducts project boot camps with the BMS to provide demonstrations of the Health PAS solution. During the RCS workshops Molina also demonstrates how the Health PAS solution meets specific West Virginia requirements. Additionally, Molina plans to conduct walkthroughs of all required deliverables as part of the deliverable submission process. From a system functionality perspective, walkthroughs will actually be reviewing Health PAS performing the task with the Bureau being able to see and respond to the actual system, not just paper documentation.

Implementation Certification Letter

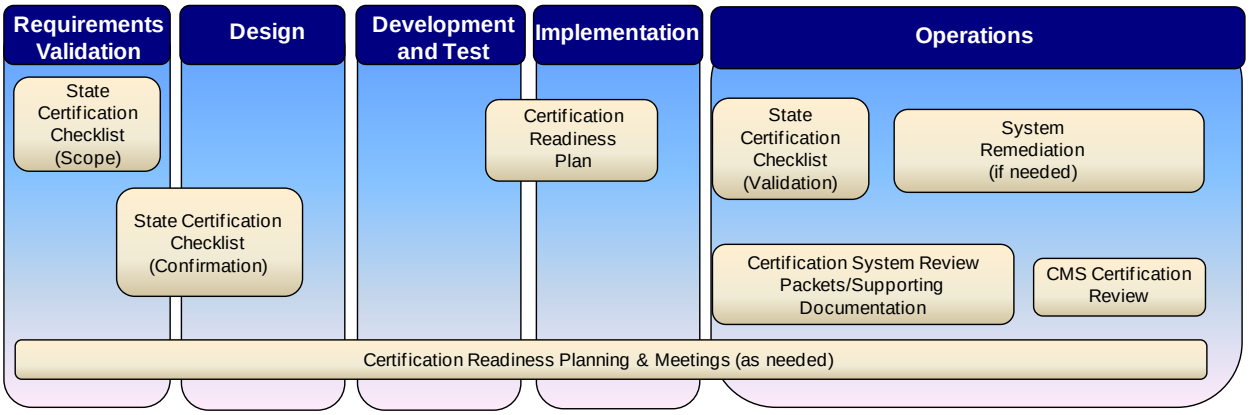
Molina's West Virginia Project Manager will be responsible for producing a certification letter to the State indicating that functional, system, and infrastructure components of Health PAS are ready to support the West Virginia Medicaid program. Molina will then seek written approval from the BMS to implement Health PAS and begin production operations. Written approval from the State will be a precondition to execution of the Implementation Plan.

To execute the detailed Implementation Plan, Molina will first certify to the State that Health PAS is ready for production. Molina's West Virginia Project Manager will be responsible for producing a certification letter to the State, indicating that the functional, system, and infrastructure components of the overall solution are ready to support the West Virginia Medicaid program. The letter will certify the following items:

- **Required training activities have been completed**—Molina's training staff will have completed the required training for both State and Molina personnel.
- **Staff have completed necessary nontechnical training**—Molina's training personnel will have completed the functional training of its staff and of State staff as necessary.
- **Required legacy data has been converted, cleansed and accepted**—Data conversion and cleansing processes will have been tested and approved by the State, and the data conversion team will have converted required legacy data.
- **Site preparation requirements have been met**—Molina facilities personnel will have completed the upgrade of the onsite facility in Charleston; equipment and communications will be in place; and Molina will be operationally ready.
- **The Help Desk is established and ready for operations**—The Help Desk function will be set up, with staff trained and ready to support the West Virginia user community.
- **User and system supports are in place**—User and system support functions will be established, Help files and/or Help processes set up, and support functions ready for operations.
- **Production processes have been through the change control process and locked down in production libraries**—The production processes will be in place and ready for execution.

Pages 5-115 through 5-119 contain confidential and proprietary information and have been redacted.

Figure 5.5.2.5-1: Certification Activities



Molina conducts all Certification Readiness and Certification Review activities necessary in support of the Bureau to attain CMS Certification.

As illustrated in this Figure, the key certification activities Molina will conduct include:

- **Certification Readiness Planning and Meetings** – Molina conducts internal meetings as well as joint meetings with the Bureau and CMS as needed beginning early in the DDI Phase and continuing through to completion of CMS Certification Review activities. The Molina Certification Manager will be the Molina lead in meetings and planning sessions.
- **Certification Scope Checklists** – Molina develops a complete set of Certification Checklists with all applicable Federal and State-specific system review criteria in place for each business objective. Molina will conduct a review of the CMS Certification Checklist to determine the certification system review criteria that are applicable and those that are non-applicable for the West Virginia Certification effort. This will also include the addition of any West Virginia specific system review criteria. Applicable system review criteria will be supported by approved MMIS requirements.
- **Certification Confirmation Checklists** – Molina develops a complete set of Certification Checklists showing all criteria which demonstrate that Federal and State requirements have been satisfied by system and operational features. This process results in a certification RTM.
- **Certification Readiness Plan** – Molina develops a detailed Certification Readiness Plan for Bureau review and approval. This plan is delivered to the Bureau at least nine (9) months prior to the go-live date for the Health PAS MMIS.
- **Certification Validation Checklists** – Molina develops a complete set of Certification Checklists showing validation of data collection that demonstrates that each applicable criterion has been met. This set of completed checklists will be reviewed by the Regional Office and ready for official submission to CMS prior to their site visit.
- **Certification System Review and Preparation of Packets/Supporting Documentation** – Molina prepares all Certification Review materials to be utilized by the State during their CMS Certification review. This will include all profile narratives, system review packets and supporting documentation (i.e. reports, operations documentation, systems documentation, etc.). This also includes preparation of the State review team for the presentation of all required Certification Review materials and system and operations including a simulated demonstration. Molina will work in close partnership with the Bureau to ensure the Health PAS MMIS meets all applicable federal and state requirements for a CMS certified MMIS. This will require the development of a final West Virginia specific MMIS Certification

Checklist that encompasses all applicable CMS and West Virginia specific Certification Checklist system review criteria. Once the final MMIS Certification Checklist has been validated by the CMS Regional Office, the Certification Profiles, Review Packets and Supporting Documentation are developed and prepared for the presentation to the CMS Certification Review Team.

- **CMS Certification Review** – This is the actual onsite review of the West Virginia Health PAS MMIS by CMS, encompassing all of the materials prepared for presentation to CMS as well as any required system demonstration activities.
- **System Remediation** – If CMS or the Bureau identifies any items that are not up to certification standards, Molina will conduct system remediation activities to bring the system in line with certification requirements. System remediation is only performed if needed due to an identified deficiency.

If issues arise, Molina onsite and remote support staff will quickly respond to resolve the issues and complete the review process. Molina has a 100-percent success rate with current clients in attaining MMIS certification and will continue its record of performance with West Virginia.

Molina will verify that the components of the certification review process under its control will meet Federal certification requirements. During certification, recertification, or other review process, Molina will support the Bureau by making the required information or resources available to confirm that the requirements are met.

Molina begins certification planning activities in the early stages of the DDI Phase, developing the certification schedule using the MECT as a guide for activities incorporated in the schedule. Molina will create a schedule for MMIS certification activities and submit the schedule for Bureau approval. The certification schedule will identify the activities for developing West Virginia-specific Certification Checklists as well as the Certification Readiness Plan. Molina will work with the Bureau as needed to identify all of the certification system review criteria.

5.5.2.5.1 CMS Certification Planning Deliverables and Milestones [3.2.6.5.1(1), 3.1.24]

The BMS will approve the content and format of all deliverables at the outset of the Certification Phase, and the BMS may reject any deliverable that is not in the proper format or that does not appear to completely address the function of the deliverable requirement. Molina works closely with the BMS to ensure all Certification Planning Phase deliverables meet West Virginia requirements. All Certification Planning deliverables and milestones will be included in the Certification project schedule and made part of the DDI work plan.

The required Certification Planning Phase deliverables are defined in **Section D02**. Molina prepares and submits all required Certification Planning Phase deliverables and attains all task milestones.

Please note that Molina has added a Project Management task to its work plan which encompasses activities that impact all project phases. This includes project management and infrastructure services activities. Some of the common deliverables required by project phase, such as weekly and monthly status reports, have been included under the Project Management task. Otherwise, the Molina work plan aligns with RFP phase requirements.

There is only one required milestone for the Certification Planning Phase - Completion and the BMS Approval of Phase 1e. This is the official end of the Certification Planning Phase with the BMS formal approval of phase completion.

Molina will work with the State to complete all Certification Planning deliverables and attain all Certification Planning milestones on the approved work plan schedule.

5.5.2.5.2 Completion of Phase 1e, CMS Certification Planning [3.2.6.5.1(2)]

Molina will work closely with the BMS in providing all required Certification Planning deliverables and attaining the BMS approval for the completion of the Certification Planning Phase. Molina will submit the required Certification Readiness Plan deliverable for the BMS review and approval, and will provide appropriate weekly and monthly project status reports to make certain both the BMS and Molina management are aware of the status and health of the Replacement MMIS project. Molina structures its RCS workshops and DDI approach based on MITA business areas, facilitating alignment with CMS Certification Requirements as listed in RFP Appendix D. Molina configures and implements Health PAS based on a framework that adheres to MITA, CMS, ONC, federal and state requirements. This compliant Health PAS framework ensures the Replacement MMIS meets the BMS business needs by applying a testing methodology that encompasses the MITA business area, CMS Checklist and all West Virginia requirements.

Acceptance criteria for completion of the Certification Planning Phase will include:

- The BMS approval of the Certification Readiness Plan
- The BMS approval of the weekly status reporting
- The BMS approval of the monthly status reporting.

The BMS approval of these three deliverables will signify Molina has provided all required deliverables for the Certification Planning Phase and the phase can now be completed.

5.5.2.5.3 Certification Planning Methodologies [3.2.6.5.1(3)]

Molina begins certification planning activities in the early stages of the DDI Phase, developing the certification schedule using the MECT as a guide for activities incorporated in the schedule. Molina will create a schedule for MMIS certification activities and submit the schedule for Bureau approval. The certification schedule will identify the activities for developing West Virginia specific Certification Checklists as well as the Certification Readiness Plan. Molina will work with the Bureau as needed to identify all of the certification system review criteria.

The CMS MECT identifies distinct protocols to follow in the preparation and execution of MMIS certification. These certification protocols provide a more consistent and detailed process for the MMIS certification of the West Virginia Replacement MMIS. The MECT is comprised of three (3) certification protocols. The protocols are further defined by a number of protocol steps and resulting products, and a detailed list of all of these items can be found in the narrative below. The three CMS certification protocols are defined in **Figure 5.5.2.5.3-1**.

Figure 5.5.2.5.3-1: CMS MMIS Certification Protocols

Certification Protocols	Definition
APD Development and Review Protocol	A set of abbreviated checklists that identify the State's business objectives for each business area. These are used to demonstrate the goals and objectives of the new MMIS.
State Certification Readiness Protocol	Provides assurance to the State that MMIS is certifiable and communicates to CMS that the State has determined that Federal requirements have been satisfied.
CMS Certification Review Protocol	Used by CMS to evaluate a State MMIS to certify that it meets all Federal requirements and, therefore, is eligible for enhanced FFP for MMIS operation.

Molina follows the protocols established by CMS for MMIS certification.

The twenty (20) CMS certification checklists are listed in **Figure 5.5.2.5.3-2,** although some of these checklists may not be applicable for the West Virginia MMIS Certification effort.

Figure 5.5.2.5.3-2: CMS Certification Checklists

Business Area	Checklist
Beneficiary Management	• Beneficiary Management Checklist
Provider Management	• Provider Management Checklist
Operations Management	• Reference Data Management Checklist • Claims Receipt Checklist • Claims Adjudication Checklist • Pharmacy Point of Service (POS) Checklist. • Third Party Liability (TPL) Checklist
Program Management	• Program Management Reporting Checklist • Federal Reporting Checklist • Financial Management Checklist • Decision Support System/Data Warehouse Checklist • Security and Privacy Checklist
Program Integrity Management	• Program Integrity Management Checklist
Care Management	• Managed Care Enrollment Checklist • Managed Care Organization Interfaces Checklist • Managed Care Prepaid Inpatient Health Plan PIHP and Prepaid Ambulatory Health Plan (PAHP) Checklist • Primary Care Case Manager (PCCM) and Gatekeeper Managed Care Checklist • Home and Community-Based Services (HCBS) Waivers Checklist • Immunization Registry MMIS Interface • Immunization Registry Owned Checklist

Molina develops West Virginia specific checklists for the MMIS certification process.

Molina will work with the Bureau and CMS to determine which CMS Certification Checklists are applicable for the West Virginia MMIS Certification Checklist. In addition, West Virginia specific functionality is added to the MMIS Certification Checklist. Using CMS protocols and checklists, Molina will conduct all planning activities associated with the MMIS certification.

Molina will create a Certification Readiness Plan to outline the detailed goals and objectives in conducting the Certification Readiness prior to the go-live date and the goals and objectives of conducting the Certification Review with the Bureau and CMS after go-live. The Certification Readiness Plan will outline the process for capturing reports, system review criteria, providing walkthroughs and demonstrations, and providing completed system documentation to the Bureau and CMS. Beginning with the capture of West Virginia requirements in Rational RequisitePro, Molina establishes firm traceability of West Virginia requirements through to implementation. These requirements will prove that the Health PAS solution and operations aligns with all applicable CMS system review criteria.

5.5.2.5.3.1 Medicaid Enterprise Certification Toolkit [3.2.6.5.1(3.a)]

The CMS Medicaid Enterprise Certification Toolkit (MECT) and newly established certification protocols provide a consistent and detailed process for the certification of a MMIS system and are the basis for Molina's certification process. The MECT is comprised of three certification

protocols and 20 checklists based on the MITA-defined Medicaid business areas. Molina will follow the preparation guidelines in the MECT, or its successor, in preparing the MMIS and Bureau management for the Certification Review. The process occurs in two phases: Certification Readiness and Certification Review.

As part of Certification Readiness, Molina will utilize the MECT to develop West Virginia-specific certification checklists which will then be stored as a project record in IBM Rational RequisitePro®. Molina will complete and provide for the BMS review and approval a completed draft of all certification protocols and checklists required by the MECT or its successor. This includes both certification readiness protocols and checklists, and certification review protocols and checklists. The Certification Readiness Phase and all associated Milestones, Objectives, Protocols, Protocol Steps and Protocol Products are listed in **Figure 5.5.2.5.3.1-1**.

Figure 5.5.2.5.3.1-1: West Virginia Certification Readiness Phase

Milestone	Objective	Protocol	Protocol Steps	Protocol Product
State Goals & Objectives	Determine goals and objectives for the new or replacement MMIS			
APD Development	State agency uses its goals/objective and the MECT to work with CMS RO in preparing the APD	APD Development and Review Protocol Event Line	Selecting Checklists	Set of applicable/non-applicable checklists
			Tailoring Checklists for APD Use	Selected checklists with business objectives reviewed and detailed system review criteria deleted.
			Completing APD checklists	Tailored version of selected checklists reduced to Business Objectives section.
			Reviewing APD checklists	CMS RO understanding the business goals/objectives of the State to be supported by new MMIS
			Using APD checklists	Approved set of checklists to be used as good starting point for RFP development.
			Keeping APD checklists up to date	Updated checklists that support communications with the RO about changes to State plans.
Release RFP/Sign contract	State agency uses the MECT while preparing the RFP and finalizing a contract with a vendor.			
Validate MMIS Functionality	State Agency uses the MECT checklists for guidance in validating the functionality of the MMIS for certification compliance.	State Certification Readiness Protocol	Selecting Checklists	Set of checklists that cover all applicable business areas, business objectives and system review criteria.
			Tailoring Checklists	Set of checklists with all Federal and State-specific system review criteria in place for each business objective. System

Milestone	Objective	Protocol	Protocol Steps	Protocol Product
				review criteria must represent all MMIS requirements.
			Filling out checklists	Fully completed checklists showing all criteria which demonstrate that Federal and State requirements have been satisfied.
			Beginning data collection	Initiation of a data collection process that demonstrates that each criterion in the checklists has been met.
			Submitting the checklists	Set of completed checklists reviewed by the RO and ready for official submission to CMS.

Molina uses the MECT to develop West Virginia specific certification checklists.

Molina will participate in all CMS Certification Readiness meetings and will provide meeting information to its SMEs to assist in certification readiness activities.

The West Virginia Certification Review Phase and all associated milestones, objectives, protocols, protocol steps and protocol products are listed in **Figure 5.5.3.2.1.2-1** in the subsequent **Section 5.5.3.2.1.2,** Completion of Certification Phase, of the **Phase 2: Approach to Operations** section.

Molina will participate in all CMS Certification Review meetings and will provide Molina SMEs to respond to questions or issues throughout the review process. Appropriate Molina personnel will be on-site during the Certification Review to ensure timely and accurate response to any CMS questions or requests. Molina will works closely with the Bureau throughout all stages of the Certification Review process.

5.5.2.5.3.2 Coordination of Tasks [3.2.6.5.1(3.b)]

The Molina Certification Manager will be responsible for coordination of tasks between the BMS re-procurement team and Molina to obtain CMS certification for Health PAS within 12 months of the production start date. Molina certification activities will be focused on attaining the maximum possible Federal Financial Participation (FFP) for all aspects of the system development and implementation effort. Additionally, Molina will provide continuity in staffing through completion of certification activities and will retain sufficient on-site systems and operations staff to resolve any problems or issues encountered during the certification process. The Molina Certification Team will include Subject Matter Experts (SMEs) in the following areas:

- Claims Receipt
- Claims Adjudication (including Prior Authorization)
- Beneficiary Management
- Provider Management
- Third Party Liability
- Program Integrity
- Decision Support System & Data Warehouse (DSS)
- Federal Reporting
- Financial Management
- Managed Care Enrollment
- PCCM and Gatekeeper Managed Care
- Security and Privacy
- Reference Data Management
- Home and Community-Based Services (HCBS) Waivers
- Program Management Reporting

These assigned SME resources will support certification activities and the Molina Certification Manager will remain in his position until CMS certification is attained. Depending on West Virginia requirements, other SMEs may be made available as needed.

5.5.2.5.3.3 Certification Requirements Traceability [3.2.6.5.1(3.c)]

As part of Certification Readiness, Molina will utilize the MECT to develop West Virginia-specific certification checklists which will then be stored as a project record in IBM Rational RequisitePro®. RequisitePro is an integrated component of the IBM Rational toolset that is utilized by Molina to capture West Virginia requirements and associated artifacts. This activity, in partnership with Molina's business process mapping efforts, establishes and provides the traceability between contractual and functional requirements, and the certification checklists. As part of the planning process, Molina develops a West Virginia customized Certification Roadmap early in the DDI Phase outlining all tasks, objectives, milestones and work products that will be achieved as part of West Virginia's certification review.

5.5.2.5.3.4 Certification Readiness Plan [3.2.6.5.1(3.d-e)]

Molina will prepare a Certification Readiness Plan to prove fulfillment of all Federal and State requirements for certification and submit to the Bureau for approval nine (9) months prior to Health PAS system implementation. Molina provides its proposed Initial Project Schedule in **Section D03** of this proposal document and a draft Certification Readiness Plan in **Section D23**. The Initial Project Schedule includes tasks, timeframes and milestones consistent with the phases described in the RFP, including the Certification Planning Phase and the CMS Certification Phase.

The Certification Readiness Plan documents the systematic approach and methodology for the CMS federal certification of the Health PAS MMIS. To attain federal MMIS certification and secure maximum FFP going back to Day 1 of production operations, CMS will validate the Health PAS MMIS based on the following criteria:

- Health PAS is designed to support efficient and effective management of the MMIS program
- Health PAS satisfies the requirements in Part 11 of the State Medicaid Manual (SMM)
- Health PAS satisfies the system review criteria contained in CMS Certification Checklist
- Health PAS is operating as described in the APD and all amendments to the APD, and the contract submitted to CMS
- Industry best practices are utilized in the MMIS program
- Certification is procured according to the guidelines outlined in the CMS MECT.

Molina will update the Certification Readiness Plan to provide contingencies for any system or business defects identified during system testing and UAT that are not resolved prior to production cutover. Additionally, Molina allocates time and resources for system remediation activities after the go-live date to address any certification deficiencies identified by the BMS or CMS.

5.5.2.5.3.5 Certification Scheduling [3.2.6.5.1(3.f)]

The Molina Certification Manager will be responsible for the development of the Certification Readiness Plan which will include a work plan and schedule of certification activities leading up to the certification visit by CMS. The Molina Certification Management will support their BMS counterpart in scheduling the actual certification visit and creating a schedule of certification visit activities. In general, the Molina certification activities will follow the timeline presented earlier in **Figure 5.5.2.5-1**.

5.5.3 Phase 2: Approach to Operations Phase [3.2.7, 3.1.27]

Molina Medicaid Solutions (Molina) has provided operational excellence to the State of West Virginia for over eight years. Molina will continue its operational excellence approach under the new contract.

During the Operations Phase Molina will conduct all West Virginia Replacement MMIS operations activities using a certified solution and remain current using approved enhancement management procedures. The Molina Operations Phase organizational structure provides the composition, experienced staff, and flexibility to effectively administer the operations and manage project-based change as defined in the following sections. The proposed replacement West Virginia MMIS has advanced systems, operational capabilities and features that align with the specific BMS Business Area Goals and Objectives for the West Virginia Medicaid Program, and will allow the Bureau to achieve these and future goals and objectives. Molina will support the Bureau's initiatives to achieve these goals during both the DDI and Operations Phases.

5.5.3.1 Phase 2a, Routine Operations [3.2.7.1]

By selecting Molina, the BMS will gain:

- A fiscal agent partner experienced with the West Virginia MMIS operational requirements
- An established, experienced operations team of Medicaid healthcare professionals
- A proven and certified next-generation COTS-based MMIS that will help the BMS meet its goals well into the future
- A company with a depth of clinical expertise and experience to help deliver improved health outcomes to West Virginia Medicaid population while containing program costs.

Molina has provided these services successfully to the West Virginia MMIS for over eight (8) years. Results over that period demonstrate our ability to continue the successful operations and claims administration for the West Virginia MMIS.

5.5.3.1.1 Operations Methodologies [3.2.7.1.1]

Molina provides responses to operations methodologies in the following sections:

5.5.3.1.1.1 Supporting Operations [3.2.7.1.1(1-a), Appendix F]

Molina has West Virginia Medicaid experience and expertise in the form of highly qualified and knowledgeable resources. The combination of the proven Molina and our subcontracted partners' resources will provide the necessary skills to continue the successful administration of the West Virginia Replacement MMIS unmatched by other vendors. **Figure 5.5.3.1.1.1-1** defines the required West Virginia Replacement MMIS business processes, including our proposed partners' roles. Although Molina is subcontracting key Operations Phase functionality to partners, Molina will retain overall responsibility for account management, performance standards, and the quality of services these partners provide. These partners are subcontractors to Molina and have performance standards requirements for administering their components that exceed those required by the BMS.

Figure 5.5.3.1.1.1-1: West Virginia Replacement MMIS Operations Approach

Business Process & Functionality	Description of Operational Services Provided
General • Data	The Molina operations are organized to provide all of the operational services as required by the West Virginia MMIS. The organization and staffing for the

Pages 5-128 through 5-147 contain confidential and proprietary information and have been redacted.

Business Process & Functionality	Description of Operational Services Provided
• Paper claim and other hard copy material maintenance • Postage cost logging • Reporting	The current parameters for keeping hard copy documents, quality assurance of imaged documents, and destroying input hard copies are reviewed with the BMS for approval during the DDI Phase, and the mail room desk level procedures updated and training completed, if necessary, based on the approved procedures. The desk level procedures include the preparation of weekly and monthly reporting of input and output metrics, service levels compliance, and issues encountered and resolution.
Web Portal • Website with role-based security • Accept email • Publish documents • FAQ • Help screens • Links • Regulation and guideline compliance • Internet security • PHI handling • Web surveys	Health PAS-OnLine will replace the current provider website to an enhanced portal framework of plug-in applications. The framework contains multiple public and secure pages for providers, trading partners and members – each containing News, Announcements, Calendars, Important Updates sections, survey capability and document libraries – all with subscription and alert notifications and all able to be updated by site staff, providing a great improvement on ease of use and efficiency. The Health PAS-OnLine component will be expanded to provide the West Virginia MMIS web portal gateway into Molina's solution for the provider, billing agents/clearing houses, health care entities, and member community. Through a secure connection, authorized providers will be able to submit and adjudicate claims, submit and review prior authorizations (PA), validate member eligibility, review member history, submit provider enrollment applications and maintain existing provider enrollment, check claim status, and view remittance advice, payment and account status. Claims and PA requests will be submitted by using either an interactive web form (real time direct data entry) or by uploading HIPAA-compliant X12N files. Providers can use the portal to retrieve their remittance advice (835) and PA responses. Health PAS-OnLine will also serve as the primary source of information for providers and members by providing user specific guides, training tutorials, FAQs, help text along with training schedules, announcements, notices, provider directory, links to other useful sites (BMS specified) and event calendars. The Health PAS-OnLine will also serve as the gateway to Health Information Exchanges and Provider Incentive Payment administration. ***"The website for Molina is great. The claims in process list and having the remits available saves us time when reviewing accounts. The Website is very user friendly."*** **Dollie Baker** **Patient Financial Services** **WVU Hospitals** The West Virginia MMIS portal will provide the capability for the user to send an email request to the appropriate Customer Service Support Center staff. Additional technical support help is available through the Technical Help Desk Support functions of the Customer Services Support Center. Technical help desk support is provided by the Provider and Member Call Centers for help with accessing portal, establishing user sign on codes, and preparing trading partner agreements; system issues are forwarded to the EDI/Web Portal Manager for resolution and response. The Molina Web Portal Administrator will add or update announcements, links and event calendars as needed without any disruption to the portal operations. All initial portal content and subsequent changes and additions to portal information will be reviewed with the Bureau for approval prior to being modified on the portal. While general information such as User Guides, announcements, notices, provider directory, links to other useful sites and event calendars will be accessible without requiring the user to sign on, access to provider activities, prior authorization, claim and financial information will be available to the users only after the providers,

Business Process & Functionality	Description of Operational Services Provided
	members and trading partners successfully sign on to the system. All system components of Health PAS will be designed and installed following HIPAA and standard business security principles. The West Virginia MMIS portal will adhere to all Internet and PHI security provisions as defined in the approved Security, Privacy, and Confidentiality Plan deliverable. The plan will address how Molina will comply with applicable State and HIPAA Privacy. Using the role and user based security provided by Health PAS, authorized users will be limited to performing only the functions that their access allows. An audit trail of West Virginia MMIS web portal access is maintained, tracks access to sensitive data, including what user is making the access. The Health PAS-OnLine's survey application will offer an efficient way to gather user opinions about the Medicaid services, programs, training, ideas and measure user portal satisfaction during the course of an online event. The survey function enables branching that can simplify the survey by displaying only questions that are relevant to each respondent based on response to previous questions. Questions that are not relevant are not displayed. Surveys will be placed on the Health PAS-OnLine website or through audience targeting by forwarding a direct link via email to the intended participants. Audience targeting is useful when eliciting feedback regarding training sessions or other programs.
Technical • System availability • Security and privacy	During the West Virginia Operations Phase, the system availability monitoring and measurement will remain the responsibility of the Systems Unit. The Deputy Systems Manager and Molina's Network Operations Center (NOC) will be responsible for the continuous monitoring of the system availability to: (1) confirm performance standards and requirements are being met; and (2) establish benchmarks for possible enhancements. Technical support desk functions will be provided by the Customer Service Support Center call centers with escalation, as needed, to the appropriate Systems Unit staff member (e.g., technical questions related to portal availability will be directed to the EDI/Web Portal Manager, pharmacy technical issues will be directed to the POS Systems Manager, etc.) The Medical/Dental and POS QA Managers conduct reviews of the actual measurements for their respective solutions as part of the normal QA processes, with results reported to the BMS. The Deputy System Manager will prepare the maintenance schedule and notify the BMS of the schedule at least 30 days prior to the actual maintenance activity; daily notification will be made to the BMS via email of the next day's system availability. All maintenance will be scheduled so that it does not interfere with production processing unless emergency situations dictate and the BMS approves the off cycle maintenance; normal maintenance will occur over the weekend between midnight and 5 a.m. Sunday morning.. The West Virginia MMIS Web portal, AVRS, and POS will be available 24 hours per day, 7 calendar days per week except for scheduled maintenance as provided to the BMS. The Molina Deputy Systems Manager will monitor the system availability service level and report adherence via the weekly status meetings and reports and as part of the Molina quality performance level dashboard. Business continuity activities and recovery will be conducted by the local Systems Unit and the NOC in accordance with the approved Disaster Recovery and Business Continuity Plan deliverable. The plan allows for switchover to the failover environment within 10 minutes of the production environment not being available. Additional information related to West Virginia systems availability is defined in subsequent **Section 5.5.3.1.1.5, Systems Performance Monitoring and Maintenance**. The West Virginia security and privacy initiatives comply with the policies and

Pages 5-150 through 5-157 contain confidential and proprietary information and have been redacted.

Figure 5.5.3.1.2-1: Sample West Virginia MMIS Post-Implementation Checklist

Index	Area	CMS Trigger	Post-Implementation Checklist		Status	Date	Progress Assess		RQMS Xref	Molina Lead(s)	BMS Lead(s)	Notes	Communication Strategy	Link
			Sub-Area	Description			Sched	Qual						
			GO LIVE											
			CONVERSION											
			MMIS PORTAL											
			EDI											
			OPERATIONS											
			CLAIMS PROCESING											
			PROVIDER											
			CLAIMS RESOLUTION											
			PHARMACY/POS/REBATE											
			MEMBER											
			WORKFLOW											
			FINANCE											
			INTERFACES											
			LETTERS											
			REPORTING											
			DSS/DW											

The checklist guides and allows reporting the post implementation activities.

The Post-implementation checklist includes a field identifying the BMS lead who will be involved to confirm or offer suggestions to the proposed validation approach, ensure that the checklist item is validated, and provide written confirmation that the checklist item has been validated. The Post-Implementation Checklist will also denote those activities that are required for CMS certification. The Post Implementation Checklist includes the link to Health PAS-InterComm portal where the results and validation confirmations are archived. All the results from the monitoring and validation will be recorded on the checklist, including updates to the status, dates, and progress assessment fields.

Molina anticipates that there will be issues associated with the production checklist items. Therefore, Molina will maintain the DDI team to triage and correct any inaccuracies discovered during the review process. If any changes are identified during this process they will be remanded to the workflow and processes defined in the approved Modification and Enhancement Plan.

Molina will establish daily meetings to review the results and will request and conduct “real time” meetings when necessary to initiate corrective actions to issues and risk triggers that are affecting a broad category of services (e.g., paying all physician claims incorrectly.) Operations staff will participate in these meetings so that communications can be prepared immediately for call center responses and external communications. All issues associated with production will be documented in accordance with the issue management process defined in the approved Issue Management Plan. If any issues arise that may impact providers and members, or other stakeholders involved with the processing (i.e., billing agents, clearinghouses, interface partners, and the BMS operational units) the protocols for communicating with these entities in the Issues Management Plan or Modification and Enhancement Plan will be followed. The first step of that defined process is to notify the BMS immediately of any identified issues.

The Customer Service Support Center staff will conduct a post-implementation evaluation to validate customer service satisfaction. The parameters for the satisfaction surveys will be defined in the approved Implementation Plan and include the BMS-designated criteria. Satisfaction survey requests will be presented to the West Virginia MMIS portal users and providers and members who use the Customer Services Support call centers. Additional satisfaction surveys will be prepared and conducted for other units/entities as requested by the BMS. The West Virginia MMIS portal survey application offers an efficient way to gather user opinions about the West Virginia services, programs, training, ideas and measure user satisfaction during the course of an online event. Molina uses the “Impact 360 Customer Feedback” component of Health PAS-Contact Manager that will enable Molina to survey providers and members who use the Molina provider and member call centers to learn about their overall experience with the Molina. The individual survey results or a graphical summary of

all survey responses will be prepared by the Customer Provider/Member Services Manager and presented to the BMS as part of the post-implementation reviews. The results of the survey may indicate additional training or communications to be determined by meetings with the BMS.

5.5.3.2 Phase 2b, CMS Certification [3.2.7.2, Appendix D 3.1.11, Appendix D 3.1.26]

Molina warrants that the proposed and implemented MMIS will meet CMS certification requirements within 12 months of go-live 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. The current Molina Health PAS solution has been certified in West Virginia as meeting all certification standards of CMS and qualifying for the highest eligible rate for FFP. The Replacement MMIS will be presented to CMS for certification based on the CMS Medicaid Enterprise Certification Toolkit (MECT) and newly established certification protocols. The toolkit and protocols provide a consistent and detailed process for MMIS certification and are the basis for Molina's certification process. The MECT is comprised of three certification protocols and 20 checklists based on the MITA-defined Medicaid business areas.

Molina has analyzed the successful process that was used to have the West Virginia MMIS previously certified and reconciled this to the latest CMS requirements. **Figure 5.5.3.2-1** illustrates a comparison between the initial West Virginia MMIS certification conducted by Molina and what we anticipate for certification of the Replacement MMIS. The items in red indicate a difference between the two certification activities.

Figure 5.5.3.2-1: West Virginia CMS versus MITA Initiative Certification Reconciliation

West Virginia MMIS Certification – 2006	West Virginia Certification – 2012/2013

Certification Checklist
• System based
  o 8 MMIS Subsystems
  o CMS Certification system review criteria
• Phases
  o Scope validation
	Certification Checklist
	• Business Area based
	  o 6 Medicaid Business Areas
	  o 20 Checklists
	  o 90 Objectives
	  o CMS Certification system review criteria
	• Phases
	  o Scope
	  o Requirements Traceability
	  o Confirmation
	  o Validation

Certification Artifacts • Subsystem Profile Narratives • System Review Packets • Supplementary system documentation • Reports	Certification Artifacts • Business Area and Objective Profile Narratives • System review packets • Supplementary system documentation • Reports
Certification Preparation • Review meetings with CMS after Go Live • Sample review packets sent to CMS for review • State preparation after creation of certification artifacts	Certification Preparation • Review meetings with CMS prior to Go Live • Certification Artifacts sent to CMS for Approval • Molina and State Teams work together throughout Certification Preparation
Certification Review • 1 week onsite review concluding with additional "Action Items"	Certification Review • Certification Artifacts approved by CMS prior to onsite review

West Virginia MMIS Certification – 2006	West Virginia Certification – 2012/2013
• Certification Letter	• 1 week onsite review concluding with Compliance Indicator • Certification Letter

Molina's successful West Virginia certification approach aligns with the MITA requirements.

Molina will follow the MECT preparation guidelines in preparing the MMIS and Bureau management for the Certification Review. As part of Certification Readiness, Molina will utilize the MECT to develop West Virginia-specific certification checklists and applicable CMS Certification system review criteria along with requirements, associated artifacts, and traceability between requirements and artifacts. This activity, in partnership with Molina's business process mapping efforts, provides the traceability between contractual and functional requirements, and the certification checklists. As part of the planning process, Molina develops a West Virginia customized Certification Roadmap early in the DDI Phase outlining all tasks, objectives, milestones and work products that will be achieved. The CMS Certification Planning is described in detail in **Section 5.5.2.5, Phase 1e, CMS Certification Planning**. A high-level view of Molina certification activities as they overlap other project phases is illustrated in **Figure 5.5.2.5-1** of **Section 5.5.2.5**. Molina begins certification planning activities in the early stages of the DDI Phase, developing the certification schedule using the MECT as a guide for activities incorporated in the schedule. These activities are documented in the CMS Certification Readiness Plan deliverable prepared and approved by the BMS during DDI Phase 1e, Certification Planning. The certification activities, resources, and effort will be included in the detailed Project Schedule deliverable presented in **Section D03**. The certification schedule will identify the activities for conducting certification during the Operations Phase.

The CMS MECT identifies distinct protocols that Molina operations and the BMS staff follow in the execution of MMIS certification. These certification protocols provide a more consistent and detailed process for the MMIS certification of the West Virginia MMIS. The MECT is comprised of three (3) certification protocols. The three CMS certification protocols are:

1. **APD Development and Review Protocol:** A set of abbreviated checklists prepared by the BMS prior to the start of the DDI Phase that identify West Virginia's business objectives for each business area. These are used to demonstrate the goals and objectives of the new MMIS.
2. **State Certification Readiness Protocol:** Provides assurance to the BMS that MMIS is certifiable and communicates to CMS that the State has determined that Federal requirements have been satisfied.
3. **CMS Certification Review Protocol:** Used by CMS to evaluate the West Virginia MMIS to certify that it meets all applicable Federal requirements and, therefore, is eligible for enhanced FFP.

The twenty (20) CMS certification checklists are listed in **Figure 5.5.2.5.3-2, CMS Certification Checklist** of preceding **Section 5.5.2.5.3, Certification Planning Methodologies**, although some of these checklists may not be applicable for the West Virginia MMIS Certification effort as determined by Molina and the BMS and included in the CMS Certification Readiness Plan.

Applicable CMS Certification system review criteria will be supported by approved MMIS requirements, resulting in a certification requirements traceability matrix (RTM). The approved CMS Certification Readiness Plan will outline the process that will be used during CMS Certification (Phase 2b) to archive and inventory system reports, system data, CMS Certification system review packets, provide walkthroughs and demonstrations, and provide completed system documentation to the BMS and CMS. Molina establishes firm traceability of West Virginia requirements from inception through implementation using ReqPro. Molina will use

these requirements to validate that the Replacement West Virginia MMIS using the Health PAS solution and operations align with all applicable CMS Certification system review criteria.

Molina will complete and provide for Bureau review and approval a completed draft of all applicable Certification checklists and CMS Certification system review criteria. The Certification Readiness activities and all associated milestones, objectives, protocols, protocol steps and products are defined in preceding **Section 5.5.2.5.3, Certification Planning Methodologies** and listed in that Section's **Figure 5.5.2.5.3.1-1, West Virginia Certification Readiness Phase**.

Molina develops a complete set of Certification Checklists showing validation of data collection that demonstrates that each applicable criterion in the Certification Checklists has been met. This set of completed checklists will be reviewed by the Regional Office and ready for official submission to CMS prior to their site visit. Molina will participate in all CMS Certification Readiness meetings and engage all necessary DDI SMEs to assist in certification readiness activities.

5.5.3.2.1 Certification Requirements [3.2.7.2.1]

Molina provides responses to Phase 2b CMS Certification in the following sections:

5.5.3.2.1.1 Certification Deliverables and Milestones [3.2.7.2.1(1), 3.1.24]

Upon contract award, the Project Schedule will be updated in accordance with the award date and items that need to be addressed from contract negotiations. Molina and the BMS will meet to review the detailed work plan, making modifications that may be required and receiving final work plan approval. The detailed work plan identifies the phases, milestones, activities, and deliverables for the project and will be used by both the BMS and Molina to monitor project progress. All milestone events in the project schedule require both Molina and the BMS approval before the milestone event is considered as attained.

The required deliverables for the Certification Phase are listed in **Figure 5.5.3.2.1.1-1**. Molina understands the criticality to the BMS of each deliverable listed and will meet the delivery timeframe specified for each deliverable. Molina includes all Certification Task milestones in its preliminary work plan, included in **Section D03 – Project Schedule**. The milestones included are listed in **Figure 5.5.3.2.1.1-1**

Figure 5.5.3.2.1.1-1: Certification Deliverables and Milestones

#	Type	Deliverables and Milestones
Phase 1e – Certification Planning		
129	Deliverable	CMS Certification Readiness Plan
130	Deliverable	Weekly Project Status Report
131	Deliverable	Monthly Project Status Report
132	**MILESTONE**	**Completion and the BMS Approval of Phase 1e**
Phase 2b – CMS Certification		
133	Deliverable	Updated CMS Certification Readiness Plan
134	Deliverable	Completed Certification Protocols and Checklists
135	Deliverable	CMS Certification Documentation and Operational Examples (CMS Certification System Review Packets, System Reports, Supporting Documentation and Operational Examples)
136	Deliverable	Shared Electronic Document Storage for Certification Artifacts

#	Type	Deliverables and Milestones
137	Deliverable	System Remediation
138	**MILESTONE**	**Completion and the BMS Approval of Certification Readiness Planning Meetings**
139	**MILESTONE**	**Pre-Certification Meeting and/or CMS Call**
140	**MILESTONE**	**CMS Certification (This is considered the final deliverable for DDI)**

Molina provides all Certification Phase deliverables and milestones.

5.5.3.2.1.2 Completion of Certification Phase [3.2.7.2.1(2)]

The completion of the Certification Phase activities will be the responsibility of the certification team including key Molina staff and the BMS-designated staff. The BMS Project Officer has overall oversight of the Certification activities. The roles and responsibilities of the Molina Certification Team are outlined below:

Project Manager - The Molina Medical/Dental and POS Project Managers will be responsible for the Molina certification staff and activities oversight.

Account Manager - The Molina Account Manager will be responsible for executing the plans and strategy to enable the successful implementation and adherence to the certification criteria for the MMIS.

Certification Manager - The Molina Certification Manager will be responsible for overall management of the certification readiness and review phases. The Certification Manager will:

- Validate the CMS Certification Readiness Plan and Certification Checklists in preparation for CMS Certification Review.
- Manage the Molina resources towards the completion of the Certification Checklists, Certification Profiles/review packets/supporting documentation and collection of all applicable supporting documentation for the Bureau staff in preparation for MMIS Certification Review with CMS.
- Designate points of contacts and chain of command for responding to certification questions, assisting with the remediation of validation issues, and overseeing the issue tracking and resolution activities.
- Provide assistance to the certification team in developing Corrective Action Plans (CAP), as needed, review remedial test plans, schedule reviews with the BMS and CMS, and facilitate formal discussions of the testing process and align results with indentified certification issues.
- Be responsible for certification status reporting to Molina and the Bureau.
- Coordinate with the State Project Manager for management and resolution of all certification activities.

Subject Matter Experts (SMEs) – The Molina SMEs will be assigned to support West Virginia MMIS certification. This team is experienced in the CMS Certification Review process.

Application Solutions Team – The Molina Application Solutions team will perform software modifications to correct defects or discrepancies identified during the certification review process.

Quality Assurance (QA) Team – The Molina Quality Assurance team will develop corrective action plans for discrepancies identified during the certification review process and will monitor adherence to project quality standards.

Documentation Specialist – A Molina Documentation Specialist will prepare and distribute final versions of the MMIS documentation. This will include systems and operations documentation.

Responsibilities of each State Certification Team role are outlined below:

BMS Project Officer – The BMS Project Officer will serve as the BMS point of contact for all external reference and project information requests, State and Federal reviews, and certification. This position will be responsible for defining the scope of the certification with CMS. In addition, this position will ensure that the appropriate BMS staff are identified, assigned to their areas of expertise, and are engaged in the certification activities as outlined in the pre-certification review meetings and the project work plan certification tasks.

State Certification Lead – Molina suggests that the Bureau assign a Certification Lead who will coordinate with Molina and be responsible for commencing the certification process with CMS. This position will schedule meetings as appropriate; communicate with CMS; prepare and present certification status reports to the BMS and CMS; prepare and conduct the State Readiness Assessment (review of checklists and review of APD); and, manage the Bureau resources.

State Certification Subject Matter Experts (SMEs) – The State Certification SMEs will work directly with the Molina Certification SMEs to review the Certification Checklists, Certification Profiles/Review Packets/Supporting Documentation and prepare for the presentation of the Final Certification Checklist to the CMS Certification Review Team. The Bureau SMEs will also work directly with CMS during their on-site Certification Review to present the West Virginia MMIS and provide any requested information to CMS as part of the Certification Review.

Molina will participate in all CMS Certification Review meetings and will provide Molina SMEs to respond to questions throughout the review process. The BMS and Molina have separate and distinct responsibilities to perform in preparation for the CMS Certification Review process. Molina will be responsible for preparing the West Virginia certification review team by capturing the evidence that meets applicable CMS Certification system review criteria and reviewing results with the West Virginia certification review team. This will include all profile narratives, system review packets and supporting documentation (i.e. reports, operations documentation, systems documentation, etc.). Molina will also be responsible for providing the West Virginia certification team with system demonstrations based on CMS guidelines as stated in the State Medicaid Manual, Part 11241 and the CMS Certification Review Protocol.

Molina will work in close partnership with the BMS to ensure the West Virginia MMIS meets all applicable Federal and State requirements for a CMS certified MMIS. This will require the development of a final West Virginia-specific MMIS Certification Checklist that encompasses all applicable CMS and West Virginia-specific Certification Checklist CMS system review criteria. Once the final MMIS Certification Checklist has been validated by the CMS Regional Office, the Certification Profiles, System Review Packets and Supporting Documentation are developed and prepared for the presentation to the CMS Certification Review Team.

If CMS or the BMS identifies any items that do not meet certification system review criteria, Molina will conduct system remediation activities to bring the system in line with applicable certification requirements. System remediation is only performed if needed due to an identified deficiency. If issues arise, Molina onsite and remote support staff will quickly respond to resolution of the issues and complete the review process.

The West Virginia Certification Review Phase and all associated milestones, objectives, protocols, protocol steps and protocol products occurring during the CMS Certification (Phase 2b) are listed in **Figure 5.5.3.2.1.2-1**.

Figure 5.5.3.2.1.2-1: CMS Certification Review Phase

Milestone	Objective(s)	Protocol	Protocol Steps	Protocol Product
Pre-Certification Meeting/Call with CMS	The BMS uses the MECT to prepare the final checklists and sample system review packets for the pre-certification meeting	CMS Certification Review - Preparation	Request for certification	Letter from State requesting certification with attestations and completed checklists
			Certification review Team formation	Establish Certification Review Team and Team Lead
			Response to Request for Certification and Specification of Data Needs	Letter to State that names the Certification Team members and specifies data and information needs of the Certification Team. The BMS response to the letter must include the requested data.
			Establishing Checklists for Onsite Visit	Set of checklists to be used for the certification visit
			Initial Review of Material	Review of information provided by and about the State and its contractor. Certification Team members are to be familiar with their designated business areas.
			Certification Review Team RO Briefing	Selected areas for focus during the onsite visit
			Pre-certification meeting/call	Mutual understanding between CMS and State of the conduct of the certification visit
CMS MMIS Certification On-site Visit	BMS and CMS use the MECT protocol and checklists to validate the MMIS for Certification compliance.	CMS Certification Review - Onsite Visit	Entrance conference	Coordination of schedule, logistics and State and contractor staff availability.
			Evaluation of the MMIS	Completed checklists, lists of strong and weak points, action items for the State.
			Exit conference with State debriefing	State understanding of the findings of the CR Team, action items and any needed Corrective Action Plans.
		CMS Certification Review - Post-review Analysis and Follow-up Phase	Analysis of data	Scored checklists, identification of problems.
			Resolution of Issues	Resolution of open issues and Corrective Action Plans; completion of scoring of checklists.
			Certification Decision	Recommendation to certify or not certify the State MMIS as of a given effective date.

Milestone	Objective(s)	Protocol	Protocol Steps	Protocol Product
			Certification Review Final Report	CMS Certification Review Final Report
			Preparation of Response to the State	Memo to Deputy Regional Administrator showing certification decision and attaching the final report.
			Conclusion of the Process	Files of records of the process; Certification Team disbanded.

Molina will participate in CMS Certification Review meetings; our SMEs will respond to reviewers' questions.

Appropriate Molina personnel will be on-site during the Certification Review to ensure timely and accurate response to any CMS questions or requests. Molina will work closely with the BMS throughout all stages of the Certification Review process. Molina will verify that the components of the certification review process under its control will meet applicable Federal certification requirements. Molina has a 100-percent success rate with current clients in attaining required MMIS certification and will continue its record of performance with West Virginia.

During the course of the certification effort, Molina will prepare and present certification deliverables for the BMS approval. Completion of these deliverables plus the results of the certification activities conducted by Molina, the BMS, and CMS will be the key factors to determine when a certification milestone has been met as defined in **Figure 5.5.3.2.1.2-2**.

Figure 5.5.3.2.1.2-2: Proposed Acceptance Criteria for Certification Milestones

#	Type	Deliverables and Milestones	Proposed Acceptance Criteria
Phase 1e – Certification Planning			
132	MILESTONE	Completion and the BMS Approval of Phase 1e	This milestone will be considered complete when the Bureau approves the initial CMS Certification Readiness Plan, Certification Checklist (Scope) and Certification Checklist (Confirmation & RTM). The Plan must define the actual work plan and timeline for certification resources.
Phase 2b – CMS Certification			
138	MILESTONE	Completion and the BMS Approval of Certification Readiness Planning Meetings	Updating the Certification Readiness Plan to provide contingencies for any system or business defects identified during system testing and UAT.
139	MILESTONE	Pre-Certification Meeting and/or CMS Call	Acknowledgement form CMS that the BMS has completed all certification preparatory activities and documentation and that the West Virginia MMIS is ready for CMS review.
140	MILESTONE	CMS Certification (This is considered the final deliverable for DDI)	Acknowledgement from the Deputy Regional Administrator showing positive certification decision to the start of operation and attaching the final report from the CMS review team. This includes successful completion of any remediation of issues, if any, defined by CMS and all documentation associated with certification.

Molina will monitor certification activities to achieve all milestones.

5.5.3.2.1.3 Methodologies for Certification [3.2.7.2.1(3)]

Molina will participate in all CMS Certification Review meetings and will make available key Molina SMEs to respond to questions throughout the review process. Key personnel will be on-site during the Certification Review to ensure timely and accurate response to any CMS questions or requests. The Molina SMEs will be the focal points for preparing Molina and the BMS project resources for the certification review that will conform that the BMS presentation team is appropriately prepared to conduct the CMS presentation and support any questions or requests from the CMS Certification Review Team.

The BMS and Molina will have separate and distinct responsibilities to perform in preparation for the CMS Certification Review process. Molina will be responsible for preparing the BMS Team by capturing the evidence to meet all applicable CMS Certification system review criteria and reviewing the results with the BMS certification review team. The Molina team will also be responsible for providing the BMS Certification team with a system demonstrations based upon the CMS guidelines as defined in the current version of the SMM, Part 11241 and the CMS Certification Review Protocol.

The Molina Certification Manager and Molina SMEs will conduct a simulated certification review using the established Certification Checklists and System Review Criteria as the basis for satisfying the requirements. This process will allow the BMS and Molina to identify and correct any areas of weakness prior to the actual CMS review. Molina will prepare a pre-certification evaluation report for the BMS review as an output of these practice sessions. The BMS will be responsible for requesting an on-site certification review and submitting the Final MMIS Certification Readiness Checklists to the CMS Regional Office for review. The submitted Checklist will include all the required data for CMS to determine the readiness for the West Virginia Certification Review.

The CMS Certification Review Team will conduct a one week on-site MMIS CMS Certification Review. The Molina team will support the MMIS CMS Certification Review process as follows:

- Schedule and conduct the activities required to prepare for the onsite MMIS CMS Certification Review and approval. The BMS, working with Molina, will schedule the actual certification review with CMS. Molina will actively participate in all required certification review activities, providing ready access to all necessary Molina personnel throughout the certification review process.
- Provide all required certification documentation and any additional information requested by the CMS Certification Review team to the BMS. The BMS will be responsible for submitting all applicable materials directly to CMS. The completed artifacts will include:
    - Completed set of MMIS Certification Readiness Checklists.
    - Completed set of system review packets.
    - Complete set of system documentation.
    - Enterprise System Diagram.
    - Network Schematic.
    - Comprehensive list of error codes.
    - Record layout of each data store including data element definitions.
    - Complete list of standard reports including a representative set of reports.
    - Substantiation that the data requirements for the Medicaid Statistical Information system (MSIS) have been satisfied.
    - Confirmation that the Health Insurance Portability and Accountability Act (HIPAA) requirements have been satisfied.

  - System integration and acceptance test results validating that the Health PAS application software produces predictable and verifiable output. For MMIS, the plan that will be provided will be the User Acceptance Test Plan.
  - Proof that a security risk assessment has been conducted.
  - Complete listing of local and off-site facilities.
  - Inventory of required reports (First Run and samples throughout the reviewed Operational phase).
- Actively participate in the pre-certification/on-site meeting with the CMS Certification Review Team. The Molina and the BMS Certification Team will provide a review of the Certification Readiness, as well as an overview of the MMIS and any applicable program improvements.
- Provide responses to any questions from the BMS and/or CMS during the review and approval process, and provide additional materials as required. The Molina project management team will establish communication channels early in this period to provide accurate and timely responses by Molina SMEs most familiar with the Health PAS feature requiring additional detailed explanation.
- Address any issues that the CMS Certification review Team may encounter during their certification review of the MMIS. Appropriate Molina staff will be onsite to support any issues. Should any deficiencies or issues be identified during the review process, Molina will work with the BMS to develop a corrective action plan to resolve the problem.

The Certification Review Process timeline will include the following two steps:

Step 1 - CMS Certification Review

- Entrance Conference – CMS summarize intent of the Certification Review
- MMIS Evaluation - CMS performs MMIS Certification Review using completed checklists, System Interaction and Interviews
- Exit Conference – CMS summarizes findings with the BMS.

Step 2 - Post Certification Review Analysis

- CMS Scorecards
- CMS Information Requests
- Final CMS Certification Verdict
- Federal Match
- Retro-active to Go Live.

During the Certification Phase, the Certification Manager will maintain and update the Certification Readiness Plan activities and will produce various reports from the plan that are indicative of project progress, such as tasks completed or tasks not started as planned. This starts with the implementation planning – the implementation plan includes the targeting, validation, and archiving of first run CMS reports and activities for use during CMS certification review.

For project tasks, deliverables, etc., that are not progressing as planned, the Certification Manager will escalate the issue to appropriate levels of Molina and the BMS (for BMS-defined activities) management for recovery and intervention. The Certification Manager will continually monitor the certification activities to confirm that required methodologies, documentation, and other activities are being met completed based on the parameters within the Certification Readiness Plan.

Certification Team adherence to the Certification Readiness Plan control discipline, processes, documentation production, and measurement are the single most effective method known to ensure certification success. Project control is the simultaneous awareness of the certification schedule, identification and documentation of the first time reports and other documentation,

certification risk status, resource availability and capabilities, and project update status, which enable the identification of necessary and effective Certification Readiness Plan continuous analysis and applying corrective actions with the approved plan.

In the event of any system issues or discrepancies, Molina will maintain a project development staff consisting of technical developers, business/ systems analysts, and SMEs dedicated to working directly with the CMS Certification Review team and the BMS throughout the system remediation process. Depending on the number of issues, functional areas of the MMIS affected, and the severity of any possible deficiencies requiring remediation, some or all of the Molina development staff assigned to the MMIS post go-live will be available to work with the BMS during remediation If the post go-live development staff assigned to the MMIS cannot handle the required remediation by the required timeframes for completion of certification remediation, other Molina development staff will be assigned to the MMIS remediation work as may be necessary. Molina will analyze any and all reported discrepancies to confirm the Health PAS application software is functioning according to design specifications and contractual requirements. The Molina Certification Manager along with the Medical/Dental and POS Project Managers will engage appropriate systems and/or operations staff as needed onsite to ensure any certification discrepancies are corrected efficiently and effectively. All related documentation and reference material will be updated to reflect any resulting design feature modifications.

In the event selected items are not certified during the initial review, Molina will expeditiously correct these items. All issues and action items identified during the CMS Certification Review will be logged in the Request Management System (RQMS) database, reviewed and prioritized by the Molina Medical/Dental and POS Project Managers for resolution. Certain items may invoke the change control process. The certification change control process utilizes the approved change control processes as defined in subsequent **Section 5.5.3.3**.

The Certification Checklists will be managed in ReqPro and reviewed monthly to track adherence of the MMIS to all applicable CMS Certification system review criteria. The BMS will generate a monthly Certification Discrepancy Report that will identify any CMS Certification system review criteria that did not pass the certification validation review. This report will allow the BMS the ability to monitor certification compliance and report this status to CMS. Molina will develop a Corrective Action Plan (CAP) in response to every item on this report after a certification issue is identified. The CAP will include the corrective action and time needed to make the correction to meet the CMS Review Team's requirements. The Molina Certification Manager will develop and present the CAP directly to CMS and the BMS. If the CAP is rejected, Molina will conduct a meeting with CMS and the BMS to resolve any outstanding issues. The approved CAP authorizes work to begin to remediate the problem. The issue will be updated in RQMS; a priority will be assigned and the CAP will be placed in an approved status. Each CAP will be assigned to appropriate Molina resources for resolution.

The Molina Certification Manager will present all remediation test results to the BMS prior to promoting any modifications or corrections to the production environment. Documentation may include input and output data, reports, and online displays. The results will confirm that the modified software or process will meet certification requirements. Software modifications will be promoted to the production environment after the BMS and/or CMS approve the remediation test results. Molina application solutions team will monitor the initial production cycle to confirm all changes are functioning as expected and the discrepancy has been resolved. It may be necessary to monitor additional run cycles to confirm that the modified logic has been exercised and produces expected results. The Molina resolution team will prepare and distribute the updated versions of any applicable Operations Manuals and System Documentation as a result of changes to the operations or system. The RQMS system will be updated and supporting documentation will be archived.

The MMIS Certification is a collaborative effort between the BMS, Molina and CMS. Molina will maintain appropriate systems and analytic resources during the certification review and remediation efforts to produce all of the certification review materials based on the approved CMS Certification Readiness Plan and the Certification Checklists. The Certification Manager and the Medical/Dental and POS Project Managers will continuously monitor the Certification Readiness Plan and the work plan to confirm that activities are being completed as planned. Molina will apply additional subject matter experts and systems resources from Molina central engineering staff to support local staff in completing their assigned tasks to meet the certification time lines.

5.5.3.2.1.4 Certification Support to the BMS [3.2.7.2.1(4)]

Molina will prepare electronic certification folders that include all State Medicaid Manual, Parts 11241 and 11243, required documentation, reports and crosswalks. Molina will work with the BMS to develop the CMS Certification Letter. The Molina Certification Manager will be the focal point for this activity and can draw upon appropriate Molina technical writing and documentation staff to assist in developing the Certification Letter as required. Molina will prepare, make available, and update all documentation, manuals, reports, letters, data and forms necessary to certification pursuant to the requirements in the MECT and the schedule in the Certification Readiness Plan. Molina uses the Health PAS-InterComm portal as a central repository of certification project artifacts, such as documentation, manuals, reports and forms. This allows designated BMS and Molina certification staff to readily access the most current version of project artifacts electronically from their desktop. Links are provided through Health PAS-InterComm to the Rational toolset that is utilized by Molina to capture West Virginia requirements and associated artifacts, such as Certification Checklists.

The process of establishing traceability between the contractual requirements and the West Virginia MMIS Certification Checklist Items is presented as part of the Molina requirements management process. A review will be conducted between Molina and the BMS to ensure that all applicable West Virginia Certification Checklist Items are traced to one or more functional requirements. This review will validate traceability of the Certification Checklist items to design and test considerations of the West Virginia MMIS. MMIS Certification Checklist traceability will be developed jointly between Molina and the BMS prior to being submitted to CMS for review. This will include a designation of all CMS Checklist items as applicable or non-applicable and inclusion of all West Virginia-specific certification checklist items. As Molina and the BMS complete the definition of these requirements, Molina will add them to the ReqPro database. The BMS and Molina will validate these items prior to the requirements being presented to the CMS Certification review team.

The West Virginia MMIS Certification Team will update the MMIS Certification Checklist items in ReqPro throughout the course of the certification effort. RTM extracts from ReqPro will be produced and distributed to the BMS for the initial and the final version of the West Virginia MMIS Certification checklist to validate the status of each CMS Certification system review criteria. Molina will work with the BMS to define the format for the RequisitePro RTM extracts prior to producing/distributing extracts.

5.5.3.3 Phase 2c, MMIS Modifications and Enhancements [3.2.7.3]

Molina provides responses to Phase 2c MMIS Modifications and Enhancements in the following sections.

5.5.3.3.1 Enhancement Request Methodology and Approach [3.2.7.3.1(1-a)]

A successful West Virginia MMIS will provide for continual upgrades and maintenance to the solution and operations to support the Bureau's objective of continuous improvement of programs and health care for its constituents and the rapid and efficient deployment of the West Virginia's ongoing vision. Molina's management and execution of MMIS modifications and enhancements will be performed using proven successful change management methodologies currently functional in West Virginia and other Molina Medicaid accounts.

MMIS Modification and Enhancement Project Execution and Control: For the West Virginia Operations Phase, the Molina Deputy Systems Manager will monitor and manage all modification and enhancement projects (medical/dental and pharmacy) using the same principles and practices that we will deploy throughout the DDI Phase and approved in the Change Management Plan and System Modification and Management Plan deliverables. The format and processes associated with the Enhancement Request (ER) worksheet are included in the System Modification and Management Plan. The System Modification and Management Plan will incorporate the key tenets from the Change Management Plan and other key management plans developed during Phase 1 (e.g., Quality Management, Risk Management, Testing Plan, etc.) The Deputy Systems Manager will monitor projects' efforts and schedules and report status to Molina and the BMS management.

Molina uses the System Modification and Management Plan, approved by the BMS during the Implementation Readiness Phase (1d), as the guide during the Operations Phase to effectively control, track, and monitor all system modification requests, whether submitted by Bureau staff, internally generated by Molina staff, or initiated based on published COTS upgrades. The modification and enhancement activity and method is a formal process built around the Rational ClearQuest and ClearCase maintenance and system modification management products.

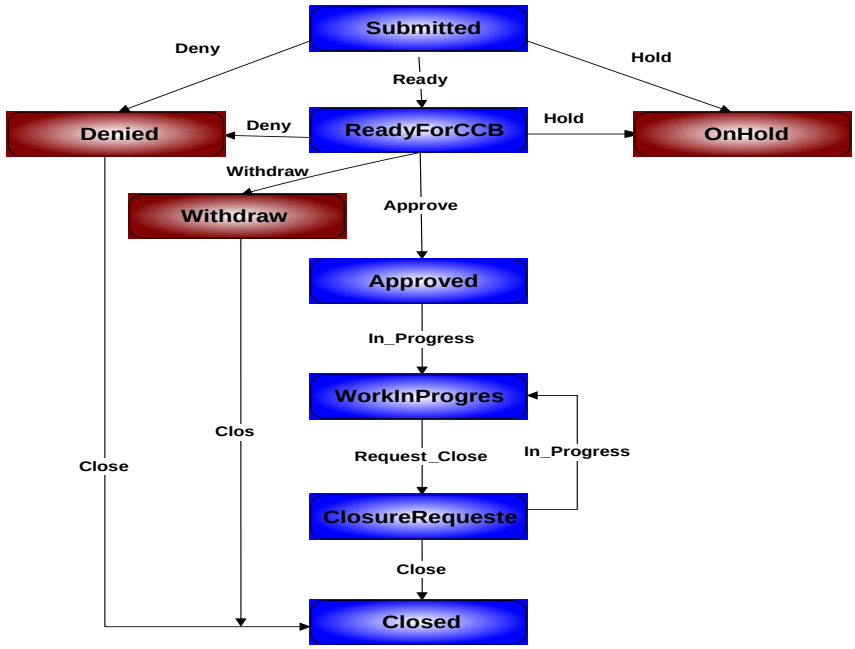
Enhancement management requires a dedicated process, therefore Molina proposes establishing a formal Change Control Board (CCB) that meets at least biweekly to review each change request and make recommendations as necessary on the best, most timely, and cost effective approach to implementing the desired change. The membership of the CCB would include the BMS staff and Molina systems and operations staff. Active BMS participation in the modification and enhancement process validates the effective communication and prioritization of all enhancements; provides approval, denial, or deferral of enhancement requests; and, provides confirmation and approval of completed enhancement requests for deployment into the production environment. All enhancement requests are assigned a priority to verify that resources are working on those enhancements that have the most positive impact overall.

If a requested or required enhancement to Health PAS is a configurable item, it is assigned to a Configuration Analyst to configure/reconfigure the system. Configurable changes can be implemented quickly, since the change requires the Configuration Analyst to modify existing processing parameters through the capabilities of Health PAS. These changes can be validated and approved immediately by the Bureau through an online test to confirm the new configuration works as desired. Once a configuration change is validated in the testing environment, it can be promoted to the baseline configuration of the system and migrated to production.

MMIS Modification and Enhancement Planning Approach: The project modification and enhancement planning approach includes the processes to identify, capture, approve, track, manage, resolve, and report on system modifications to the West Virginia MMIS after the start of operations – it is the process of enhancement management. Enhancements represent new functionality initiated by the Bureau after CMS certification of the new MMIS; modifications are changes requested to existing functionality and programs including maintenance to correct

identified defect resolution. The general activities and flow of requested enhancement management process using the CCB method are defined in **Figure 5.5.3.3.1-1**.

Figure 5.5.3.3.1-1: Operations Phase MMIS Modification and Enhancements Enhancement Workflow



This workflow guides the activities to manage an enhancement from request to final disposition.

During planning for each modification and enhancement project, Molina will develop and present a Statement of Work (SOW) of the change requirements, impact assessments, as well as enhancement work plan, schedule, resource, and effort estimates necessary to complete the requested project. The plan incorporates not only the system components, but also:

- System modifications to infrastructure and hardware
- Adjustments to Molina and the BMS desk level processes
- Provider and user manuals
- Internal and external training
- Communications with providers and other stakeholders
- Updates to deliverable documents.

All modification and enhancement plans will be uniquely identified in a consolidated work plan for the West Virginia MMIS account, so that schedule and effort progress against the plan's estimates can be monitored as well as measured against all other active enhancement project plans. Molina can determine and report on constraints and variances in time, resources, and costs during the projects' progress and adjust the priorities and timeline when necessary.

Molina will continually update the work plan for each project's tasks and the Deputy Systems Manager will provide a weekly status report that summarizes all modification, enhancement, and deficiency resolution projects' progress, report schedule variances, and variance corrective action plans. For a task that falls significantly behind schedule, Molina will apply the resources and effort to return the project to schedule.

Project Change Control Board: Molina will meet with the Bureau during the Implementation Readiness Phase (1d) to establish the CCB. The CCB will be the governance body responsible for review and approval of all account Enhancement Requests (ERs). During the biweekly

meetings, the combined resources of the CCB would recommend any of the following actions concerning an enhancement request:

- Recommend for implementation as a reconfiguration of Health PAS
- Recommend for implementation and scheduling as a software modification task
- Refer to the Molina Health PAS product review board for inclusion in a future Health PAS product release
- Defer for further information and analysis
- Place the enhancement request on hold based on schedule or anticipated future activities considerations
- Withdraw the enhancement request from further CCB consideration when the enhancement is no longer determined to be required.

CCB members provide their expertise in systems or functional areas to facilitate and manage the enhancement requests. They consider the impact of enhancements, and determine whether to escalate for additional information or management review. Both Molina and the Bureau may be asked to provide additional subject matter experts to complete or review requests, associated assessments, and plans for completion. Molina proposes the following CCB members and roles for both the Bureau and Molina. The "CCB Officers" designation identifies those individuals, or their designee, that must be present at all meetings for decisions to be made and accepted. The CCB officers may define a "quorum" system to ensure that even if one of the officers is absent decisions can be made and accepted.

- **Facilitator** – The Facilitator would be responsible for transitioning the enhancement management process from the DDI Phase to the Operations Phase; scheduling and facilitating the CCB meetings; documenting CCB decisions in RQMS; preparing and disseminating CCB meeting agendas and meeting minutes; and, following up for any assigned action items from the CCB meetings. Molina proposes that the facilitator be a shared function for the Bureau's designated Project Manager for MMIS Re-procurement and the Molina Medical/Dental Project Manager or the POS Project Manager depending on the Health PAS component being modified.
- **Enhancement Management Process Owner (CCB Officer)** – The Enhancement Management Process Owner will oversee and monitor the enhancement process effectiveness. The process owner generates enhancement management reports for meetings. Molina proposes that the enhancement management process owner be a shared function for the Bureau's designated Project Manager for MMIS Re-procurement and the Molina Medical/Dental Project Manager or the POS Project Manager.
- **BMS Decision Maker (CCB Officer)** – Molina proposes that the Bureau's Project Officer become the BMS decision maker. The CCB decision maker sets the ER's priority, communicates enhancement information to respective BMS management, requests The BMS subject matter experts, establishes any schedule constraints, and is the final decision maker for the ER's next steps. The Bureau's Project Officer will be responsible for approving all ERs and all decisions to escalate (e.g., if the enhancement will require contractual or fiscal authorization.)
- **Molina Decision Maker (CCB Officer)** – The Molina decision maker will be the Molina Deputy Systems Manager. This individual will have the authority to make Molina's decisions concerning enhancements to the installed solution. The Deputy Systems Manager will review and confirm all Molina-prepared impact assessments and arrange for Molina SMEs to be present at CCB meetings when necessary. The Deputy Systems Manager is also responsible for ensuring the approved enhancements are made accurately and timely.
- **West Virginia and Molina Project Management Office (CCB Officers)** – The designated West Virginia MMIS account Project Manager for MMIS Re-procurement and the Molina

Medical/Dental and POS Project Managers share responsibility for receiving input and information from their respective account team members on potential changes and conduct initial analysis of these requests for completeness and works with the team members to gather and document all required information necessary for the enhancement, facilitates initial enhancement impact assessments, and submits the formal Enhancement Request (via the request management tool, RQMS, as defined in subsequent **Section 5.5.3.3.2**).

- **Contract Manager (CCB Officers)** – This is the Molina and West Virginia team member responsible for compliance to contractual requirements. These individuals establish the boundaries and provide direction for any ERs which require interpretation.
- **System or Operational Subject Matter Experts** – West Virginia and Molina system and operational team members may be asked to participate in CCB meetings and provide the subject matter perspective on the feasibility, impact, and levels of complexity and difficulty of a submitted ER and will vary based on the nature of the ER and attend by invitation only.
- **Scribe** – The Scribe is a Molina team member who is responsible for capturing, preparing, and distributing the results of CCB activities and decisions rendered by the board. Meeting minutes will be posted on the West Virginia MMIS Health PAS-InterComm portal after review by a CCB representative for accuracy and completeness prior to the next CCB meeting. The posted minutes are subject to review and approval during the subsequent CCB meeting.

5.5.3.3.2 Managing Development and Implementation of Modifications and Enhancements [3.2.7.3.1(1-b)]

Molina's management framework for MMIS modifications and enhancement is a professional approach to strategy alignment, process optimization, quality assurance (QA), and management of enhancement performance using formalized procedures modeled from current West Virginia best practices and processes proven in other Molina MMIS accounts. These experiences have demonstrated the importance of strong enhancement management, staff discipline and maturity, processes and methodologies appropriate for the unique components of the West Virginia Operations (e.g., highly integrated business processes, multiple touch points, no disruption to stakeholders, etc.)

Molina understands the Bureau's responsibilities - the Bureau and IV&V teams are key contributors to the project management effort. Bureau and IV&V reviews of Molina prepared modifications and enhancement status, results, and performance provide the Bureau insight into enhancement progress. Bureau participation also provides the formal checkpoints for successful approval of enhancements and the completion of tasks and deliverables through reviews and approvals. This user participation and feedback is essential to Molina meeting the needs of the MMIS and the BMS.

Organization for Modifications and Enhancements Management: The Deputy Systems Manager will be overall responsible for the modifications and system maintenance of the West Virginia MMIS in accordance with the MMIS Modification and Enhancement Plan. The Medical/Dental Systems Manager will be responsible for the non-pharmacy Health PAS modifications; and, the POS Systems Manager will be responsible for the pharmacy modifications. These managers will oversee the systems management, systems maintenance, systems modification staff, configuration management, workflow solution management, database administration, web portal, computer operations, and program support operations. The Deputy Systems Manager will enforce that project processes, methodologies, and other standards are adhered to for deliverable quality management; communication management; risk management; and adherence to Bureau policies, standards, service levels, and contract management.

Both the Medical/Dental and POS Systems Managers and their respective Unitss will be responsible for system maintenance and system modification of the West Virginia MMIS for their respective solutions and will report to the Deputy Systems Manager. The Medical/Dental and POS System Groups are responsible for identifying and triaging system issues; collaborating with the other Systems Group when medical/dental and pharmacy system activities are interrelated; preparing requirements analysis documents for major changes; designing, configuring, constructing, and/or modifying the system solution; planning for and testing and presenting for verification any solution changes required by system modification and maintenance requests; implementing the resolution changes; and, updating system specifications, user manuals, and run guide documents.

Supporting the Systems Managers will be the respective Medical/Dental Project and POS Project Managers. These Project Managers will bring project management expertise, tools, templates, and other experiential intellectual capital to each individual maintenance and system modification project to control and manage each project. Using the approved management plans and the proven methods presented herein, Medical/Dental Project and POS Project Managers will establish and enforce the project management discipline for the respective system units for the West Virginia MMIS account, verifying that required project management processes are followed, standards are applied consistently, project plans are established and managed for the each project, Bureau required approval protocols are followed, and project deliverables are met. Both Project Managers will continually monitor the status and health of the individual modification and enhancement projects and verify that appropriate support or intervention is applied when projects fail to satisfy certain criteria. For projects that are not progressing as planned, the respective Project Manager will escalate the issue to the Deputy System Manager and the Account Manager so that proper resources can be applied to facilitate recovery of the project.

MMIS Enhancement Management Process and Procedure: To manage changing requirements for the West Virginia MMIS project, an ER is prepared by either the Bureau or Molina and submitted to the CCB as defined above and managed using a tool called “Request Management System” (RQMS). RQMS is a web-based centralized request capture, tracking, and management system. It is used to submit and track enhancement requests, as well as operational management issues and action items. RQMS uses IBM’s Rational® tool, ClearQuest, as the framework for enhancement requests and the backend database is Microsoft SQL. RQMS provides ad hoc query and data export capabilities for manipulation in analytical tools such as Microsoft Excel or Access.

When an enhancement has been identified, internally reviewed, and determined to be valid and ready for CCB consideration, the requester completes and adds the ER to RQMS. Each RQMS ticket is assigned a unique reference number by ClearQuest. The RQMS ticket will be the repository for all enhancement management recording activities throughout the enhancement management process. The enhancement management process includes several procedural steps with the RQMS tool as the repository for a change control actions and documentation.

- **Identify Step**: During the Identify Step, the West Virginia project team members, both Molina and Bureau, submit requests for enhancement into RQMS.
- **Capture Step**: The ER is initiated using the RQMS and enters the “Submitted” state with automatic email notifications generated based on site-specific rules. An initial analysis of the impact of the ER is completed by the appropriate SMEs, both technical and operations.
- **Ready for CCB Step**: Upon successful verification and completion of the impact assessment, the ER status is changed to “Ready for CCB” for consideration at the next regularly scheduled CCB meeting.

- **On Hold Step**: The CCB may determine that the ER requires additional information; in this case the CCB will change the ER status “On Hold”. While in “On Hold” status, the requester will be notified and asked to provide additional information; and, when added, the State and/or Molina Deputy Systems Manager will change the ER to “Ready for CCB”.
- **Approve Step**: During the “Approve Step”, the CCB reviews the ER and impact assessment information to make the decision to approve/disapprove the request. During the review of the ER’s impact assessment relative to other ER s’ priorities, the CCB may decide, based on the estimated effort and schedule, that the ER cannot be accomplished with the available staff. In this case, Molina and the Bureau will establish priorities based on the project’s business needs. If approved, the ER is moved to “Approved”, when denied, the reason fo rth denial is added, and the ER is “Denied” and no further action is required.
- **Work in Progress Step**: When the State’s Project Manager approves the ER, the decision reasons, acceptance criteria and project impacts are documented in the RQMS ER ticket prior to the ER status being changed to “Approved”. The ER status must be in “Approved” status in order for the ER status to be updated to the “Work In Progress” status. During this step, the enhancement is designed, tested and certified by the Bureau’s test leader; stakeholder communications planned, prepared and approved; documentation updated; and, the enhancement implemented. All ER deliverables must be approved by the BMS Project Manager at which time the ER status is changed to “Closure Requested”. Test results certifying the enhancement and the State’s approval notification and schedule for implementation, when appropriate, will be attached to the ER in RQMS.
- **Closure Requested Step**: Once the enhancement is at the Closure Requested Step, the CCB verifies that all deliverables and acceptance criteria have been met. The ER is changed back to “Work In Progress” if the CCB determines that the ER has not been completed, or there are defects found in a Deliverable.
- **Closed Step:** If, after CCB review, the ER is rejected by the CCB it will be placed in either the “Denied” or the “Withdrawn” status; the requester will be notified and the rejected ER will be moved to the “Closed” status by the Molina Deputy Systems Manager. If the ER had been “Approved” and the CCB determines that all Deliverables are complete, the ER status is changed to “Closed”.

Molina identifies any training and communications requirements associated with a planned enhancement as part of our general impact assessment of the requested or required enhancement. If external training is required, appropriate Molina operations management or their designated staff provide input to the ER impact assessment, and develop and provide the training materials to supplement the software changes. If internal training is required, Molina training staff provides any required training to Bureau and Molina staff. The ER is not “Closed” until all planned training is successfully completed. External provider or member training materials are prepared, approved by the BMS, and training conducted.

The ER and its associated delivery documentation remain on RQMS for the term of the contract for archive and research purposes. The RQMS tool has the capability to export maintenance and system modification query results in a delimited format for use by analytical tools such as Excel or Access. Each designated RQMS user has the ability to create ad-hoc queries, export the results for further analysis, and format as desired. ER statistics are generated by the Molina Deputy Systems Manager in support of West Virginia project weekly and monthly status reports.

The Molina Deputy Systems Manager will also track the number of allotted annual system modifications hours actually used, estimated to be used based on enhancement work plans, hours not being applied to the allocated annual hours, and allocated hours remaining and report the metrics in the weekly and monthly project status reports.

The Molina Medical/Dental and POS Quality Assurance Managers, as part of the Molina Quality Assurance Unit (QAU), will conduct unbiased reviews of the MMIS modification and enhancement activities. The QA Unit is responsible for conducting quality review of all change output, including ensuring the quality of all operational deliverables prior to installing into production.

Enhancement Project Management: The Molina West Virginia MMIS organization will include a Medical/Dental Project Manager and POS Project Manager on site at the Charleston office during the Operations Phase as an independent unit reporting to the Account Manager. These units will be managed by project management professionals who will supply the project management expertise and processes to support the ongoing operations overall solution maintenance, business process improvement, and enhancement management activities. The Molina Project Managers and system teams will have the expertise, discipline, tools, templates, and experiential capital to monitor the status and health of individual enhancement requests as defined in Figure 5.5.3.3.2-1 below.

Figure 5.5.3.3.2-1: Enhancement Management

Project Management Activity	Enhancement Management Activity
Project Management organization, authority, and application independence.	Outlines the specific authority and staff for ongoing solution maintenance and enhancements.
Present project management methodologies, tools and tools usage, and procedures and schedules	Defines the role of the project management team and the project management deliverables within the enhancement management process.
Project work plan scheduling and assignment of priorities when conflicts of resources and schedules are identified	Describes the prioritization of available resources to meet multiple schedules associated with approved enhancements and upgrades to the solution.
Managing enhancement project scope; scope expansion or contraction mitigation strategies	Describes the Molina and Bureau activities to review and resolve change of scope issues associated with a particular enhancement.
Modifications and enhancement management	Enforces the approved procedures for requesting and executing change for an established solution.
Managing project costs and resources, identifying resource and schedule efficiencies and applying them to the project	Defines the project management measurement and review process to evaluate the allocated resources and approved timelines for enhancement requests.
Managing and resolving issues	Provides outline of formal procedures included in the approved Issues Management Plan.
Managing and resolving project risks	Provides outline of formal procedures included in the approved Risk Management Plan; risks are associated with the ability to meet ER plans and scheduled, impact of change on program stakeholders, operational performance standards, and contractual requirements.
Methods for monitoring, measuring, and reporting project progress and performance	Defines the project management performance measurement methods, reports, and expectations for managing each approved enhancement.
Project Management web portal (Health PAS-InterComm), objectives, capabilities, usage, reporting, communication and alerting, version management, and standards	Defines the approved document maintenance protocols, communications requirements and processes, version control rules, planned content, and deliverable and document archiving.

Project management guidelines provide the framework for enhancement management oversight.

Pages 5-177 through 5-182 contain confidential and proprietary information and have been redacted.

5.5.4 Phase 3: Turnover and Close-Out [3.2.8, 3.2.8.1]

Molina shares with the state of West Virginia the mission of providing consistent, uninterrupted service to West Virginia Medicaid constituents. Having both incoming and outgoing fiscal agent experience, Molina's approach to turnover offers the BMS a proven plan to facilitate continuity of operations.

Molina understands its role as fiscal agent and its responsibility to the state of West Virginia Bureau for Medical Services (BMS) to consistently and effectively meet the interests of the state of West Virginia and its Medicaid stakeholders. If fiscal agent responsibilities are transferred to another vendor, Molina will uphold its duties to facilitate as transparent a transition as possible to the BMS, West Virginia members, and providers. Molina's plan provides the State with continuity for its program. With 28 years of experience in fiscal agent operations, Molina has gained considerable knowledge and qualifications. This dual perspective gives Molina a clear understanding of each party's turnover responsibilities and the key factors contributing to a successful transition. Molina will facilitate cooperation among the successor fiscal agent, other contractors, the state of West Virginia, and Molina. Planning and transfer of operations will allow uninterrupted continuation of services to the State of West Virginia members and the provider community.

Molina will make certain there is a smooth transition to facilitate continuity of operations. Molina has successfully turned over Medicaid operations in other states, such as Florida and Kentucky, without issues.

Molina realizes the need to foster the integrity of both data and program files throughout the turnover process and that claims must continue to be adjudicated in an accurate and timely fashion. Molina will provide a turnover strategy supported by plans, complete documentation, and trained staff (including dedicated special resources as necessary). This strategy will offset the risk of transferring the Medicaid operations and processes to another contractor.

Key elements of Molina turnover strategy include the following:

- A comprehensive Turnover Plan
- Current documentation on the system and operational components of the program
- Staff understanding of their roles and responsibilities during turnover
- Proven processes for monitoring and controlling Quality Assurance (QA)
- An effective package for reporting turnover progress.

Figure 5.5.4-1 depicts the key events associated with preparing for and transferring services to a new contractor.

Figure 5.5.4-1: Turnover and Closeout Phase Activities

1 = BMS Notice of Intent to Transfer, Organize Turnover Management Team; Develop Turnover Plan and Requirements Statement , Turnover Training Plan, Turnover Detailed Methodology , Production Job Listing, MMIS Documentation Inventory List

2 = Update Turnover Plan and Requirements Statement

3 = Submit updated MMIS Turnover Plan and Requirements Statement

4 = Provide data to support parallel testing

5 = Provide Acceptance Testing Support

6 = Turnover to State or New Vendor all applicable data and reference tables, computer programs, operations logs, systems documentation, etc., related to MMIS system operations and update on a monthly basis as required.

7 = Update Turnover Plan and Requirements Statement

8 = Begin Scheduled training of New Vendor staff

9 = MMIS is frozen except for mutually agreed upon Federal or State mandates

10 = Complete training State or New Vendor staff

11 = Submit Turnover Results Report

Molina's transition activities will support the State's objective of continuity of services and payments.

Molina's approach to turnover is designed primarily to prevent disruption of ongoing service. Turnover planning activities will begin about 18 months before the end of the contractual period and complete shortly after the contractual end date, or as extended through contract provisions or amendments, in a timeframe agreed upon with the BMS. For planning purposes, Molina assumes that this phase will begin on January 1, 2020 and end on July 30, 2021, unless the contract is extended. The Turnover and Closeout Phase will be moved one year for each year of contract extension, and Molina will adjust the work plan accordingly. Every effort will be made to foster a MMIS turnover that is transparent to clients, providers, and users. The BMS plays a significant role as mediator and advisor during the Turnover and Closeout Phase and must review the steps taken during this period to facilitate the continued focus on the BMS goals and interests. Molina understands and acknowledges the State's responsibilities and will support the BMS in performing Turnover and Closeout Phase responsibilities.

Molina's account management will verify that the required performance standards continue to be satisfied while completing the planned and scheduled turnover activities. Operations at the time of turnover will continue to function as during normal operations. Molina will work diligently to retain a positive relationship with the BMS, provider and client communities, Centers for Medicare and Medicaid Services (CMS), and other West Virginia Medicaid stakeholders. Molina will support a smooth transition and assist the new fiscal agent in the approved turnover responsibilities. Molina will complete the Turnover and Closeout Phase requirements with the

same professionalism and excellence that it brought to its contract obligations to foster the State's welcoming Molina back as its fiscal agent if a future opportunity arises.

In the remainder of **Section 5.5.4**, Molina presents its Turnover and Closeout Phase strategy. Molina has organized this section of the proposal to sequentially address the RFP requirements.

5.5.4.1 Phase 3 Deliverables and Milestones [3.2.8.1(1), 3.1.24]

Molina will supply all deliverables and meet all milestones for the Turnover and Closeout Phase. Molina provides a brief discussion of all Turnover and Closeout Phase deliverables in **Section D02** – WBS and Deliverables Dictionary. Molina provides all Turnover and Closeout Phase deliverables and meets all scheduled milestones.

5.5.4.2 Completion of Phase 3: Turnover and Close-Out [3.2.8.1(2)]

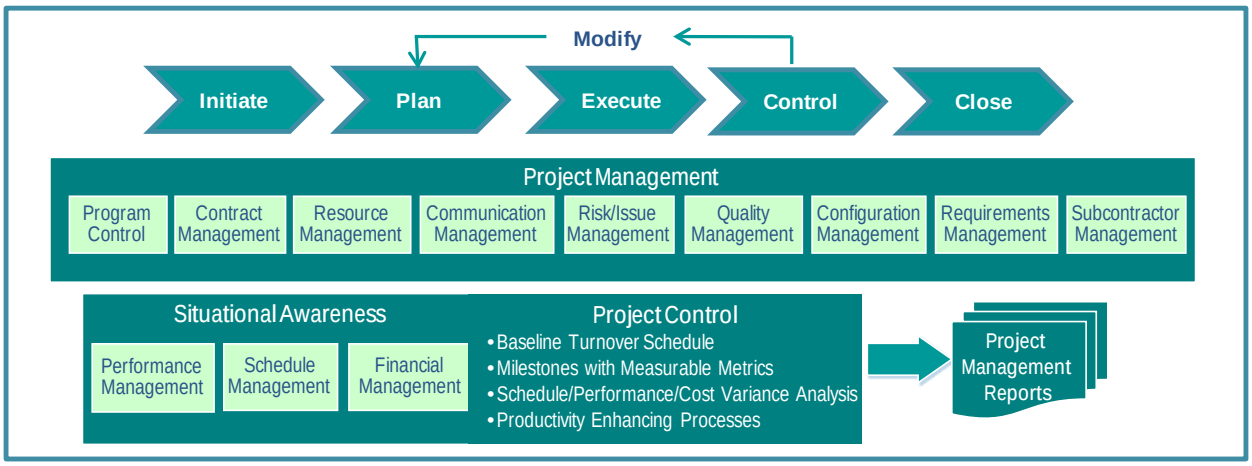
Molina develops a Turnover Plan which will be used to guide project turnover activities. Incorporated in the Turnover Plan are the tasks required to prepare and submit all required phase deliverables. All deliverables are submitted to the BMS for review and approval, and approval of all required phase deliverables is the criteria for successful completion of the Phase. Additionally, Molina will provide training to the incoming contractor on the use of Health PAS and performance of fiscal agent responsibilities. The BMS will approve the training plans and schedule for Turnover and will provide approval that all required training has been successfully completed. The BMS approval of Molina's Turnover training will constitute attainment of the "Completion and the BMS Approval of Turnover Training" milestone.

Once all required deliverables have been approved and once the turnover training is completed and approved, Molina will request that the BMS approve the "Completion and BMS Approval of Turnover and Contract Close-out" milestone. The BMS approval of this milestone will complete Molina's contractual obligations for the West Virginia MMIS project.

5.5.4.3 Turnover Methodologies [3.2.8.1(3)]

Molina utilizes a sound project management framework, illustrated in **Figure 5.5.4.3-1**, to support management of all Turnover and Closeout Phase activities.

Figure 5.5.4.3-1: Turnover Project Management Framework



Molina maintains complete situational awareness of all Turnover and Closeout Phase activities.

The key to a successful project management approach for the Turnover and Closeout Phase rests with thoughtful and detailed preparation and execution of the Turnover Plan. The Molina

Page 5-186 contains confidential and proprietary information and has been redacted.

implementation of all the turnover tasks listed in the contract and in the Turnover Phase work plan to ensure the tasks are performed in accordance with the contract requirements including:

- The assessment and update of MMIS documentation
- The submission of a Turnover Project Plan
- The transfer of contract operations.

The assessment of MMIS documentation will include:

- A complete and comprehensive documentation review and evaluation
- The identification of documentation requiring updates
- A gap analysis identifying specific documentation requiring updates or revisions
- Notification to the BMS of the findings.

Molina will submit the assessment of MMIS documentation for written approval from the BMS prior to proceeding with updates and revisions.

Health PAS is something new to the MMIS arena – a COTS based MMIS solution using commercially available software products with an extensive government and commercial customer base. Molina will provide all production documentation, such as user and operations manuals, system documentation in hard and soft copy, needed to operate and maintain the Health PAS MMIS and the procedures of updating computer programs and other documentation. For the COTS components of Health PAS, Molina will turn over the system documentation provided by the vendor and allowed by their respective licensing agreements.

The Molina Turnover Plan will encompass State-mandated tasks, deliverables, and milestones. The detailed Turnover work plan will be constructed and maintained in Microsoft Project, a powerful tool for identifying, scheduling, controlling, integrating, and documenting the performance of project activities. The high-level tasks and activities for the development of the Turnover Plan will be included in this work plan. Molina will incorporate State activities in the work plan developed for turnover activities and track the progress of both Molina and State activities during execution.

The BMS is the focal point for turnover activities with the incoming fiscal agent. Molina will support the BMS in these activities. During the Turnover and Closeout Phase, Molina envisions a core turnover team to include Molina members, designated subcontractors, and members from the state of West Virginia. This team will drive the turnover effort and turnover activities.

5.5.4.5 Working with Successor Fiscal Agent [3.2.8.1(3.b)]

Molina will work in close cooperation with the State and the incoming Fiscal Agent during the Turnover and Closeout Phase. This is to verify that Molina responsibilities for the turnover are carried out professionally and the incoming contractor receives required transition support. Molina's Turnover Manager will make specific Molina staff available to answer questions, provide information and coordinate turnover activities with the BMS and the new Fiscal Agent.

In providing the required turnover services, Molina will work with the successor contractor willingly and professionally. This will include meeting with the successor contractor regularly during the transition period and verifying that the work schedules are agreeable to the State and the successor contractor, while simultaneously minimizing disruptions to day-to-day operations.

Molina will also provide training to the State and the incoming fiscal agent in the operation of the Health PAS MMIS. The training will include an overview of each subsystem's automated procedures and business operations, along with other specific items to facilitate an adequate transfer of knowledge to the new contractor. Molina's turnover project team in Charleston will

identify Molina personnel who can best meet each specific training requirement. The Turnover Manager will arrange for the participation of staff members with their managers.

5.5.4.6 Turnover Resources [3.2.8.1(3.c)]

Molina will provide the necessary resources to ensure a smooth turnover while continuing to perform contractual fiscal agent operations through contract close-out. Molina will designate a Turnover Manager to facilitate turnover activities. The Molina Account Manager will have authority over the West Virginia fiscal agent contract, will be the State's Single Point of Contact (SPOC) and will have accountability for project matters. During the Turnover Phase, the Molina Turnover Manager will have authority for turnover tasks. Reporting to the Molina Account Manager, the Turnover Manager will be the SPOC and will have accountability for the turnover activities associated with this phase. The Turnover Manager can draw on resources from the Molina Central Engineering, Program Services, and Infrastructure organizations to verify completion of tasks and deliverables. Molina's Turnover Manager will work in cooperation with the incoming contractor's designee to facilitate turnover activities.

One area of obvious concern during the Turnover and Closeout Phase to existing Molina employees is their job status. Molina will work cooperatively with the incoming Fiscal Agent to develop a Staff Transition Plan to transfer those Molina staff where there is a match between new Fiscal Agent staffing needs and the capabilities of Molina's staff. This activity will be performed in such a way as not to negatively affect Molina operations during the Turnover and Closeout Phase and will allow the Medicaid knowledge and expertise represented by Molina's staff to be retained and transitioned for the benefit of the State. Critical to the success of a Turnover Plan is for Molina staff to be positioned to facilitate smooth transition to a new Fiscal Agent, while confirming that current Fiscal Agent operations maintain full servicing of the State and the Medicaid community. Transfer of Molina staff to the incoming Fiscal Agent will provide continuity of institutional knowledge of the West Virginia MMIS program.

5.5.4.7 Approach to Close-Out Financial Reconciliation [3.2.8.1(4)]

Molina is responsible for enabling the Medicaid bank account to remain balanced and all payments and receipts to be accurately documented. Using established financial procedures throughout the contract's operating period, and supported by Health PAS financial functionality, Molina will continue to perform its financial responsibilities during the Turnover and Closeout Phase to:

- Reconcile the MMIS bank account(s)
- Settle all outstanding financial transactions in the bank account(s)
- Settle all Molina invoices
- Reconcile all accounts receivable
- Account for any retained funds or liquidated damages assessed against Molina.

Molina will prepare a bank account reconciliation analysis detailing the activity in the bank account(s) and an itemization of all outstanding transactions processed through the MMIS, but not posted to the bank account(s). This includes all BMS required accounts.

The reconciliation package will include, at a minimum, a book-to-bank reconciliation analysis, a book balance itemization analysis that itemizes monthly receipts and disbursements from the bank account, an outstanding balance analysis that details all check disbursements not posted to the bank account, and any interest-earning statements that document interest generated in the account.

5.6 Drug Rebate Solution [3.2.9]

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5.7 Vendor Proposed Services [3.2.10]

There are moments when the opportunity exists to change the course of human events, and The State of West Virginia and Molina are at such a point right now. The passage of federal health care reform has provided West Virginia and other states such an opportunity. The American Recovery Reinvestment Act (ARRA), the Broadband Act (for which West Virginia is seen as a national innovator and leader), the Patient Protection and Affordable Care Act (PPACA), the HITECH Act, and other regulation have caused states to look many years in advance for their planning and resource allocations. These laws and others have once in a lifetime funding mechanisms, whose timelines and compliance must be adhered to in order for states to receive these funds.

To seize these opportunities States must be innovative, leverage the best practices within their borders while leveraging the experience of other states, and exercise diligence in adhering to the path they choose over the next five to ten years. While West Virginia has long been a leader in health care innovation and has a large number of providers and healthcare officials who know what it takes to be in the vanguard of health care quality improvement, today's opportunity is for West Virginia to take all of the best practices from across the health care arena and expand upon them. This involves an integrated focus on operational efficiencies, and the collapse of administrative overhead. A clinical focus will also be necessary, including defining measurable clinical goals, efficiencies and outcomes.

Throughout this proposal we continually focus on the fact that no other company but Molina has consciously integrated the best of MMIS and MCO services and functionality for the Medicaid population in order to achieve the vision of a fully integrated health care delivery system. Molina's best in class software and hardware management assures that we can:

- Bring up a system to pay claims accurately in 23 months, with a low-risk implementation strategy
- Deliver state of the art multi-payer, multi-benefits information technology to support the State's multiple benefit packages and other programs outside of Medicaid, and even outside of the State
- Deliver state of the art program integrity information technology to support existing State staff in their operations
- Deliver best in class care coordination/care management information technology to support internal and external care teams in their operations by giving users and case managers, access to Medicaid patient health data and to the State health information exchange data
- Deliver state of the art pharmacy information technology to support internal and external end users in their operations
- Molina was conceived to deliver a best of breed State healthcare partnership enabling us to work side by side with states to deliver innovative and state of the art service delivery solutions. This is not a "cookie cutter" or "one-size-fits-all" approach. The Molina vision is a fully integrated, but loosely coupled service-oriented approach to addressing health care business problems, providing people, processes, systems, and services to bear directly on state-specific issues.
- Molina recognizes that this procurement, while incorporating services and systems previously provided by Molina as the fiscal agent, is far more than an MMIS replacement opportunity. It is an opportunity to redesign systems and processes to enable the transformation of the system of care for West Virginians.

As the chosen vendor, Molina will assist the State and the BMS in appropriately redesigning business processes, as needed, as well as ensuring a smooth and successful Certification

process by CMS. Throughout this proposal, we demonstrate our understanding of West Virginia's current functional challenges and goals, as well as the innovative direction which it has undertaken.

Molina recognizes the importance of West Virginia's technical and application infrastructure to the future of the Medicaid Enterprise and its beneficiaries. West Virginia has already enhanced its management capabilities through federal waivers and grants such as the Broadband Initiative, as well as state-sponsored care based initiatives such as e-prescribing. In addition, DHHR, the BMS, and Molina have demonstrated fiscal and operational efficiencies for the future by designing a solution to bring BHHF onto the MMIS platform. Furthermore, this same partnership is working with CMS Regions 2 and 3 to develop a multi-state / territory platform beta by bringing the United States Virgin Islands (USVI) onto West Virginia's MMIS platform. These improvements enhance the BMS' ability to improve access to appropriate, cost-effective, quality healthcare to all West Virginians.

However, the integration of systems and processes, both internal and external to the BMS is a prerequisite to true system transformation. Molina is prepared to bring the technology and know-how to the table to enable the transformation of the health care system in West Virginia.

The Future

Over the next few years West Virginia, like all states will be facing unprecedented challenges in managing federally required and recommended Medicaid program initiatives. Mandated legislative requirements presented in the Deficit Reduction Act (DRA), the American Reinvestment and Recovery Act (ARRA) and coinciding "Meaningful Use" stipulates, the HiTech Act, the Broadband Act, the Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act (HIPAA) and Medicaid Information Technology Architecture (MITA), will have profound impact through 2015 and beyond. Just a small sampling of the areas impacted from now through 2015 is illustrated in **Figure 5.7-1**.

Figure 5.7-1: Major Program Impacts through 2015

Major Medicaid Program Impacts Through 2015	Timeline by Year				
	2011	2012	2013	2014	2015
HIE/EHR/HIT Activities	✓	✓	✓	✓	
Federal 5010, D0 and ICD-10 Activities	✓	✓	✓		
E-Prescribing Activities		✓	✓		
Fraud and Abuse Activities	✓	✓	✓		
Meaningful Use Activities	✓	✓	✓	✓	✓
Patient Protection and Affordable Care Act	✓	✓	✓	✓	✓

Medicaid faces unprecedented challenges between now and 2015.

All of the items listed in the graphic presented above represent multiple change items impacting the MMIS during each respective year listed. For example, specific fraud and abuse activities in 2012 include:

- Develop fraud and abuse transference reporting to regional ZPICs with MMIS (also requires connectivity to Medicaid HIE / EHR) and to state Medicaid Fraud Units
- Implement provider screening module in MMIS for fraud and abuse to include licensure checks (including across state lines), DOBs, NPI identifiers, NPDB licensure, HHS OIG exclusion, tax ID number, tax delinquency, death of provider, criminal background checks, fingerprinting, and database checks

Pages 5-203 through 5-204 contain confidential and proprietary information and have been redacted.

Molina Healthcare has decades of experience providing utilization management, disease management, case management, and care coordination programs that encourage members to play an active role in their health status, and cost efficiency without compromising quality of care. Molina offers several culturally appropriate disease management programs including asthma, diabetes, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), hypertension and Chronic Obstructive Pulmonary Disease (COPD). Each program is managed by a collaborative team of practitioners who utilize evidence-based, nationally-recognized clinical practice guidelines that form the foundation of all of Molina's disease management programs. These guidelines originate from national guidelines such as the American Diabetes Association Guidelines for the diagnosis and management of diabetes, the National Heart Lung and Blood Institutes' Expert Panel Reports for Asthma and The American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depressive Disorder.

Molina identifies members for inclusion in its disease management programs with the goal to improve clinical outcomes through continual rather than episodic care, and to enable members to manage their symptoms optimally to improve their quality of life. Members may also be referred by utilization management staff, providers or themselves for evaluation. All members identified as eligible for participation are automatically enrolled in appropriate programs and mailed an introductory welcome letter and program materials. The success of member engagement in Molina Healthcare care management programs is reflected in a consistently low opt-out rate of less than one percent of those enrolled in the programs.

The focus of Molina's care management programs are interventions to ensure that the member and/or family understands key self-management concepts and has the resources for implementation and is engaged in the process. All education is consistent with nationally accepted guidelines for the respective chronic condition. Members enrolled in moderate- or high-levels of disease management care are assigned to a care manager, who collaborates with the member to develop an integrated care plan that addresses the member's individual conditions and needs. Lifestyle issues such as smoking, activity and exercise level, weight, nutrition and substance abuse can influence the scope and requirements of the care plan.

Recent results of our disease management programs include:

- Molina's Breathe with Ease Adult Asthma Program - disease-related annual inpatient admittance rates per thousand were 174 in 2007 and 49 in 2009; disease-related costs Per Member Per Month (PMPM) were $134 in 2007 and $57 in 2009
- Molina's Healthy Living With Diabetes pediatric diabetes program - disease-related annual inpatient admittance rates per thousand were 340 in 2007 and 219 in 2009, disease-related costs PMPM were $274 in 2007 and $194 in 2009
- Molina's Healthy Heart Program for Heart Failure- disease-related annual emergency department visit rates per thousand were 357 in 2007 and 149 in 2009, disease-related costs PMPM were $542 in 2007 and $223 in 2009
- Molina's Healthy Heart Program for Coronary Artery Disease- disease-related annual inpatient admittance rates per thousand were 193 in 2007 and 59 in 2009, disease-related costs PMPM were $231 in 2007 and $85 in 2009
- Molina's Chronic Obstructive Pulmonary Disease (COPD) program - disease-related annual emergency department visit rates per thousand were 395 in 2007 and 161 in 2009, and disease-related costs PMPM were $290 in 2007 and $145 in 2009
- Incorporated text4baby SMS text service to provide gestational, age appropriate messaging for pregnant mothers in 2010 (http://www.text4baby.org/partner.html.)

In Maryland, Molina manages the Rare and Expensive Medical Case Management (REM) program. Molina is responsible for the care of approximately 3,000 Medicaid recipients with

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5.8 BMS Optional Services [3.2.11, 3.1.23]

Molina brings to West Virginia a wealth of experience in innovative approaches that increase efficiency and reduce cost in the health care arena, including providing data and clinical experience to better manage health care costs The use of COTS products allows Molina to focus on West Virginia DDI activities while the vendors of the COTS Health PAS components focus on incorporating requirements presented in the DRA, the ARRA and Meaningful Use, the HITECH Act, the Broadband Act, the Patient Protection and Affordable Care Act, HIPAA, and MITA.

In this section, Molina provides its proposed approach to the BMS optional services listed in **Figure 5.8-1**.

Figure 5.8-1: BMS Optional Services

Proposal Section	Topic	Overview
5.8.1	Drug Rebate	Please refer to proposal section 5.6 Drug Rebate Solution. Per Addendum 3, dated 3/18/2011, this optional service has been removed from the RFP.
5.8.2	Care Management	Molina's Care Management process combines superior technical solutions with best practices for disease and care management, utilizing nationally recognized guidelines and proven clinical management techniques. Molina recommends the following services to maximize healthcare value: Utilization Management, Disease Management, Case Management, and Nurse Advice Line.
5.8.3	Care Management Registry Management	Molina's comprehensive Health PAS ARRA solution suite is comprised of HIE connectivity tools, virtual health record display tools, Personal Health Record and care coordination care management tools that allow Molina to help facilitate connectivity and sharing of various data streams with the State Health Information Exchange and with authorized providers, patients and state users.
5.8.4	Healthy Rewards Program Management	Molina's recommended Healthy Rewards programs utilize methods proven successful in our Medicaid programs combined with the foundation already present in West Virginia including engagement and response methods to improve the level of involvement of members with their health care. Incentive points are expected to increase the use of preventive services, compliance with treatment care plans and reinforce behavioral changes. Rewards to providers are based on points awarded to assigned members with the assumption that providers will encourage their patients to earn points. These reinforcements increase the likelihood of desired behavior without changing benefit or cost structure within the existing Medicaid program.
5.8.5	Personal Health Records (PHR)	Molina's approach to a PHR system provides an invaluable tool in Medicaid patient care for West Virginia. The PHR enables patients to have a view into

Proposal Section	Topic	Overview
		their data in a clinically appropriate, informative presentation. Patients become an active member in their care by using the technical tools to stay informed and in active communication with their providers regarding their care needs – creating a true continuous circle of care between the payer, provider, case manager, and patient.
5.8.6	Personal Health Improvement Plans Management (PHIP)	Molina's PHIP combines proven wellness interventions with a dynamic web-based platform, allowing members to craft their own health improvement plan with goals and milestones, along with access to their personal health information, links to local resources, wellness education materials, and any care plan goals and objectives. Offering meaningful programs with tangible outcomes via a robust member web portal will encourage members to take a more active role in their own health care management.
5.8.7	HITECH: Electronic Health Records (EHR) Incentive Program	Molina's optional Health PAS Provider Incentive Payment solution provides comprehensive ARRA registration, attestation, oversight and reporting EHR capabilities that will continue to evolve as the Stage 2 and Stage 3 Meaningful Use requirements and analysis are finalized.
5.8.8	HITECH: Health Information Exchange (HIE) Models	Molina offers the BMS a comprehensive HIE solution that can be leveraged by Medicaid to provide bi-directional data exchange with providers, payers, hospitals, laboratories, and non-standard data sources, in near real time delivery, to a Statewide HIE. Users of the various supporting applications have access to vast amounts of clinical and administrative data on the patient, enabling a virtual health record for patient review and analysis.
5.8.9	Eligibility Determination System	Molina has teaming partners that can provide this capability including integration with our proposed MMIS replacement system. Due to the time constraints of the proposal response and the fluctuating regulations in this area of Health Reform, Molina would prefer to have work collaboratively with the Bureau to select the best partner and approach. Upon contract award, Molina will work the Bureau to select the teaming partner that best suits West Virginia needs.
5.8.10	Permanent Member Cards	Molina's proposed permanent member cards provide durability, security, flexibility and a more cost effective alternative to monthly paper ID cards.
5.8.11	Real Time Member Eligibility	Molina's Member Eligibility Gateway (MEG) facilitates real time member eligibility loads in addition to batch processing of large monthly eligibility files.
5.8.12	Enhanced Member Web Portal	Molina's member web portal includes a suite of

Proposal Section	Topic	Overview
	Functionality	clinical, educational, and reporting tools for individuals designed to improve long-term health care and reduce medical expenditures by informing the patient on their care history, care authorizations and care needs. Additional administrative capabilities are recommended to improve the members overall interaction with the Medicaid program.
5.8.13	Interfaces with External Data Stores	Molina's optional solution enables batch and real time connection to disparate data sources that are external to the MMIS for use by the MMIS or DSS, as well as the State Health Information Exchange.

As a health care organization Molina is uniquely positioned to assist the BMS with optional services to provide effective services to providers and members while improving the health of the Medicaid community.

5.8.1 Drug Rebate [3.2.11, #1]

Please refer to proposal section 5.6 Drug Rebate Solution. Per Addendum 3, dated 3/18/2011, this optional service has been removed from the RFP.

5.8.2 Care Management [3.2.11, #2]

Molina proposes a comprehensive, data-driven care management option.

In this section the Molina Healthcare Care Management programs are presented in detail. As an optional service to the RFP, our Care Management process combines superior technical solutions with best practices for disease and care management. Our clinical programs utilize nationally recognized guidelines and proven clinical management techniques. These tools are available as an optional service and are not included in the care management functionality provided in our standard MMIS product.

Molina Healthcare started as a single clinic opened in 1980 by C. David Molina, M.D. as a safety net provider dedicated to caring for underserved members in a patient-centered, Medical Home environment. Today, Dr. Mario Molina, Molina's Chief Executive Officer and C. David Molina's son, provides physician leadership to direct the activities of Molina Healthcare's administration of individualized, outcomes-focused managed care services for Medicaid, CHIP, Medicare and other government programs serving approximately 1.6 million members in ten states. Molina Healthcare's core services include preventive and primary care, urgent care, long-term care, behavioral health, prenatal care, care for children with special health care needs, pharmacy services, case management, disease management and other services as required by the applicable state agencies. Molina Healthcare also offers health information management and business process outsourcing solutions for state Medicaid programs through its subsidiary, Molina Medicaid Solutions, which holds MMIS contracts in Idaho, Louisiana, Maine, New Jersey and West Virginia. Combined, Molina's services touch approximately 4.3 million Medicaid beneficiaries and 189,000 providers in 15 states, making it one of the largest national Medicaid vendors.

Molina is committed to its core mission of administering healthcare services to the underserved. 98.5% of its total members are Medicaid beneficiaries and the majority of its Medicare members are also dually eligible for Medicaid. Molina has significant experience in providing both healthcare and fiscal agent services to Medicaid beneficiaries. We are uniquely positioned to meet West Virginia's Medicaid needs through a single-sourced, integrated suite of services.

Pages 5-212 through 5-268 contain confidential and proprietary information and have been redacted.

5.8.10 Permanent Member Cards [3.2.11, #10]

Molina's proposed permanent member care optional solution provides more durable, flexible, and efficient identification (ID) card management.

Currently, West Virginia Medicaid and Foster Care members receive monthly paper cards with a predefined monthly range of eligibility for medical and pharmacy benefits.. The plastic ID cards will replace the functionality of the monthly paper cards.

The ID cards are not Electronic Benefit Transfers (EBT) cards and do not hold any monetary value. A Personal Identification Number (PIN) will not be associated with usage of the ID card for either the member or provider. Each member will be issued their own ID card. For example, a family of four (4) who is on Medicaid would receive four (4) individual ID cards.

Figure 5.8.10-1: Proposed Permanent Member Cards Features and Benefits

Feature	Benefit
Durability and Security	• The permanent ID card is durable. All updates to eligibility and status are accessed, not defined, by the card via the data on the magnetic strip • Possession of the card does not verify eligibility • The card does not contain enough information to allow Medicaid fraud. Status and eligibility are maintained in MMIS, not on the card • The Permanent ID Card can be updated with additional information in the future – such as a PIN or other information to support MITA compliance and improve service to the member • Procedures for invalidation and destruction of undeliverable cards ensure security.
Cost	Postage costs are better controlled.
Flexibility	• Replacement ID cards are not required each time eligibility changes (e.g., medically needy members with 'spend down' eligibility) • This approach supports temporary eligibility, lock-in, and other features to manage eligibility in a more proactive and efficient manner.

5.8.10.1 Solution Scope Description

Molina and the BMS will work together on the design of the plastic ID card. The front of the card will display three critical data elements:

- Member name
- Medicaid member ID
- Card Control Number (CCN.)

The plastic ID card will have a magnetic strip to store the above mentioned data points and other personal identification values, however it will not include periods of eligibility. Medical history for the member will not be stored in the magnetic strip. The magnetic strip will store the following data elements:

- Member Medicaid ID (MAID)
- CCN
- Member name
- Member date of birth.

The holder for the card will contain the BMS and Molina contact information and important messages for the member that is currently available on the monthly paper cards.

Molina provides applicable business and technical specifications with proposed solutions in the following table:

Permanent Member Cards Capabilities and Solution Description	
Requirement Number	Business and technical specifications with proposed solution
1	*Card Input and Usage*
• The source data for the card generation will be obtained solely from West Virginia (WV) Medicaid Management Information System (MMIS) • The MMIS ENTITY name and External Gap table for address and primary person information will continue to be received from Recipient Automated Payment and Information Data System (RAPIDS) and Family and Children Tracking System (FACTS) daily and monthly demographic files when there is active eligibility reported • One card for a RAPIDS member in active status will be mailed to the Primary Person • One card for a FACTS Foster Care member in active status will be mailed to the Primary Person (Provider/Guardian) • A member with both an active RAPIDS and FACTS Foster Care eligibility segment will receive 2 cards.	
2	*Card Specifications*
• The ID cards are not smart cards and will only contain a magnetic strip • The ID card will be issued at the individual level not case (family) level • The ID cards will display the following information on the front of the card: member Medicaid ID (MAID) number, member name, and Card Control Number (CCN.)	
3	*Card Generation*
Oberthur will handle the creation, generation, and mailing of the ID cards.	
4	*Card Security*
• All previously issued cards are deactivated • An inactive card cannot be made active • No changes will be performed in the AVRS system and 271 transactions.	
5	*Returned Cards*
• The United States Postal Service returned cards will be sent to the Molina Card Verification Unit Post Office box • The updated address information available thru the WV MMIS User Interface (UI) and/or Member Interface Analysis (MIA) Report can be used to re-label and resend returned cards.	
6	*Replacement Cards*
The Molina Card Verification Unit will verify the member's identify before qualifying for a replacement card.	

5.8.10.2 Project Tasks and Deliverables

Molina proposes the following project tasks:

- Develop the identification card design
- Review the identification card design with the BMS
- Develop member and provider notification letters.

Molina proposes the following deliverables:

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5.9 Project Management [3.2.2]

Pages 5-291 through 5-292 contain confidential and proprietary information and have been redacted.

MMIS project. The Molina toolset is flexible in that its methodology allows Molina to select the right tools to meet the needs of a particular project. Molina updates and refines the project management tools selected based on the best practices and lessons learned from Molina successes in prior implementations of Health PAS. Molina applies integrated COTS project management tools to consolidate reports and update management plans required for the West Virginia MMIS project.

Molina actively uses industry standard professional project management standards, methodologies and processes to ensure the West Virginia MMIS project is delivered on time, within scope, within budget, and in accordance with the Bureau's quality expectations. The Molina PMI-based methodology is structured to be uniformly applied across all project phases, from Phase 1 – DDI and CMS Certification Planning to Phase 3 – Turnover and Close-out. Use of a consistent, repeatable project management methodology facilitates positive results.

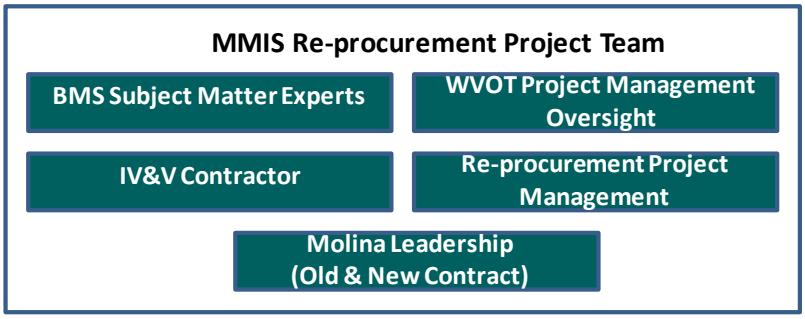
PROJECT CONTROL APPROACH

Molina will establish a formal PMO on site at the office in Charleston, West Virginia. The PMO adheres to PMI standards and principles as recorded in the PMBOK and is responsible for producing the project documentation required in managing the MMIS project. The PMO is charged with supplying project managers as needed to support the implementation effort, and during ongoing operations to support larger projects. The Molina PMO will bring expertise, tools, templates, and other intellectual capital to promote success of the project. The PMO also will be the keeper of the project management discipline for the West Virginia account, verifying that all required project management steps are followed, that standards are adhered to, that project plans are established as appropriate, and that project deliverables are met. The PMO will also monitor the status and health of individual projects, and verify that appropriate support or intervention is applied when projects fail to satisfy certain criteria.

Assigned Molina project managers will maintain and update project work plans and produce various reports from the plan that are indicative of project progress, such as tasks completed or tasks not started as planned. For activities that are not progressing as planned, the PMO will be able to escalate the issue to appropriate levels of Molina management to facilitate recovery and get the project back on track. The PMO will check to see that project processes, methodologies, and other standards are adhered to from the perspective of quality management, communications management, risk management, adherence to regulatory policies, standards, contract management and other areas.

Molina will effectively integrate with the MMIS Re-procurement Project Team, illustrated in **Figure 5.9.1-2**.

Figure 5.9.1-2: MMIS Re-procurement Project Team



The Molina West Virginia project team integrates easily with the MMIS Re-procurement Project Team.

Sound project control practices and processes are the single most effective method known to increase a project's probability of success. Project control is the simultaneous awareness of

project finances, schedule, requirements, risk status, and QA status, which enable the identification of necessary and effective impact analysis and corrective actions; comparing the status of multiple control areas within the baseline project plan. The result provides the project team with a clear view of a project's inner workings and necessary awareness of the project's status. This knowledge enables the project team to anticipate and understand project issues, risks and mitigation strategies.

Project control includes project plan updates and control system maintenance. Proposed changes to the project plans must be submitted through the project's control process and be approved before they are implemented. **Figure 5.9.1-3** depicts the main elements of the Molina integrated project control methodology.

Figure 5.9.1-3: Integrated Project Control

Molina's integrated project control approach will encompass the project—fostering accurate control and project performance.

The project control process is the responsibility of all members of the West Virginia MMIS management team, including the Account Manager, functional managers and project managers who must confirm that project control is exercised in sufficient detail consistent with the needs of the lowest level of management. The use of project metrics is a key element of identifying and maintaining information used in project control.

For individual projects, the Molina project manager is responsible for working with the Molina PMO to prepare regular project status reports. Molina status reporting process will comply with the RFP requirements. The Molina Account Manager and the individual project manager, or his

or her designees, will represent Molina at project status meetings. If required, supporting Molina managers for West Virginia will also attend and present material appropriate to their areas of responsibility. To control costs, remotely located managers and key personnel will participate through the Molina teleconferencing capability, as mutually agreed upon with the Bureau.

Project team members will prepare weekly status reports, and the Molina Account Manager will approve the final consolidated version. The report will contain an executive summary of the overall status of the project, including progress against the Bureau -approved work plan and deliverable schedule. Variances to schedule or budget will be reported to the State, and Molina will work with the Bureau to address variances to verify overall completion of the project within time and budget constraints. Molina will provide project status information to the MMIS Re-procurement Project Manager in the timeframes and in the agreed-upon format. When necessary, Molina will work with the Bureau for approval of fast-tracking or reallocation of resources to get a project back on schedule and within budget.

PROJECT GOVERNANCE

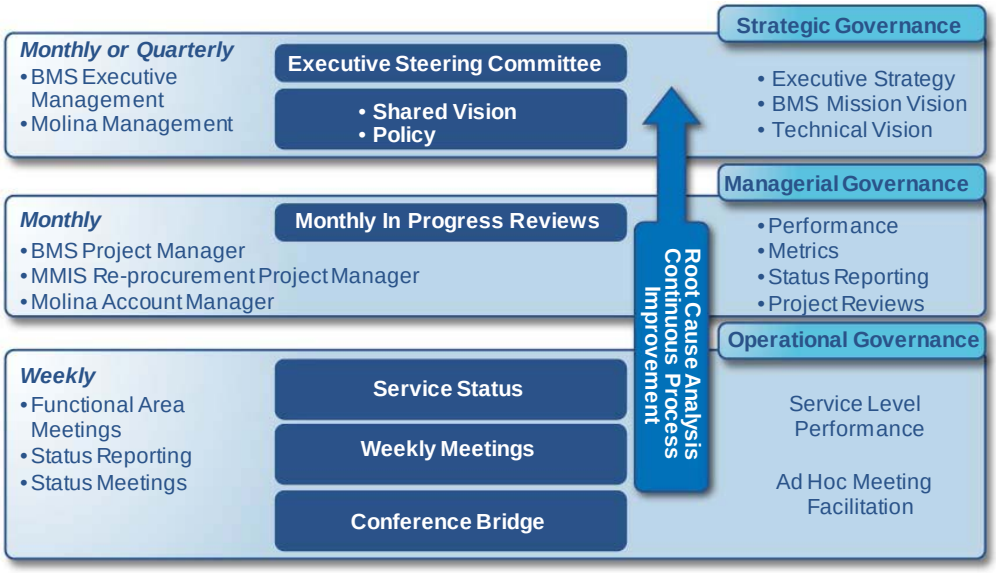
Molina's PMO will be charged with keeping the project work plan updated weekly and providing project plan reports to track the progress and health of the project. The Charleston Management Team will conduct weekly project status meetings; review project plan updates; and provide input to the MMIS Re-procurement Project Manager's project status reports. Molina will meet weekly with the BMS and/or the MMIS Re-procurement Project Team to review project status and identify, discuss, and implement corrective actions for issues affecting the project.

The Molina Account Manager will be responsible for directly overseeing project activities and escalating project issues to Molina executive management when required. At least quarterly, and more frequently when required, the Molina account team will meet with Molina executive management to review project status and identify issues. This executive oversight will help the project stay on track and provide a means to facilitate additional support when required.

Molina proposes establishing a joint Executive Steering Committee to provide oversight and guidance. Molina account management will prepare the agenda and serve as secretary for Executive Steering Committee meetings. The secretary will distribute meeting minutes within 24 hours of meeting adjournment. Molina will work with the State to include on the Executive Steering Committee positions that the State finds appropriate. The Executive Steering Committee will meet monthly with an agenda set in advance—providing a forum to review project progress and determine if changes in direction are required.

Molina believes that a close BMS and Molina Team partnership is critical to meeting project objectives and delivering and maintaining value. The partnership approach enables open communications, promotes close cooperation, and maintains the positive working relationship necessary for project success. **Figure 5.9.1-4** depicts Molina's proposed governance framework, the timing of various status reviews, the primary Molina contact, and the objectives under which Molina's organization will operate at each level.

Figure 5.9.1-4: Governance Framework



Molina's proposed governance model will promote close management cooperation, communication, and active participation at all levels of management.

Molina Team internal weekly meetings and briefings will be used to provide a status update and plan of the week's activities. Additionally, weekly meetings will be scheduled between the Molina Account Manager and the BMS counterpart to provide a formal status of activities. Monthly meetings will be held between the Molina Account Manager and appropriate BMS management to discuss overall program activities and the status of tasks in progress.

Weekly, monthly, and quarterly meetings will provide defined communication conduits that verify the levels of management are kept informed of the status and health of the West Virginia MMIS project. The Molina Account Manager will facilitate ongoing communication between State contacts and the Molina Team.

INTERACTION WITH THE BMS PROJECT PLAN

Molina's project management methodology and approach is based on PMI standards and will interact effectively with the overarching the BMS Project Plan, which was also developed using industry recognized project management methods. Molina will work cooperatively with the MMIS Re-Procurement Project Team for successful execution of the MMIS project.

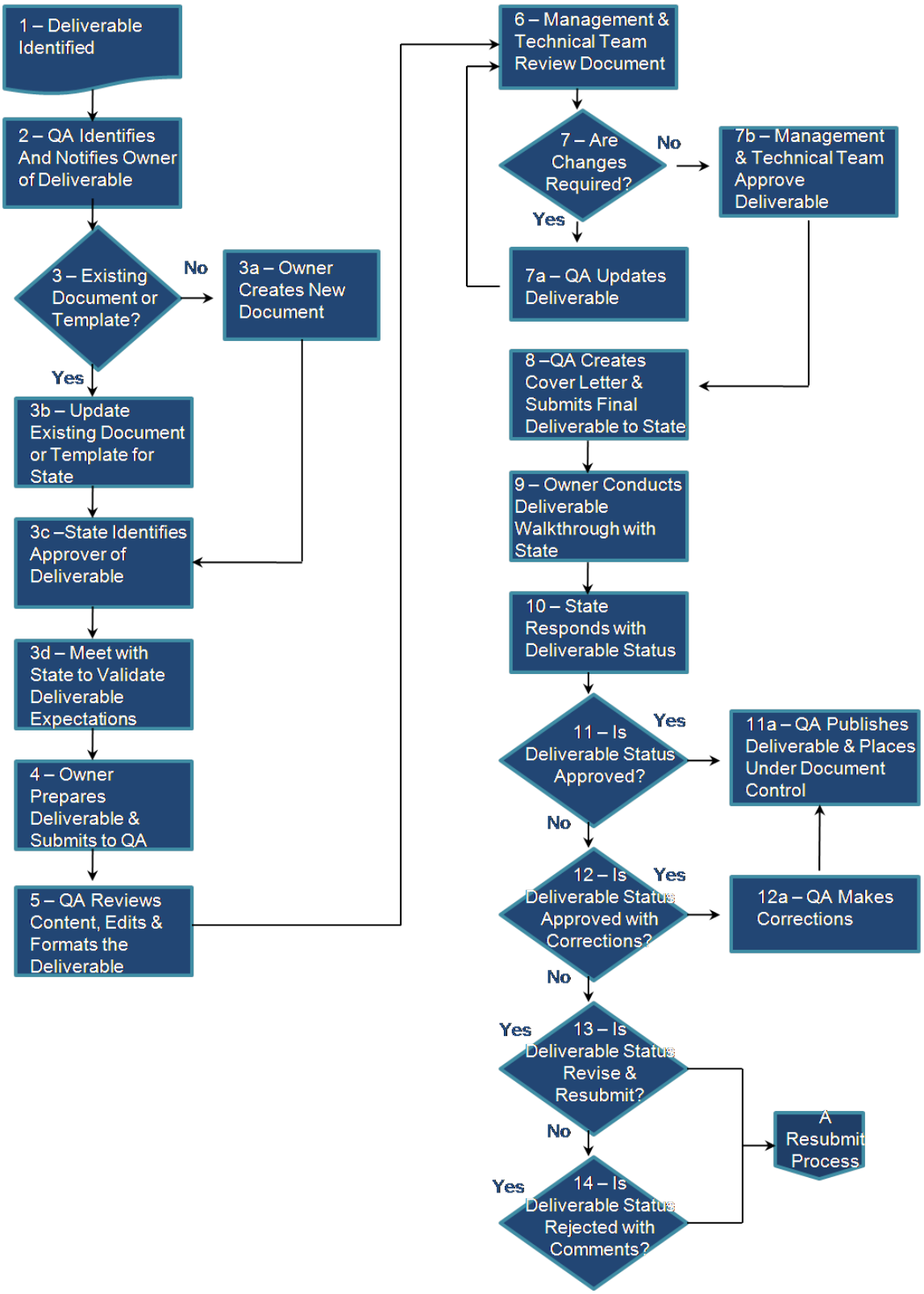
5.9.2 Deliverable Acceptance Process [3.2.2.1]

For the West Virginia MMIS project, the BMS requires the deliverables listed in **Section D02 – WBS and Deliverables Dictionary.** Molina understands the criticality to the State of each deliverable listed and will meet the delivery timeframe specified for each deliverable. Molina will provide the required deliverables for the West Virginia MMIS project.

Please note that Molina has added a Project Management task to its work plan which encompasses activities that impact all project phases. This includes program and infrastructure services activities. Some of the common deliverables required by project phase, such as weekly and monthly status reports, have been pulled up into this project management task. Otherwise, the Molina work plan aligns with RFP phase requirements.

As depicted in **Figure 5.9.2-1**, Molina QA personnel will be involved in developing and reviewing the West Virginia MMIS deliverables.

Figure 5.9.2-1: Deliverables Process Flow



Molina will use a clearly defined process to develop and provide quality deliverables to the BMS.

Molina also makes use of deliverable templates when possible and then tailors them to meet West Virginia requirements. For instance, Molina has standard templates for project plans, such as the Risk Management Plan, Quality Management Plan, and others. Use of these standard templates will save effort and help Molina provide quality, professional deliverables to the BMS. Molina will also leverage existing project plans as a means to facilitate the deliverable submission process.

Molina's approach to meeting milestone and deliverable timelines, and completion of major activities, will center on diligent monitoring of the Project Work Plan and proactive project management. Molina structures all key project management plan deliverables with the expectation that these plans are evergreen documents that may need revision due to evolving program requirements. Molina will update deliverables at the request of the BMS to align with major changes in project approach or methodology, or to include new or updated information that was not available at the time the deliverable was first submitted and approved.

All Molina project plan deliverables have a Revision History at the front of the document to maintain an audit trail of changes to the plan. This is illustrated in **Figure 5.9.2-2**.

Figure 5.9.2-2: Plan Revision History

REVISION HISTORY

Version	Date	Author	Summary of Changes
1.1			Initial release

Molina maintains a revision history for all project plan deliverables.

DETAILED DELIVERABLE PROCEDURES

The step-by-step process that Molina will use to produce and provide quality deliverables to the BMS encompasses the following:

- **Deliverable Identification**—The RFP identifies the deliverables required by the BMS (see Figure 5.9.2-1). Each deliverable is included in the draft PWP provided in **Section D03 Project Schedule**. Molina's West Virginia QA group will be responsible for confirming that deliverables are identified and appropriately assigned.
- **QA Identification and Notification of Author/Owner**— Molina's QA group will identify the appropriate author/owner of each deliverable. For instance, the Quality Management Plan will be assigned to members of the quality staff, and the DRP will be assigned to a team of data center, network, and operations personnel. One person will be assigned as owner of the deliverable to lead the effort in developing it. Molina's West Virginia QA staff will notify the assigned author/owner of each deliverable of their responsibilities and timelines for completing the deliverable. QA staff will also notify the manager of the author/owner so everyone in the chain of command is aware of who is responsible for deliverable production.
- **Determine Deliverable Document or Template**—Molina maintains a library of baseline deliverables and templates for deliverables, such as templates for a PMP or Quality Management Plan. If Molina does not have a document or template for a deliverable in this library, Molina will perform a search for an appropriate template from its teaming partners or suppliers. If a document or template is identified, Molina will tailor it to meet West Virginia requirements. If a document or template is not identified, QA will work with the author/owner to create an appropriate deliverable template. As the incumbent fiscal agent, Molina has many of the RFP-required deliverables already developed and approved by the BMS.

Molina will use these approved deliverables and update them as required to meet RFP requirements.

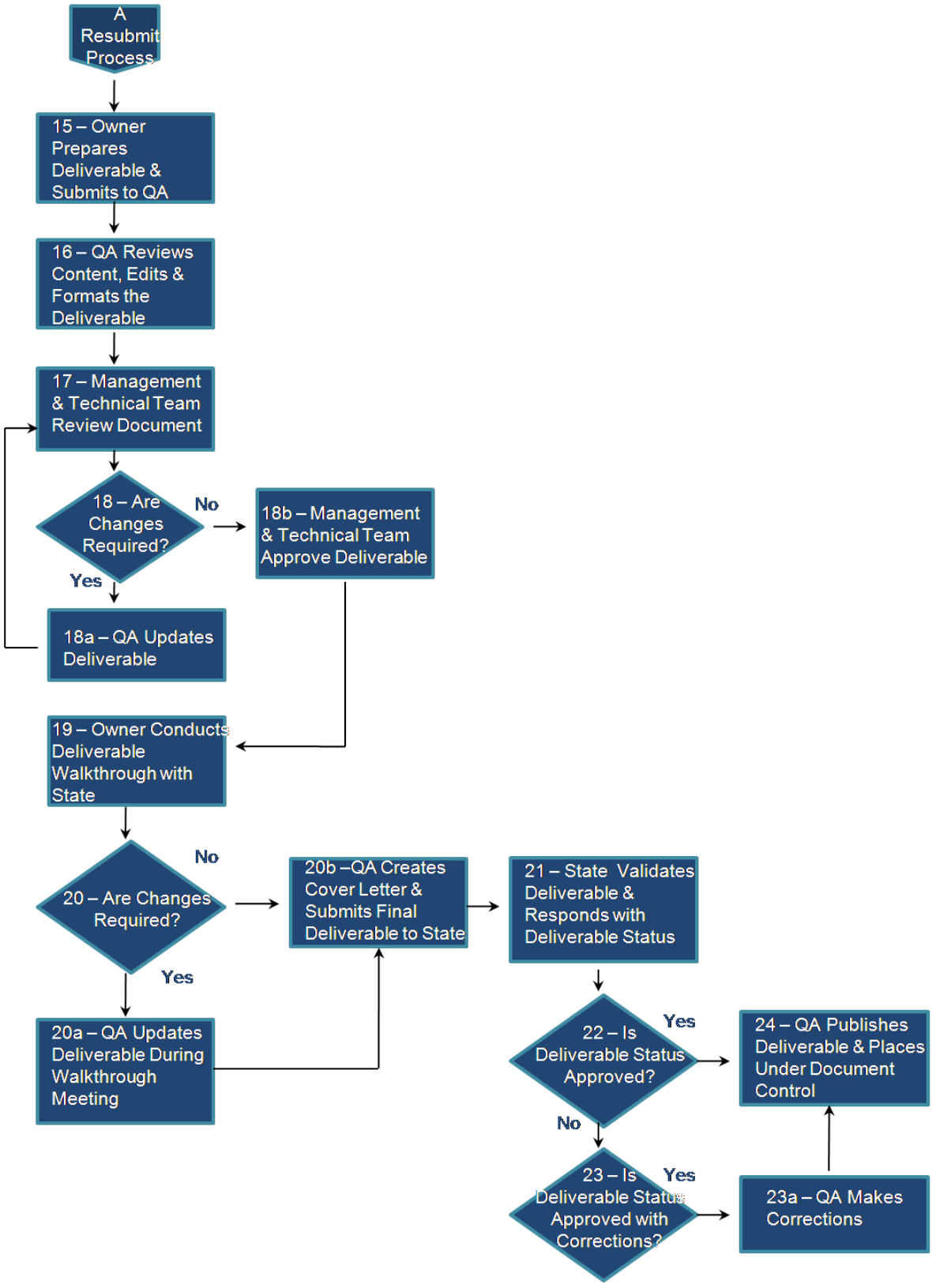
- **Identify the BMS Deliverable Approver**—For each deliverable, the BMS will identify the primary person responsible for deliverable approval. This is the primary contact person that the Molina deliverable owner will interact with in deliverable walkthroughs/reviews, will be the primary contact person for questions and issue resolution, coordinate and reconcile comments from all BMS reviewers and have final approval authority.
- **Set Deliverable Expectations**—Deliverable and work products will be carefully specified and described, including purpose, content, due date, and approval and acceptance criteria during the 2 to 3 day expectations workshops to be held during the Start Up Phase immediately following the kickoff meeting. The purpose of these workshops will be to verify that expectations are set early in the engagement and the BMS and Molina have a mutual understanding of each deliverable and work product, including content, level of content, format, and acceptance criteria. This practice is consistent with the PMI's recommended engagement with stakeholders in the earliest part of a project's initiating phase. Molina personnel will also review the updated deliverable templates with appropriate BMS personnel to confirm that the template meets the BMS expectations.
- **Molina Owner Prepares Deliverable and Submits to QA**—The Molina deliverable owner is responsible for preparation of the deliverable. If a deliverable requires multiple authors, the Molina deliverable owner will coordinate their activities. For example, for a DRP, there may be someone who concentrates on the data center DR requirements, someone who concentrates on the network requirements, and someone who concentrates on the operations DR requirements. This approach allows Molina to divide the areas of responsibility among personnel most knowledgeable in a given process or area and produce a more viable deliverable product. Individual authors will submit their section to the Molina deliverable owner. The owner then will combine sections received into the complete deliverable format and conduct an initial review—addressing discrepancies or issues identified. During this process, the Molina deliverable owner may solicit information or feedback from their BMS counterpart.
- **QA Review**—The deliverable owner will submit the deliverable to the QA group, which will edit the deliverable and conduct a review of it. Project deliverables will be subjected to an internal review before submission to the BMS. The review will verify that the format, content, and quality of each deliverable meets Molina standards, complies with the BMS requirements, and will be acceptable to the BMS. QA personnel will work with the deliverable owner and authors to address discrepancies or issues identified.
- **Management and Technical Team Review**—Molina conducts an internal management and technical team review of the deliverable. The focus of this review is to validate the deliverable meets the requirements for the deliverable, and that from both a management and technical perspective the deliverable is accurate, complete, and meets Molina standards. If issues are found, the QA team will update the deliverable with the changes identified in the review. The management and technical review team then approve the deliverable as ready for submission to the BMS.
- **Submit Deliverable**—Molina QA personnel create a cover letter to accompany the deliverable and prepares and submits the deliverable package to the BMS.
- **Deliverable Walkthrough and the BMS Review**— The Molina deliverable owner will conduct a walkthrough of the deliverable with the BMS deliverable Approver and other appropriate BMS personnel. Walkthroughs will be designed to facilitate the BMS

understanding of content and address questions, comments, and concerns, and to ensure both the BMS and Molina personnel are on the same page with regards to the deliverable. The BMS will have at least 10 working days to review the deliverable and make comments or identify required changes. Molina will provide a template for the BMS comments that will facilitate identification of duplicate comments and reconciliation of any conflicts before the BMS provides comments to Molina. The BMS will send written notification to the Molina Account Manager on the status of the deliverable. The status can be one of the following:

- **Approved**: Deliverable meets expectations and can be published as a final version
- **Approved with Corrections**: Deliverable meets expectations, but needs minor corrections before being published as a final version. Corrections are minor and the deliverable does not need to be re-submitted for review and approval. The deliverable must be revised, then published and the BMS notified. The BMS will validate the revisions.
- **Revise and Resubmit**: Overall content of the deliverable meets expectations, but a moderate to major revision is required and the revised deliverable must be re-submitted for review and approval.
- **Reject with Comments**: Deliverable does not meet expectations.

- **Incorporate the BMS Comments**
  - If the deliverable status is “Approved” or “Approved with Corrections”, the QA team makes any necessary adjustments to the deliverable. A final version of the deliverable will be prepared, along with an appropriate formal sign-off sheet for the deliverable.
  - If the status is “Revise and Resubmit” or “Reject with Comments”, the deliverable is returned to the deliverable owner for rework. The Molina deliverable owner is responsible for incorporating all the BMS comments and addressing the BMS concerns. Significant defects or non-acceptance of a deliverable by the BMS will prompt the Molina Team to identify the necessary corrective action, assign resources, and make the appropriate notifications and updates to the project plan to verify that the deliverable is quickly modified and approved. Molina will adhere to documented and agreed upon resubmit requirements for deliverables that fail initial BMS acceptance. Internal reviews must once again be conducted before the deliverable is ready for the walk through with the BMS. This walkthrough again focuses on the collaboration with the BMS Approver who brings all the appropriate BMS resources to the review meeting. In this walkthrough the Molina team demonstrates that the comments received on the initial document have been addressed. As agreement on the document changes are reached during the review session, the document is updated and ready for subsequent resubmission. The complete resubmission process is depicted in **Figure 5.9.2-3**.
  - **Submit Final Deliverable**—The final deliverable and sign-off sheet will be submitted to the BMS within 10 business days of receipt of the BMS comments. Once the BMS accepts the deliverable, an acceptance letter, signed by the BMS, will be submitted to the Molina Account Manager. The BMS’s written approval will constitute acceptance of the deliverable product.
  - **Finalize Deliverable**—Once Molina receives the BMS sign-off on the deliverable, Molina will update the PWP to indicate that the deliverable completion milestone has been achieved. The approved deliverable will be placed under document management control and subsequent updates to the deliverable will be made only with appropriate BMS and Molina management approval, using approved change management processes.

Figure 5.9.2-3: Deliverables Resubmit Process Flow



Molina uses an expedited process to address and resubmit a deliverable not approved by the BMS.

Molina will provide deliverables in electronic format using the Health PAS-InterComm project portal as the central repository of contract-required deliverables. Molina's work plan will be structured to allow the BMS 10 business days after the receipt date to review and comment on the deliverables. Molina does not count the receipt date as one of the review days. Molina has structured the work plan based on the BMS conducting one comprehensive review of each deliverable and, after the incorporation of the BMS comments, the deliverable being resubmitted for final approval. This will avoid project delays from repeated rounds of submission, review and comment, incorporation of comments, and resubmission.

DELIVERABLE TRACKING

Molina submits all required deliverables to the State for review and approval. The state of West Virginia or Molina may request that a deliverable review walkthrough be scheduled soon after the deliverable is submitted. Molina generally schedules a deliverable walkthrough for more complex deliverables. Either the BMS or Molina may request a post-submission review be scheduled depending on the complexity of the deliverable.

The State will perform an initial review of the deliverable. Ten (10) business days are scheduled for State review. At that time the State Project Manager will determine if an expanded review cycle is appropriate based on the importance, complexity, and/or scope of the deliverable. The expanded time for review is communicated to the Molina Project Manager so that the Project Work Plan can be updated. Expanded time for review may impact the project schedule.

The State Project Manager will send the deliverable to the BMS reviewers with a review deadline. The State reviewers will read and assess the deliverable and record their comments and severity of the comment on the Deliverable Review Tracking Log. All comments will be returned to the State Project Manager or delegate via the Deliverable Review Tracking Log. The State will consolidate the review comments into a single Deliverable Review Tracking Log, remove duplicated comments, and verify the applicability of the comments.

State comments and Molina responses relating to each deliverable are recorded and tracked to completion using the Deliverable Review Tracking Log, a draft of which is provided in **Figure 5.9.2-4**. This draft Tracking Log will be included in the Deliverable Acceptance Process artifact that is reviewed with the State during the initial period of the DDI Phase. Any feedback from the State is incorporated into the final Tracking Log used throughout the DDI Phase.

Figure 5.9.2-4: Draft Deliverable Review Tracking Log

DELIVERABLE REVIEW TRACKING LOG								
DELIVERABLE or ARTIFACT			[Deliverable OR Artifact Identification Number and Name]					
West Virginia Bureau Reviewer Comments						Molina	Department 2d Review	Molina
Document: - Artifact - Expectation - Draft (+ version #) - Final	Comment #	Reference in Deliverable (Section #)	Initial Bureau reviewer comments	Severity (Major or Minor)	Status (Open or Closed)	Response (Brief comment related to Bureau's comments and resultant Deliverable update)	Comments (Based on Molina's response and/or updates to Deliverable)	Response (Brief comment related to Bureau's comments and resultant Deliverable update)

The Deliverable Review Tracking Log provides an audit trail of all BMS comments and Molina responses for each version of each submitted deliverable.

A blank Deliverable Review Tracking Log will be included with the submission of each deliverable, including the Deliverable's Expectation Document and artifact. Molina will use the State-completed log to make the necessary updates to the deliverable and, when needed,

contact the State for further clarification of a comment. The Deliverable Review Tracking Log will also be used as the guide to record comments during Molina reviews and walkthroughs of the deliverable with the State after the initial submission.

The State will also be expected to complete the Deliverable Review Tracking Log for the Deliverable Expectation Documents and Artifacts. The comments related to the Expectation Document will be used to update either the format or anticipated content of the initial deliverable (i.e., Molina will not complete the Deliverable Review Tracking Log but instead will apply the comments to the actual deliverable.) Similarly, State comments related to artifacts will be used by Molina to update the submitted artifact.

Molina will provide celiverables in written and electronic format. The Health PAS-InterComm project portal will provide a central repository of contract-required deliverables. Molina's work plan will be structured to allow the State 10 business days after the receipt date to review and comment on the deliverables. Molina does not count the receipt date as one of the review days. Molina has structured the work plan based on the State's conducting one comprehensive review of draft deliverables and, after the incorporation of State comments, the deliverable's being resubmitted for approval and finalized. This will avoid project delays from repeated rounds of submission, review and comment, incorporation of comments, and resubmission. This will require the State to verify that stakeholders for a deliverable are included in the review process of the draft deliverable.

As can be seen from the above discussion, Molina provides a clearly defined process for identifying, preparing and submitting deliverables, and for acquiring deliverable acceptance by the BMS. The proposed Molina deliverable process:

- Establishes a process for agreeing upon measurable acceptance criteria for each deliverable during the deliverable expectation workshops
- Documents that those criteria have been met with the submission of the deliverable
- Provides a 10-day review period for the BMS review of deliverables, and a subsequent 10 day review of the deliverable if revisions are required
- Establishes a timeline and process for remediating deficiencies and the format to be used for the BMS signatory approval using the Resubmit Process Flow illustrated in **Figure 5.9.2-3** above.

Molina includes sample reports, forms and deliverable formats in **Section D**.

5.9.3 Project Management Plan [3.2.2.1]

Project planning will be a crucial element of West Virginia MMIS project success and meeting management objectives. For Molina, the key project planning component will be the Project Management Plan (PMP), which will comprise many plan components, as depicted in **Figure 5.9.3-1**.

Page 5-304 contains confidential and proprietary information and has been redacted.

required plans, such as the Human Resources Management Plan. In its project management library, Molina maintains standard plan templates that document its detailed management processes, and these templates are customized to meet the specific needs of the project. Each sub-plan will be developed as a project deliverable and provided to the BMS for review and approval. Once approved, the respective plans will be baselined and placed under configuration management control. This process will verify that subsequent updates to the plans will undergo a formal review and approval process with appropriate BMS and Molina management before the updated plans are executed.

Project Planning and Management Principles

- **Clear goals** are essential for successful projects
- Adherence to formal and continually improving **best practice processes** will verify that solutions and deliverable products meet their stated requirements
- **Planning and scheduling** of tasks and resources and subsequent **monitoring, control and reporting** are essential to solution delivery
- Agreeing on deliverables and facilitating an **effective change management** process are essential to satisfying requirements

Molina will work closely with the BMS to develop and update the PMP and required sub-plans. Molina will provide deliverables in electronic format using the Health PAS-InterComm project portal as the central repository of contract-required deliverables. Molina's work plan will be structured to allow the Bureau 10 business days after the receipt date to review and comment on the deliverables. Molina does not count the receipt date as one of the review days. Molina has structured the work plan based on the BMS conducting one comprehensive review of each deliverable and, after the incorporation of Bureau comments, the deliverable being resubmitted for final approval. This will avoid project delays from repeated rounds of submission, review and comment, incorporation of comments, and resubmission. Also, in some cases Molina may provide a deliverable in an earlier task than that required in the RFP. This may be done to make certain a later RFP required deliverable or milestone is met.

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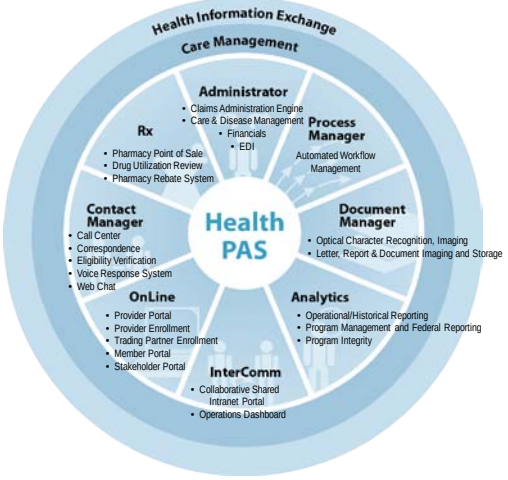
6.0 SOLUTION ALIGNMENT WITH BMS' BUSINESS AND TECHNICAL NEEDS [4.1.10]

Molina will implement a modern web-enabled configurable solution, which is a comprehensive suite of COTS and public domain products that support the West Virginia Medicaid program business management needs. Health PAS will provide BMS with immediate access to the information needed to support operations and with the flexibility to remain compliant with the large number of federal mandates impacting Medicaid between now and 2015.

Molina proposes our state-of-the-art MMIS, Health PAS, configured to meet the West Virginia Medicaid program requirements. Health PAS is a modern, web-enabled, browser-based solution built on a foundation of best-in-class public-domain, proprietary, and COTS software products that are integrated to provide maximum flexibility and user control to deliver a full portfolio of functionality required for modern public healthcare programs. Using relational database architecture, Health PAS represents an integrated approach to information management. Health PAS will provide the Bureau with advanced claims processing functionality, sophisticated workflows, and access to programmatic information in a format and with the speed required to support the critical decisions needed to effectively manage the West Virginia Medicaid program.

The components of Health PAS are illustrated in **Figure 6-1**. Health PAS provides a modular approach for functionality required across the Medicaid enterprise. Users who support the various business functions are able to make use of the same Health PAS tools regardless of the department in which they work or the business function they support.

Figure 6-1: Health PAS Solution Components



Health PAS provides a modular and comprehensive suite of products to support the West Virginia Medicaid business requirements.

Health PAS utilizes a unified relational database, Web browser interface, and modular, configurable design through several discreet components that collectively provide full-scale MMIS functionality delivering complete claims, member, and provider management capability.

Health PAS uses a Service Oriented Architecture (SOA) approach. In the solution implementation, individual services may be user interface (UI) based, document- or message-oriented, record-based, or batch in nature, with these interconnections remaining consistent with the conceptual system design. By using SQL and Web service interconnects, the solution becomes more decoupled and more resilient because it is less dependent on the brittleness of fixed record structures or versioning issues common to single-entity and tightly coupled architecture designs.

Pages 6-2 through 6-9 contain confidential and proprietary information and have been redacted.

- **Health PAS-Contact Manager** to operate the call center and automated eligibility verification systems
- **Health PAS-OnLine** to handle the web portals
- **Health PAS-Document Manager** to provide imaging and reporting.

Molina accepts all member management business process requirements and will leverage the capability of Health PAS, our in-depth knowledge of Medicaid processing, and our fiscal agent experience to assist the BMS in meeting its objectives for the member management business processes.

With our Health PAS suite, Molina offers the state of West Virginia a configurable solution that shifts the emphasis from the traditional approach of systems and programming to one of integrated, expandable technology and business analysis. This evolutionary approach will move the state of West Virginia to the forefront in Medicaid processing and provide tangible benefits in reduced costs, proven efficiencies, and increased member satisfaction.

6.2.2 Provider Management [Appendix E, PM.1-PM.306]

The provider community represents a major component of the West Virginia Medicaid Program. Molina has long recognized the importance of this key constituency. The Health PAS suite of programs proposed for the new MMIS consolidates these business processes; the state of West Virginia will continue to have immediate access to provider data for enrollment, training, reimbursement, communication, and maintenance functions. The end result will be maximized provider participation and satisfaction.

Throughout our history as a fiscal agent, Molina has developed a deep understanding of the provider functions entailed in a Medicaid program. We have combined this Medicaid business knowledge with our technical expertise to a complete provider processing package with our Health PAS solution. The following are among the advantages that Health PAS affords the state of West Virginia:

- Provides a single source of provider data
- Receives, accurately processes, and tracks provider documentation
- Determines eligibility and verifies licensure and qualifications (Molina agrees to incur all costs associated with accessing and acquiring provider licensure and certification data)
- Manages provider inquiries
- Collects, controls, and maintains a variety of data for providers, provider groups, billing agencies, and trading partners
- Accommodates multiple payment methods, including institutional rates, capitation rates, discount and saving rates, and fee-for-service
- Accommodates capture of multiple relationships, such as payers and provider/payer contracts, to a single provider record with the ability to assign different payment methods to each unique relationship
- Configures reimbursements based on category of service, provider class, provider type, specialty, benefit plan, or networks
- Maintains category of service and other information as part of accounts receivable information
- Establishes an Internet portal for providers to access, submit, and exchange information

Health PAS provider management provides:

- **Enroll provider**
- **Provider contracts**
- **Disenroll provider**
- **Inquire provider information**
- **Manage provider communication**
- **Manage provider appeal**
- **Manage provider information.**

- Monitors and reports on provider activities.

Molina Health PAS provides advanced functionality to support all provider business management functions—including complex provider reimbursement methodologies, referrals, utilization review, capitation processing, claims adjudication, care management, call tracking, and financial reporting. With the system's flexibility and fully integrated relational database, provider information is available to all processing functions in real time. This singular source of data facilitates more timely and accurate processing and eliminates data redundancy. Health PAS-Administrator's modular structure and distributed architecture also permits establishment of exhaustive fee schedules at the environment level, linked to state-specific criteria at the processing level, which combine to offer virtually unlimited rate-setting and application capability.

6.2.3 Operations Management [Appendix E, OM1.1-OM7.71]

Due to our Medicaid fiscal agent and managed care experience, we are very familiar with the current and future business objectives regarding Medicaid claims processing and payment activities. Molina has tracked the progress of Medicaid from simple fee-for-service paper claims processing to the current multiple and complex programs incorporating web technology, extant fee-for-service processes, managed care monitoring, sophisticated waiver programs, and a great deal of exception processing. Molina understands that West Virginia must have immediate and uncomplicated access to data for instant analysis and have the capability to proactively and timely manage a progressive program as budget and utilization considerations effect policy and mandate initiatives. Molina knows that it is extremely important to have highly efficient systems and documented processes to verify that we capture, control, and process claims data according to West Virginia-specific rules. With a vision that includes integrating legacy processes, with which some providers remain comfortable, and advanced features for current and future processing flexibility, Molina proposes to implement its Health PAS suite of products to support the Operations Management Business Function. Health PAS features a consolidation of open-architect and commercially available products coupled with partnerships with other vendors that provide best-of-breed integrated solutions. As the payment management engine, Health PAS-Administrator provides a configurable rules-based engine to capture, control, process, and adjudicate all claims according to any existing and future rules established for the West Virginia Medicaid Program as directed by the BMS, other state units, or the federal government.

Health PAS operations management provides:

- **Service authorization**
- **Payment management claims and encounters adjudication**
- **Payment and reporting**
- **Capitation and premium payment**
- **Payment information and management**
- **Member payment information**
- **Cost recoveries.**

Using Health PAS, the Molina Team can produce payments to the provider community for services rendered to any category of eligible members. The Molina solution enables us to adjudicate claims and encounters for both in-state and out-of-state providers for all acceptable services as allowed within the West Virginia Medicaid Program. The system generates these payments on time, accurately, and appropriately. Health PAS provides the state of West Virginia with an advanced payment management system designed to meet the needs of both fee-for-service and managed care programs. The Health PAS solution provides a powerful set of tools that enable Molina's West Virginia-based staff to perform their functions quickly and effectively, reducing the administrative costs of traditional Medicaid fiscal agent contracts. Configurable

program rules allow the BMS to model apply and track cost and utilization management initiatives as the need is identified and not wait for lengthy software development and/or modification. This solution enables Molina to meet the state objectives listed by the BMS in the RFP for the Operations Management Business Function.

Our system enables Molina staff to control the receipt of claims and encounters submitted on paper or electronically. Health PAS-Administrator is a HIPAA-compliant system that processes all required standard transaction sets. Authorized users can access claims history, respond to inquiries, and locate claims in process according to federal requirements.

Health PAS includes all required external interfaces, inputs, and outputs as currently required and anticipated for future administrative initiatives. Molina's solution provides all of the tools needed to meet the defined requirements listed in the RFP and those that are sure to be developed over the course of the contract period. That is a major advantage of implementing the Health PAS solution.

HMS, Molina's proposed subcontractor for Medicare buy-in services, uses multiple files in their approach including Medicaid eligibility, BENDEX, Medicare Enrollment Database (EDB), and Medicare Buy-In Part A/B. As the current supplier of Medicare Buy-In services, HMS is aware of the program status codes eligible for Medicare Buy-In benefits. HMS has the experience and a proven methodology to determine those members eligible for premium assistance and those members no longer eligible for State buy-in assistance.

We know that our solution provides the next generation solution to support both the BMS' program and MITA initiatives now and in the future. Molina acknowledges and agrees to meet or exceed the Operations Management Business Function responsibilities defined in the RFP.

6.2.4 Program Management [Appendix E, PG.1-PG.405]

Health PAS brings end users integrated, up-to-date COTS flexibility. It encompasses functionality for managing rate setting and 1099s, performing accounting functions, querying, reporting, statistical analysis, performance analysis, program information management, as well as benefit and reference information management. Using West Virginia MMIS historical and operational data, as well as other state-specified data sources, Health PAS will support West Virginia Medicaid program management.

Health PAS program management provides:

- **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.**

Provider contracts are the vehicle used by Health PAS-Administrator to manage rate setting (reimbursement methodologies) used in claim adjudication. A provider can be paid differently based on their affiliation to another provider through the contract associated with the affiliation. This allows the BMS to pay providers differently by assigning the required contract and associated reimbursement methodology and to perform all other rate setting capability as defined in the RFP.

Molina will integrate a 1099 software package from Convey Compliance Systems, Inc., tax reporting software with the Health PAS suite. This solution provides modern, Windows-based software that leverages advanced web and relational database management system technology and will provide the State with a centralized solution for all aspects of reporting on provider 1099 information. Convey specializes in keeping processing requirements current and confirms

Pages 6-13 through 6-24 contain confidential and proprietary information and have been redacted.

7.0 SUBCONTRACTING [4.1.11]

Molina has assembled a team of proposed subcontractors that have the qualifications and experience to provide the required services for the West Virginia Replacement MMIS.

Molina conducted a detailed review of the RFP requirements and identified the most qualified team to deliver the best solution for the BMS. Supporting Molina in this endeavor will be Molina's three subcontractors: GTESS Corporation, Health Management Systems, Inc. (HMS), and Thomson Reuters. **Figure 7-1** is a summary of the Molina proposed subcontractors' project roles and qualifications. The subsequent section provides a summary of each subcontractor's role.

Figure 7-1: The Proposed Molina Team

Company	Role	Qualifications
GTESS BETTER THAN HUMANLY POSSIBLE	Conversion of paper claims into electronic format as well as indexing of documents for loading to document management system	• Healthcare company with more than 15 years of experience serving the healthcare market with data capture of claims and related documents • Serving Medicaid clients for 10 years • Applying technologies that ensure quality and improve claims adjudication processing.
hms	Medicare Part A and Part B buy-in processing	• Healthcare company with the sole focus of third party liability and cost containment services for governmental and public health care programs • More than 25 years of experience in Medicaid and other state social services programs.
THOMSON REUTERS	Data analytics	• Healthcare information company with 18 years of experience in Medicaid • Specialized expertise in healthcare performance measurement and quality improvement • A proven track record of success in helping state Medicaid agencies contain cost and improve the quality of care.

Molina has assembled a team of proposed subcontractors second to none.

7.1 GTESS

GTESS has been providing imaging and data capture services since its inception in 1990 and focuses exclusively on the healthcare and dental market. Their unique software comprises the company's workflow system and proprietary and adaptable optical character recognition technology, along with a number of advanced technology processes, including patent pending technology for selecting the correct provider and member on submitted claims. Essentially, GTESS' system applies logic – in an automated fashion – that would normally fall to a human to apply, achieving enhanced data quality. As part of the Molina team, GTESS will establish an office in Charleston to convert claims data into electronic media and index paper documents received for subsequent retrieval through the electronic document management system.

7.2 HMS

HMS leads the nation in designing and deploying cost containment; coordination of benefits, and program integrity services for government and public health programs. More importantly, HMS is an experienced West Virginia contractor that understands the BMS' mission and policies, supporting them for more than 17 years and saving $350 million. HMS brings that experience to the Molina team to deliver a proven Medicare buy-in solution.

7.3 Thomson Reuters

Thomson Reuters has the longest experience of any company in the Medicaid decision support business and has worked for CMS for more than 30 years integrating large Medicaid data sets for research and policy analysis. As part of the Molina team, Thomson Reuters will provide DataProbe for analytics that exceed those provided by the MARS data mart.

To meet the analytic needs identified in the RFP, Thomson Reuters will provide the DataProbe System as a service. DataProbe is a powerful healthcare data investigation tool designed for use by skilled analysts. A full time experienced analyst will be assigned to produce report output and analysis as directed by the BMS. Thomson Reuters will build a customized DataProbe database containing fully-adjudicated claims data, encounters, eligibility data, provider information, and waiver program data. The data is updated on a monthly basis. Each report is custom designed and can be rerun periodically or upon request. Thomson Reuters will enhance the DataProbe database and reporting capabilities by applying certain analytic methods, such as Medical Episodes Grouper (MEG).

8.0 SPECIAL TERMS AND CONDITIONS

Molina does not offer any specific special terms and conditions in our proposal. We do acknowledge the Bureau's commitment in Addendum number 3's questions and answers to honor COTS products' license agreements.

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9.0 SIGNED FORMS [4.1.13]

Molina Medicaid Solutions (Molina) provides all necessary complete and signed forms.

9.1 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. The 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, now 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 the 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 income 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 to 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 amendments, modifications, alterations, or changes 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: Molina Medicaid Solutions
Signed: _____	Signed: [signature]
Title: _____	Title: CFO and Sole Manager
Date: _____	Date: 4/22/11

9.2 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: Molina Medicaid Solutions

Authorized Signature: _____ Date: 4/22/11

State of West Virginia, to-wit:

Taken subscribed and sworn to before me this 22 day of April, 2011.

My Commission expires September 9, 2017, 20__.

AFFIX SEAL HERE **NOTORY PUBLIC** Barbara K. Holmes

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Barbara K. Holmes
5403 Melwood Dr.
Cross Lanes, WV 25313
My commission expires September 9, 2017

9.3 HIPAA Business Associate Addendum

Molina will comply with the Appendix K - HIPAA Business Associate Addendum (BAA) requirements.

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.

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, 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.**
    a. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy and Security Rules.
    b. **Privacy Rule.** 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.
    c. **Security Rule.** Security Rule means the Standards for the security of electronic protected health information found at 45 CFR Part 164, Subpart C, as amended.
    d. Security Incident. Any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.
2. **PHI Disclosed; 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 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.
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 to whom the PHI is disclosed 10 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.
f. **Documentation.** Associate agrees to document disclosures of the PHI and information related 10 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:
    i. the date of disclosure;
    ii. the name 01 the entity or person who received the PHI, and if known, the address of the entity or person;
    iii. a brief description of the PHI disclosed; and
    iv. 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.
g. **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, 45CFR §164.528.
h. **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.
i. **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.

j. **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 3.1 of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

k. **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.

l. **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.

m. **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.

n. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI, and provide data security procedures for the use of the Agency at the end of the contract period. These steps shall include at a minimum, the requirements contained in the West Virginia Office of Technology Policy No. WVOT-P01001 (1-18-07) which may be found at: http://www.state.wv.us/oVPDF/Document center/SecurityPol0107.pdf.

o. **Notification of Breach.** During the term of this Agreement:

    i. The Associate shall notify the Agency immediately by telephone call plus e-mail 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 (see www.state.wv.us/admin/purchase/vrc/agencyli.htm) and the Office of Technology Help Desk at (304) 558.9966; (877) 558.9966 (Toll Free); or servicedesk@wv.gov.

    ii. 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 the Office of Technology Help Desk 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; (e) 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 stale taws requiring individual notifications of breaches are triggered.

iii. All associated costs shall be borne by the Associate. This may include, but not be limited to costs' associated with notifying affected individuals.

p. **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 inactions or actions by the Associate, except where Associate or its subcontractor, employee or agent is a named adverse party.

4. Termination.

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 sale discretion, allow Associate a reasonable period of lime 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, 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.

d. **Survival.** The respective rights and obligations of Associate under Section 3.j. and 3.0 of 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.

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 of 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.

9.4 Vendor Preference Certificate

Molina does not qualify for the vendor preference certificate.

A ROLES, RESPONSIBILITIES, AND SKILL SETS [3.2.3.3, #2]

Roles and responsibility charting is a way of systematically clarifying functional roles and positions as well as set expectations for each role. This charting ensures accountability with the person responsible for specific project work. The roles and responsibility chart is an ever-changing document as the needs of the project emerge. **Figure A-1** details the roles, responsibilities, and skill sets for each organizational chart position found in **Section 4**.

Figure A-1: Roles, Responsibilities, and Skill Sets

Role	Responsibilities	Skill Set
Account Manager	• 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, at a minimum: • Integration management between Medical/Dental and POS. • 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. • Oversees the MMIS Replacement DDI and Certification and all sub-phases. • Is responsible for establishing and maintaining a positive client relationship. • Primary responsibility for account strategy and performance. • Overall management of the WV MMIS project. • Administer all Molina resources dedicated to MMIS operation to ensure contract objectives are met. • Responsible for oversight of Service Level Agreements and other contractual requirements. • Monitor quality assurance reviews to ensure that contract objectives are met. • Responsible for budget management (service revenue, operating expenses, gross margin). • Oversee and coordinate all subcontractor and consultant activities. • Direct ongoing operations activities and serve as final authority for all personnel and operations decisions. • Serve as a chief liaison with the state Secretary, Deputy Secretary, Governor's Office and legislators. • Represent MMS upon request, at meetings and	• Bachelors degree or GED • 8 years experience working in a management position, with at minimum, 4 of those years' in a management position at a Medicare or state-level Medicaid program • Excellent verbal and written communication skills • Must be proficient in conflict resolution • Ability to abide by Molina's policies • Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA) • Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers • Knowledge of legislative process • Knowledge of State and National politics • Knowledge of Governmental processes • Knowledge of health care policy, particularly in relationship to Medicaid.

Role	Responsibilities	Skill Set
	hearings of legislative committees and interested governmental bodies, agencies and offices. • Respond to operational and administrative problems as appropriate in the administration of MMS site activities. • Provide personal leadership that encourage employee productivity and responsiveness to the needs of the customer. • Ensure programs are established to comply with all relevant federal, state and local regulations.	
Adjustments	• To ensure the timely adjudication of financial transactions associated with the WV contract. • Receive and enter suspense and adjudication items. • Research and re-enter adjustment errors. • Prepare balancing reports and other financial support activities as appropriate.	• High School Diploma or GED • 2 years experience with related medical activities. • Knowledge of policy as it relates to financial transactions.
Analytics	• Produce standard and ad hoc reports • Participate in work estimation, prioritization, and scheduling meetings.	• Bachelor's Degree or equivalent experience • A thorough understanding of Thomson Reuter's DataProbe product • Medicaid knowledgeable • Excellent written and oral communication skills
Application/ Systems Security	• Applies extensive technical expertise with full knowledge of the Health PAS solution including all sub-systems • Design, develops and deploy technical solutions to complex problems seamlessly integrating different COTS products (QNXT, Letter Manager, Process Manager etc.) and custom software components • Exercises considerable latitude in determining technical objectives of assignment without direction • Guide the successful completion of major programs and may function in a project leadership role • Interact with senior internal and external personnel on significant technical matters often requiring coordination between organizations • Represent the organization as the prime technical contact on contracts and projects • Provides technical consultation to other project teams within the assigned program including off-shore developers • Ability to analyze programs including performance, diagnosis and troubleshooting and	• Bachelors Degree or equivalent experience • 5+ years software application development • 5+ years of problem solving and analysis experience • Strong Knowledge of Software Development Life Cycle (SDLC) • Strong Knowledge of Object Oriented and Service Oriented Design and Development • Extensive knowledge of Windows / Windows Scripting/ .NET/Configuration/Windows architecture/IIS/Web. Configuration/Registry/Global Assembly Cache Troubleshooting .NET IE and WEB based applications • TSQL/Stored Procedures/SSIS/ shell scripting and batch files • Extensive knowledge of Microsoft Access, and all MS Office Tools

Role	Responsibilities	Skill Set
	hook disparate systems together that make up the entire solution.	• Working knowledge of Biztalk • Architecture knowledge of QNXT Connect/QNXT/ QFramework and other TriZetto and QCSI applications • Extensive knowledge of Connect Direct and our custom wrappers – including troubleshooting issues with those applications • Extensive working knowledge of the Resubmitter and troubleshooting issues with the application • Extensive knowledge of MS Visual Studio 2008/2010, MS.NET C#, ASP.NET, Visual Basic .NET, Visual Basic 6, SQL, Web Services, ADO.NET , SOAP, SSIS, MS SQL Server 2005/2008, SSIS, Java Script, C++, Java, Biztalk, Connect Direct, RUP, XML, XSD, HTML • Excellent verbal and written communication skills
Auditor	• Conducts audits to assess departmental compliance with standards, • Medicaid contract requirements and regulatory requirements. • Compiles audit results and reports to appropriate oversight committee / department head(s). • Revises / develops audit tools to reflect current standards, contract requirements and regulations. • Communicates clearly and effectively with staff on compliance reporting requirements, ad hoc requests, and other communiqués. • Investigates and reports on suspected recipient and provider waste, abuse, and fraud. • Assists with filing of investigation instances of suspected Fraud within the health plan. • Performs other duties as assigned.	• Bachelor's degree or equivalent experience • 3 to 5 years management experience preferred • Knowledge of Medicaid contract and requirements • Effective verbal and written communication skills • Ability to develop, organize, analyze and implement procedures • Effective interpersonal skills • Management negotiation skills • Familiarity with standards • Certified Coder helpful but not required.
Business Analyst	• Assist with modifications and future enhancements. • Performs data conversion activities. • Develops and maintains Business Operations process models based on the MITA business areas/processes. • Leads requirements to COTS specifications.	• Bachelor's degree or equivalent experience • 5 years of healthcare experience • In depth knowledge of MITA standards • Knowledge Health PAS components

Role	Responsibilities	Skill Set
		• Specific knowledge of claims, enrollment, and/or authorizations in a Medicaid environment • Possesses analytical and creative problem solving skills • Excellent verbal and written communication skills.
Business Architects (claims, utilization management, member, third party liability, provider, reference, finance)	• Provides advanced leadership and solution designs for specified MITA business areas. • Creates and presents DDI project training for project Boot-camp sessions for internal and external staff. • Continuously works with solution teams to improve processes and delivery for their functional MITA business areas. • Facilitates or presents MITA Business process end-to-end solutions in initial Requirements to COTs Specification (RCS) workshops, serving as a role model for MITA Systems Analysts to lead subsequent sessions. • As needed, works with the cross-functional teams or Health PAS component owners to define the design for MITA Business Process end-to-end solutions for specific functions. • Manages and mentors the MITA Systems Analysts reporting up to them to coordinate team tasks and deliver on-time work packages for steady state engineering tasks. • Provides support to site management for new initiatives and meetings. • Provides performance reviews, coaching, mentoring and conflict resolution for team. • Provides support, when needed, of product development, pre-sales, and business development. • Creates Product Design Requests for critical functionality to be added to the QNXT product to eliminate the need for gap processes.	• Bachelor's degree or equivalent experience • 7+ years experience one or more business aspects of MMIS development or other areas of healthcare system development • Advanced to expert leadership skills • Advanced critical thinking and problem solving skills • Strong familiarity with change management; project management; and technology management • Dedicated to knowledge sharing with team and customer • Advanced Medicaid and QNXT knowledge; and advance knowledge of business process models • Moderate to advanced knowledge of other Health PAS COTS software • Strong Healthcare system knowledge • Excellent presentation skills • Excellent verbal and written communication skills • Advanced knowledge of business process models.
Certified Coder	• Review and research billed unlisted procedure codes to determine if a more specific code exists. • Supply cover and pricing information to client Medical Director regarding unlisted codes. • Conduct meetings with state client to discuss procedure code coverage and ensure coding decisions are implemented. • Own archive of all Procedure Code Workgroup (PCW) agendas, minutes, and related materials. • Maintain HIPAA reason and remark code lists	• Bachelor's degree or equivalent experience. • Certified Professional Coder (CPC) • Minimum of 2 years of professional coding experience, professional or hospital • Knowledge of insurance claims processing • Proficient in MS Office Suite • Ability to work independently,

Role	Responsibilities	Skill Set
	and provide code updates to the HIPAA Code Workgroup, when necessary. • Support the Claims Department by working edit reports as assigned. • Provide Provider Relations with coding issues and updates to be shared with providers to ensure timely and accurate claim payment. • Maintain a library of code books and relevant resources to be available to personnel, when necessary. • Serve as a resource for the client and co-workers with question related to coding issues.	with minimal supervision • Excellent verbal and written communication skills.
Claims Manager	• Maintains responsibility for claims payment activities to include claims resolution, claims adjustments, and claims data entry. • Oversees mailroom operations from scanning, keying, mail sorting, document printing, and mailing • Responsible for administration of prior authorization activities. • Maintains oversight for the management of financial activities and state fund disbursements. • Develops and oversees claims processing operations and all associated manual processes. • Develops and coordinates changes and enhancements and identifies the impact these modifications shall have on the claims processing subsystem. • Claims processing staff management. • Establish and maintain relationships with the State • Communicates with providers concerning complex claims adjudication processes • Manages the daily operations of the Claim Department and Mailroom • Meets with the State regarding policy and procedures • Ensures external Claims Data vendors meet contractual obligations for timely and accurate claims transmission and processing. • Ensures that all quality standards are met to assure claims processing accuracy. • Delegates and prioritizes task assignments of claims and mailroom staff. • Evaluate processes for improvement • Contributes a positive attitude to the team in order to meet department goals. • Supports all departmental initiatives in	• Bachelor's degree or equivalent experience. • 5 years experience as a claims operations manager in a healthcare environment. • Strong knowledge of Medical Claims Payment systems. • Thorough understanding of CPT/HCPCS and ICD9 coding procedures and guidelines • Knowledgeable in Microsoft office products such as word and excel • Excellent verbal and written communication skills.

Role	Responsibilities	Skill Set
	improving overall efficiency.	
Claims Resolution	• Process claim forms, adjudicate for allocation of deductibles, co-pays, co-insurance maximums and provider reimbursements. • Follow adjudication policies and procedures to ensure proper payment of claims. • Resolve pends based on Medicaid rules and regulation established for final processing. • Meet established production requirements consistently • Maintain an accuracy rate of 98% or better. • Contribute a positive attitude to the team in order to meet department goals. • Support all departmental initiatives in improving overall efficiency. • Meet all attendance policy requirement.	• High School diploma or GED • 1 – 2 years general office experience in a claims environment • Knowledge of Microsoft Office products • General knowledge of personal computer • Good verbal and written communication skills.
Claims Supervisor	• Responsible for supervising claims processing staff and monitoring daily operations according to department's policies and procedures. • Delegates and prioritizes task assignments of staff. • Updates departmental desktop procedures. • Maintains productivity to ensure staff meets production standards.	• High School Diploma or equivalency • Working knowledge of mailroom operations • 5 years supervision/lead in a claims processing environment.
Contract Specialist	• Create and maintain all contracts in QNXT. • Update contract terms with new fee or payment methodology (RBRVS, UCR, Custom Fee, etc). • Complete all Change Requests within specified timeframe • Develop and maintain the Nursing Home Application for quarterly rate updates. • Research and respond to contract questions from client and Provider Relations. • Create and maintain all contract process documentation. • Meet with client regarding changes in business requirements for contracts and special projects. • Work with client and Manager to lead special projects to completion. • Serve as Subject Matter Expert on changes to three stored procedures and systematic contract updates. • Train on-site staff and client on contracts and stored procedures. • Assist Claims Manager with claim issues and resolutions.	• Bachelor's degree or equivalent experience • 4 years experience with QNXT preferably current level • Knowledge of claims processing • Proficient in SQL and MS Office Suite • Analytic and critical thinking skills are required • Ability to work independently, with minimal supervision • Excellent verbal and written communication skills.

Role	Responsibilities	Skill Set
Controller	• Ensures that all financial transactions for the contract are properly administered and monitored, including Accounts Payable, Accounts Receivable as well as Weekly, Monthly, Quarterly and Annual Financial Reports that support the MMIS • Provide analytical support and analysis of the Financial system surrounding adjudication and payment processing	• BA/BS in accounting, business administration or equivalent experience. • 3 to 5 years working in healthcare finance operations with at least two years of financial analysis and management experience • Knowledge of implementing financial claims adjustments and monitoring the processes. • 1+ year SQL Server processing and coding.
Conversion Lead	• Develops Conversion and Interface Strategy. • Manages the data conversion and interfaces requirements, design, construction, testing and implementation activities. • Provides direction overall direction to interface and conversion resources. • Establishes objectives and oversees the progress against interface and conversion tasks in the work plan. • Collaborates with data suppliers to assure availability of data to facilitate the execution of conversion tasks in the project schedule. • Provides day-to-day direction to the Conversion Team. • Defines and validate the customer business requirements and solution requirements for data conversion • Develops the data mappings for the legacy Data Conversion from the source database to the target database • Designs, tracks and reports the integration of data between the Health PAS solutions and produce comparative reports for previous periods of operation. • Supports testing for data conversion. • Assists department in developing business rules for situations where a straight conversion is not feasible. • Crosswalk data to allow continued application of all edits, audits, service authorizations, drug exception requests, rebates, calculations, and to meet all other system processing requirements.	• Bachelor's degree or equivalent experience • 3 to 5 years healthcare experience • 3 to 5 years project management experience • Strong knowledge of the life cycle development process in reference to requirements gathering and software development • Strong knowledge of a project management tool such as Primavera or Microsoft Project • Strong knowledge of Microsoft SQL Server • Strong knowledge of a Structured Query Language (SQL) such as Microsoft SQL Server T-SQL • Working knowledge of word processing and spreadsheet software such as Microsoft Word and Excel • Working knowledge of the Rational Tool Set • Excellent verbal and written communication skills.
Courier	• Delivers and collects mail daily to local Post office. • Delivers and collects documents twice daily to the State offices. May require additional trips to various State offices, as needed.	• High school diploma or GED • Valid state drivers license • 1 year prior courier experience preferred • Ability to lift up to 50 lbs

Role	Responsibilities	Skill Set
	• Delivers and collects mail to various departments within Molina. • Logs in all deliveries by special carriers (UPS, FedEx, etc). • Maintains transportation log for van and ensure timely maintenance. • Opens and sorts all incoming mail. • Prepares, for mailing, Return to Provider (RTP) letters.	• Basic knowledge of Microsoft Office Outlook.
Data Architect	• Understands database management systems and tools used by the DBA group and recommends innovative approaches to solving issues and improving existing processes. • Recommends database tools that could benefit our projects. • Researches and prototype approaches for improving database efficiency and performance, then documents and rolls out successful approaches to the DBA project teams. • Recommends database server architecture requirements and works with Infrastructure on building database servers. • Determines database disk capacity and speed requirements and work with Infrastructure on implementation. • Tune sand troubleshoots databases and database applications. • Identifies database processes that can be automated and rolls out automation techniques to the DBA project teams. • Participates in the DBA on-call rotation. • Provides technical leadership and guidance to the DBA team. • Trains DBAs in new or unfamiliar database features and performance tuning techniques. • Assists DBAs with solving complex technical issues. • Establishes, documents, and rolls out database processes and procedures. • Provides recommendations, alternatives, and guidance to DMG management, DBA team leads, and other MMS teams regarding database questions and issues. • Communicates effectively with a variety of audiences including management, DBAs, and members of other MMS teams. Tailor the message to the audience.	• Bachelor's degree or equivalent experience • 3 to 5 years of MS SQL Server 2005 database administration in a production environment. • 5 to 7 years of hands-on relational database experience. • Database architecture or capacity planning experience. • Advanced to expert level SQL Server 2005/2008 administration and tuning skills • Experience with large databases up to 2 terabytes in size and a solid understanding of the effects of various factors on the health and performance of large, transactional SQL Server databases • Excellent problem solving skills • Solid understanding of Health PAS architecture and processing and of how database architecture and design relates to larger project objectives • Self-motivated, takes initiative to identify, communicate, and resolve potential issues • Excellent verbal and written communication skills.
Data Conversion Specialist	• Provides guidance to site management including cost analysis. Also provides guidance to other MMS teams.	• Bachelor's degree or equivalent experience • 3 to 5 years analysis

Role	Responsibilities	Skill Set
	• Provides guidance to other MMS teams regarding ETL questions and issues. • Provides guidance to the Infrastructure team for ETL application server architecture requirements and disk capacity/performance needs. • Mentors other team members in areas of expertise. • Develops and manages packages and applications. • Packages ETL packages for deployment to development, test, and production environments. • Identifies, develops, and documents processes and procedures. • Automates processes where appropriate. • Participates in the ETL on-call rotation. • Ensures that assigned tasks are completed on or ahead of schedule. Prioritizes assigned tasks appropriately. • Informs the team lead and Central Engineering management of project issues; escalate issues in a timely manner, and ask for assistance when needed. • Communicates effectively with a variety of audiences including management, peers, and members of other MMS teams. Tailors the message to the audience. • Understands our processes and procedures, communicates processes and procedures to other groups, and enforces adherence to processes and procedures. • Solves complex issues in innovative ways.	experience • 3 to 5 years ETL design and/or development experience, • 3 - 5 years database experience in SQL environment • 3 - 5 years with ETL tools such as SSIS, Informatica, DataStage or Ab Initio • Analytical skills in a SQL environment • ETL design and development knowledge • Database knowledge utilizing tools such as SSIS, Informatica, DataStage, or Ab Initio. • Excellent verbal and written communication skills.
Data Entry – Special Claims	• Enters special claims data into system while interpreting coding and understanding medical terminology in relation to diagnoses and procedures. • Follows adjudication policies and procedures to ensure proper payment of claims. • Meets established production requirements consistently • Maintains an accuracy rate of 98% or better. • Contributes a positive attitude to the team in order to meet department goals. • Supports all departmental initiatives in improving overall efficiency. • Meets all attendance policy requirements.	• High School diploma or GED • 1 to 2 years general office experience • Knowledge of Microsoft Office products • General knowledge of personal computer • Good verbal and written communication skills.
Data Entry - Drug Rebate	• Posts and reconciles all drug rebate payments in PRIMS in an accurate and timely fashion and/or other claim types.	• High school diploma or GED • MS Office Suite, PRIMS, Crystal Reports, Remote

Role	Responsibilities	Skill Set
	• Travels to state building as needed to pick up payments and correspondence. • Maintains and communicates weekly deposit and correspondence status spreadsheets. • Disburses fully posted payments to appropriate analyst (scanning where necessary). • Compiles/files appropriate paperwork for staff not housed in local office. • Pulls from files and posts old payments as needed for historic resolutions. • Files all payments after they have been addressed by the analysts. • Creates diskettes sent to the labelers during quarterly invoicing. • Manages deposit spreadsheets and coversheets for all EFT payments sent by labelers.	Desktop • 10-Key proficiency skills • Excellent accuracy and efficiency skills • Attention to detail • Excellent verbal and written communication skills.
Database Administrator	• Oversees Health PAS database administration, backups, and recoveries, verifying the security and integrity of the database. • Creates and maintains database schema definition, performance tuning, and capacity planning. • Collaborates with other systems and operations units to maximize the value of the data and determine the impact of changes on Health PAS. • Verifies that databases and data dictionaries are updated according to specified schedules. • Executes development scripts to update the database. • Works with team members to resolve database questions or problems. • Coordinates systems resource availability with database analysts, system and application programmers, and other users. • Maintains industry-recognized policies, procedures, and standards relating to database management.	• Bachelor's degree or equivalent experience • 5 years hands-on relational database experience • 2 years as a SQL Server database administrator in a production environment. Familiarity and comfort with ordinary maintenance tasks such as moving tempdb, migrating databases, changing server configuration parameters, dropping/adding users and logins. • Solid understanding of relational theory and how it applies to production environments. • Advanced to expert level SQL Server 2005/2008 administration and tuning skills • Experience with large databases up to 2 terabytes in size and a solid understanding of the effects of various factors on the health and performance of large, transactional SQL Server databases • Excellent problem solving skills • Ability to lead complex database-related technical tasks, identify and resolve potential issues, and drive tasks to successful completion on or

Role	Responsibilities	Skill Set
		ahead of schedule.
Deputy Account Operations Manager	• 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. The Deputy Account Manager assists with oversight the MMIS Replacement DDI and Certification and all sub-phases.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 5 years required below can be substituted for a degree.
Deputy Systems Manager	• Directs responsibilities for the MMIS systems areas as assigned by Account Manager. • Assists in the overall management of the MMIS project which includes operation, add-on business and upgrades to the system. . • Responsible for achievement of Service Level Agreements and other contractual requirements. • Develops budget inputs for areas of responsibility. • Serves as the primary point of contact in the absence of the Executive Account Manager which would entail the following duties: • Have primary responsibility for this Contract in the Contractor's organization. • Manage overall relationship between Contractor and the Department. • Act as chief liaison between Contractor and Department management. • Administer all Contractor resources dedicated to the WVMMIS • Coordinate, monitor and maintain to current status oversight of all quality control and quality assurance activities with the Systems functions. • Coordinate, monitor and maintain to current status, all performance reporting. • Serves as the primary points of contact with the client on technical system issues for operational and new business opportunities. • Directs activities of the team functions and operations under direct report. • Facilitates communications with the MMIS units by preparing operation reports and attending meetings as required by client/state. • Establishes annual performance goals with department managers, in conjunction with the	• Bachelor's degree or equivalent experience in the healthcare field per contract requirements • 8+ years' experience working in a management position supporting a Medicaid/or large claims processing system environment or as required by contract. • 8-10 years working in a claims processing system is preferred. • Health care environment experience • Excellent verbal and written communication skills • Must be proficient in conflict resolution.

Role	Responsibilities	Skill Set
	Executive Account Manager, so that department goals support overall account level objectives • Facilitates weekly management review process of key operations to include, performance measurements, goal • Manages appropriate department/functions to ensure compliance with Molina policies and procedures • Represents Molina on State committees and councils associated with Medicaid program, if requested. • Acts as facilitator for monthly review with client to review contractual metrics/issues. • Serves as a liaison between Molina site and client/state management.	
Document/ Process Manager	• Analyzes, models, designs, develops and implements at least one Integrated Solutions component for Medicaid sites including the Document / Process Manager. • Designs, develops and implements customized functionality for at least one Integrated Solutions component to accommodate business processes related to that Integrated Solutions component. • Identifies the need for and develops new Integrated Solutions functionality to accommodate new business processes and procedures as they are introduced to the solution. • Assists and mentors peers with understanding Integrated Solution components, technical architecture, custom development, and operations support. • Represents the Integrated Solution as a new implementation lead or existing customer support lead, potentially managing junior Integrated Solutions resources.	• Bachelor's degree or equivalent experience • Combined 5-10 years of health care, system engineering, and project management experience. • Business Analysis and Modeling knowledge, applying technical solutions to business processes • FileNET configuration of document classes, indices and distribution queues (Storage Manager) • Possesses knowledge of one or more of the following: Venetica (Process Manager), Cincom (Letter Manager), ASG Cypress (Report Distribution Manager), Apropos AVRS, Call Center Toolsets (Contact Manager) • Knowledge of Microsoft Structured Query Language (SQL), VB Script, Visual Basic for Applications (VBA) Java Script, HTML and extensive knowledge of Markup Language (XML), and Active Server Pages (ASP • Knowledge of Project Management • Excellent verbal and written communication skills.
Documenta-tion Specialist	• Reviews site policies, operating procedures, work instructions, forms, etc. for format consistency.	• High school diploma or GED • 2 years experience writing and editing business documentation

Role	Responsibilities	Skill Set
	• Reviews documents and written external communication for format, consistency, and compliance with existing procedures. • Maintains revision control and a tracking spreadsheet for all controlled documents. • Ensures all submitted change request forms, required signoffs/signatures and documentation components are accurate and complete. • Performs site word processing and graphics tasks. • Trains staff on document control policies and procedures. • Proofreads and edits documentation and correspondence to the State and other external entities.	• Practical knowledge of document control management systems • Excellent MS Word, Excel, PowerPoint and Adobe skills. • Detail oriented and organized • Excellent editing, verbal, and written communication skills.
Drug Rebate Manager	• Manages drug rebate operations/personnel in a variety of forms to include complete or partial technical and operational duties. Includes managing tasks within the drug rebate business/system application, including problem resolution, quality control, performance and client relationship. • Coordinates and documents the requirements, specifications, design and testing efforts for drug rebate implementations. • Prepares and maintains documents required for drug rebate operations and system modifications. • Prepares training materials and trains State/Molina staff on drug rebate operations. • Prepares and maintains desk level procedures for drug rebate operations. Manages staff productivity/performance. • Communicates with customers to provide first-class support/response. Manages client relationships for rebate.	• Bachelor's degree or equivalent experience • 3 years experience managing Medicaid rebate operations. • Project/program management • Knowledge of Federal/state drug rebate regulations and best practices • MS Office Suite, PRIMS, Crystal Reports, basic SQL queries • Excellent verbal and written communication skills.
Drug Rebate Report Analyst	• Performs Monthly Medical/Dental Claims Load into PRIMS (Pharmacy Rebate Information Management System). • Performs Monthly Formulary Load into PRIMS. • Performs Monthly Provider Load into PRIMS. • Performs Monthly Pharmacy Claims Load into PRIMS. • Creates the appropriate Medicaid invoice item activity record to account for CMS Prior Period Rate Adjustments. • Creates the appropriate Medicaid Supplemental invoice item activity record to account for Prior Period State Rate Adjustments. • Creates the appropriate invoice item activity record to account for a prior period claim	• Bachelors degree or equivalent experience • 2 years experience in claims processing environment • SQL, TSO, IOF, ISPF, CICS, FILEAID, VPS, COBOL, Easytrieve, JCL, FTP • Excellent verbal and written communication skills • Prefer a strong background/emphasis in finance.

Role	Responsibilities	Skill Set
	reversals for both Medicaid and Medicaid Supplemental. • Creates and prints the invoices when requested by the State. • Performs Invoice Verification running reports to verify invoice amounts. • Generates Invoice Mailings by printing invoices for the different Medicaid programs. • Checks Entry and Payment Posting/Reconciliation for Medicaid, Medicaid Supplemental, and JCode Invoices. • Responsible for analyzing report data for trending purposes and reporting those variances to BMS and gathering business requirements, report development, QA and delivery of reports to BMS for approval.	
EDI/EDMS Business Analyst	• Analyzes, models, designs, develops and implements EDI & QNXT Data components and X12 Transaction Sets for Medicaid sites. • Designs, develops and implements customized functionality to accommodate business processes related to EDI & QNXT Data components. • Identifies the need for and develop new EDI & QNXT Data functionality to accommodate new business processes and procedures as they are introduced to the solution. • Assists and mentors peers with understanding EDI & QNXT Data components, technical architecture, custom development, and operations support. • Assists all other Molina Medicaid groups involved in integration efforts across the practice that involve EDI & QNXT Data. • Identifies and prescribes technical solution requirements in support of the MMS Business Development group's efforts in writing proposals and responding to RFPs and RFIs, etc. • Represents the EDI and QNXT Data group as a new implementation lead or existing customer support lead, managing junior Integrated Solutions resources.	• Bachelor's degree or equivalent experience • Combined 5-10 years of healthcare & EDI experience • In depth knowledge of HIPAA/EDI X12 4010/5010 healthcare-related transactions including 270-271, 276-277, 278, 834, 835, 837, 997, 999, 824, and NCPDP 5.1 & D.0 • Knowledge of EDI applications including the EDI Gateway, Edifecs suite of tools, Microsoft Biztalk, Microsoft SQL Server, and other applications in support of EDI processing • Knowledge of QNXT Administrator and QNXT Connect • Fluent with commonly used EDI concepts, practices and procedures within a heath care field • Medicaid domain knowledge • Expert knowledge of industry standard health data code sets such as ICD-9/ICD-10, CPT/HCPCS, revenue codes • Knowledgeable with regulatory requirements associated with 5010 and ICD-10 • Specific knowledge of claims, enrollment, and /or Authorizations in a Medicaid environment

Role	Responsibilities	Skill Set
		• Possesses analytical and creative problem solving skills • Excellent verbal and written communication skills.
EDI Call Representa-tive	• Coordinate the set up and approval of providers, clearinghouses, and billing agencies for the web portal including the completion of agreements and transaction forms. • Responsible for validating, researching and resolving daily EDI data received from providers, clearinghouses and billing agencies. • Resolve problems related to specific EDI documents that generate 997, TA1 and 824 errors. Work with vendors/trading partners to identify, define, develop, and implement changes to correct errors. • Manage EDI projects and communicate directly with providers, clearinghouses and billing agencies in a call center setting. • Reading, understanding and professionally communicating Extensible Markup-language (XML) data and ANSI X12 format including 835 and 837 Professional, Institutional and Dental formats. • Provider assistance with Direct Data Entry (DDE) submission of claims, 270/276 transactions, retrieval of electronic remittance advices and related reports on the MMIS web portal.	• High School Diploma or GED • Provider Relations experience • Microsoft Word, Excel, Outlook and Internet • Excellent verbal and written communication skills • Strong organizational skills, attention to detail and problem solving • Ability to perform tasks with a high degree of accuracy.
EDI/Web Portal Manager	• The EDI Manager/Web Portal Manager oversees electronic data interchange activities, provide support for HIPAA transaction compliance, and develop and maintain implementation guides for Medical/Dental and POS. The EDI Manager/Web Portal Manager supports expanding health information initiatives for Medical/Dental and POS such as but not limited to: HIE and ePrescribing.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 5 years required below can be substituted for a degree.
End User Support – LAN, Desktop, AVRS	• Responsible for providing the technical support of hardware, systems, sub-systems and/or applications for local MMS customers and/or employees. • Reviews, analyzes, and evaluates information technology systems operations. • Applies basic diagnostic techniques to identify problems, investigate causes and recommend solutions to correct common failures and support of local PC's and applications • Provides technical support for Computer Room, Printer Room, and Network/Phone support. • Assists Infrastructure and Applications teams	• Associate's Degree or equivalent experience • 3 - 5 years computer experience • Knowledge of Windows 2000/2003/2008 Server administration • Knowledge of 2005 R2 Virtual Server • Computer room/network/phone and printer support skills • Personal computer hardware and applications support skills.

Role	Responsibilities	Skill Set
	implementing changes. • Responsible for all Personal Computers and Desktops and for disposal of obsolete equipment. • Orders and sets up new staff equipment. • Supports server Microsoft patches/ printers/facility tasks. • Provides upgrades of computer systems to Molina Standards. • Supports on-call as required on a rotating basis 24/7.	
Enrollment Analyst	• Perform member cleanup from member eligibility loads. • Conduct member analysis and demographic updates as submitted by client or on-site staff. • Perform daily and monthly Medicare clean-up. • Serve as Lead for multiple meetings (internal and with customer), i.e. RAPIDS meeting, client eligibility meeting, etc. • Develop and maintain all process documents regarding member module and key responsibilities. • Train staff members in Member maintenance.	• Bachelor's degree or equivalent experience • Minimum of 2 years experience working with QNXT, preferably knowledge of current version • Knowledge of insurance claims processing. • SQL, Visual Basic MS Project, MS Office Suite • Ability to work independently, with minimal supervision • Excellent verbal and written communication skills.
Enrollment Supervisor	• Ability to handle heavy inbound call volume • Assist providers via telephone to resolve claims and payment issues related to their provider file, as well as, claim status and accuracy • Call track claim issues clearly and concisely • Update provider files with certifications and license updates in addition to taking calls • Facilitate all provider changes such as change of address, phone/fax update, physician specialties, etc. • Ability to navigate multiple licensing and physician specialty board internet sites to obtain updates • Review provider enrollment applications and supporting documentation for accuracy and correspond with providers regarding any discrepancies • Follow up with providers on outstanding issues within contractual guidelines set by our customer • Display excellent customer service • Show good judgment with providers and know when to elevate calls, and identify the root cause • Accurately record calls in call tracking system • Must be able to meet and retain all quality and	• High school diploma or GED • Excellent organizational skills • Customer Service/ Call Center Experience • Familiarity with Data Input • Knowledge of Microsoft Office • Excellent verbal and written communication skills • Knowledge of Microsoft Office • Ability to abide by Molina Healthcare and Molina Medicaid Solution policies • Maintain regular attendance based on agreed-upon schedule • Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA) • Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers • Ability to multi task in a high paced environment and retain

Role	Responsibilities	Skill Set
	production standards set by management and/or customer. • Responsible for timely and professional interaction with providers including escalating recurring or critical issues to Manager in a timely fashion.	information.
ETL Analyst	• Provides guidance to site management including cost analysis. Also provides guidance to other MMS teams. • Provides guidance to other MMS teams regarding ETL questions and issues. • Provides guidance to the Infrastructure team for ETL application server architecture requirements and disk capacity/performance needs. • Mentors other team members in areas of expertise. • Develops and manages packages and applications. • Packages ETL packages for deployment to development, test, and production environments. • Identifies, develops, and documents processes and procedures. • Automates processes where appropriate. • Participates in the ETL on-call rotation. • Ensures that assigned tasks are completed on or ahead of schedule. Prioritizes assigned tasks appropriately. • Informs the team lead and Central Engineering management of project issues; escalate issues in a timely manner, and ask for assistance when needed. • Communicates effectively with a variety of audiences including management, peers, and members of other MMS teams. Tailors the message to the audience. • Understands our processes and procedures, communicates processes and procedures to other groups, and enforces adherence to processes and procedures. • Solves complex issues in innovative ways.	• Bachelor's degree or equivalent experience • 3 - 5 years analysis experience • 3 - 5 years ETL design and/or development experience, • 3 - 5 years database experience in SQL environment • 3 - 5 years with ETL tools such as SSIS, Informatica, DataStage or Ab Initio • Analytical skills in a SQL environment • ETL design and development knowledge • Database knowledge utilizing tools such as SSIS, Informatica, DataStage, or Ab Initio. • Excellent verbal and written communication skills.
Executive Assistant	• Maintains, processes, tracks, and reconciles expense reports in a timely and accurate manner for upper management • May processes New Hire setup /Termination paperwork (I.e. credit cards, cellular phones, security clearance, etc.) • Schedules travel arrangements for manager and upper management	• High School diploma or GED • 5 years office/clerical experience • Excellent proficiency with Microsoft Office Suite and/or other software packages such as Visio, Citrix, Siebel, Kronos, and Concur.

Role	Responsibilities	Skill Set
	• Manages calendars including scheduling appointments, meetings, confirming appointments, recognizing and resolving conflicts, and ensuring that meeting logistics are addressed and communicated to attendees • Coordinates Meetings/Lunches including catering, equipment and supplies needed, etc. • Creates meeting agendas and other site related documents • May update web portals on a daily basis or as needed • Prepares complex reports; maintaining records requiring classification and compilation of varied information. • Participates and takes meeting minutes as needed • Effectively interacting with individuals in a broad range of situations in an increasingly challenging and complex work environment. • Orders business supplies as needed • May process facility requests • May process incoming, outgoing mail and shipments.	• Ability to multitask • Ability to prioritize and manage workload to ensure primary responsibilities are met before secondary responsibilities • Excellent organizational skills • Ability to work well independently with little or no supervision • Ability to interact and support team-members and leadership at all levels • Excellent verbal and written communication skills.
Finance Report Analyst	• Assists the client with creating the allocation process for fund distribution. • Participates in financial requirements workshops for the purpose of gathering financial business needs and stakeholder requests. • Develops financial requirements specifications using industry best practices ensuring that the requirements and related business rules are complete, consistent, concise, comprehensible, traceable, feasible, unambiguous, and testable. • Controls “scope creep” due to missed requirements and leakage of “unofficial” requirements into the project. • Facilitates peer reviews of financial requirements documents. • Participates in peer reviews of work products derived from financial requirements specifications to ensure that the requirements were interpreted correctly. • Manages changes to base line financial requirements using established project change control processes and tools. • Assists in the creation of objectives, agendas and other meeting materials in preparation for financial workshops. • Supports the development and test teams as needed, providing walkthroughs, answering questions, creating data, etc.	• Bachelor’s degree preferred; or equivalent combination of education and additional years of directly relevant experience. • 3 years direct experience with Flexi Financial System • 2 years client-facing experience • 2 years workshop facilitation experience. • 2 years Medicaid/Medicare experience • Familiar with CMS Financial Reporting • Good interviewing skills, ability to talk with various user groups about their needs and ask the right questions to glean essential requirements information • Good listening skills, ability to understand and translate into features and ultimately system requirements • Excellent analytical skills, ability to evaluate information to reconcile conflicts, decompose high-level information into details, and distinguish user

Role	Responsibilities	Skill Set
	• Manages and reports status of ancillary components such as database scripts, interfaces, etc. • Identifies ways to assist product management in product planning through financial requirements development and analysis. Proposes new product features and updates • Responsible for analyzing report data for trending purposes and reporting those variances to BMS. • Responsible for gathering business requirements, report development, QA and delivery of reports to BMS for approval.	requests • Ability to lead requirements workshops and make "real-time" changes to artifacts • Ability to effectively communicate features and requirements to stakeholders and technical staff • Excellent organizational, interpersonal and verbal and written communication skills • Ability to work with the vast array of information gathered during elicitation and analysis and to cope with rapidly changing information • Ability to help negotiate priorities and to resolve conflicts among project stakeholders (such as customers, product management, and engineering.)
Financial Manager	• Manages the on-site Financial Operations team; responsible for the day-to-day activities of the financial accounting system. • The Financial Operations team handles all accounts payables and account receivables as well as works with and provides analysis for the Flexi financial system. • Ensures that all financial transactions for the contract are properly administered and monitored, including Accounts Payable, Accounts Receivable as well as Weekly, Monthly, Quarterly and Annual Financial Reports that support the MMIS • Provide analytical support and analysis of the Financial system surrounding adjudication and payment processing • Oversee the day-to-day financial adjustment team including personnel and related claim and the flexi finance system processes. • Develop, review, and distribute various reports as needed • Develop, review and update policies and procedures as needed • Monitor financial processing issues based on claims payment by using SQL Server Studio and reviewing package processing error logs.	• Bachelor's degree in accounting, business administration or equivalent experience. • 3 to 5 years working in healthcare finance operations with at least two years of financial analysis and management experience • Knowledge of implementing financial claims adjustments and monitoring the processes. • 1+ year SQL Server processing and coding.
Health PAS Administra-tion (QNXT)	• Applies extensive technical expertise with full knowledge of the Health PAS solution including all sub-systems	• Bachelors degree or equivalent experience • 5 years software application

Role	Responsibilities	Skill Set
	• Design, develops and deploy technical solutions to complex problems seamlessly integrating different COTS products (QNXT, Letter Manager, Process Manager etc.) and custom software components • Exercises considerable latitude in determining technical objectives of assignment without direction • Guide the successful completion of major programs and may function in a project leadership role • Interact with senior internal and external personnel on significant technical matters often requiring coordination between organizations • Represent the organization as the prime technical contact on contracts and projects • Provides technical consultation to other project teams within the assigned program including off-shore developers • Ability to analyze programs including performance, diagnosis and troubleshooting and hook disparate systems together that make up the entire solution.	development, • 5 years analysis and problem solving experience • Strong Knowledge of Software Development Life Cycle (SDLC) • Strong Knowledge of Object Oriented and Service Oriented Design and Development • Extensive knowledge of Windows / Windows Scripting / .NET / Configuration / Windows architecture / IIS / Web.Configuration / Registy / Global Assembly Cache / Troubleshooting .NET IE and WEB based applications • TSQL / Stored Procedures / SSIS/ shell scripting and batch files • Extensive knowledge of Microsoft Access, and all MS Office Tools • Working knowledge of Biztalk • Architecture knowledge of QNXT Connect / QNXT / QFramework / and other Trizetto and QCSI applications • Extensive knowledge of Connect Direct and our custom wrappers – including troubleshooting issues with those apps • Extensive working knowledge of the Resubmitter and troubleshooting issues with the application • Extensive knowledge of MS Visual Studio 2008/2010, MS.NET C#, ASP.NET, Visual Basic .NET, Visual Basic 6, SQL, Web Services, ADO.NET, SOAP, SSIS, MS SQL Server 2005/2008, SSIS, Java Script, C++, Java, Biztalk, Connect Direct, RUP, XML, XSD, HTML • Excellent verbal and written communication skills.
Health PAS-Administrator Subject Matter Expert by MITA	• Provides expert leadership and solution designs for specified MITA business areas. • Creates and presents DDI project training for project Boot camp sessions for internal and	• Bachelors degree or equivalent experience • 5 years in one or more business aspects of MMIS development or other areas of

Role	Responsibilities	Skill Set
Business Area	external staff. • Continuously works with solution teams to improve processes and delivery for their functional MITA business areas. • Facilitates or presents MITA Business process end-to-end solutions in initial Requirements to COTs Specification (RCS) workshops, serving as a role model for MITA Systems Analysts to lead subsequent sessions. • As needed, works with the cross-functional teams or Health PAS component owners to define the design for MITA Business Process end-to-end solutions for specific functions. • Manages and mentors the MITA Systems Analysts reporting up to them to coordinate team tasks and deliver on-time work packages for steady state engineering tasks. • Provides support to site management for new initiatives and meetings. • Provides performance reviews, coaching, mentoring, and conflict resolution for team. • Provides support, when needed, of product development, pre-sales, and business development. • Provides support or presents solution at customer site to win new business. • Creates Product Design Requests for critical functionality to be added to the QNXT product to eliminate the need for gap processes.	the healthcare industry • Advanced to expert leadership skills • Advanced critical thinking and problem solving skills • Strong familiarity with change management; project management; and technology management • Dedicated to knowledge sharing with team and customer • Advanced Medicaid and QNXT knowledge; and advance knowledge of business process models • Moderate to advanced knowledge of other Health PAS COTS software • Strong Healthcare system knowledge • Excellent presentation skills • Excellent verbal and written communication skills • Continuously analyzing processes to improve quality and delivery.
HIPAA Compliance Officer	• Develops, maintains and revises policies and procedures on the appropriate use and disclosure of PHI and other HIPAA standards. • Provides guidance to subsidiary staff regarding state-specific privacy requirements and helps ensure policies and procedures are matched with appropriate processes and controls to promote compliance. • Assists in managing the organization's privacy incident response process including investigation, mitigation, reporting, training and remediation. • Performs ongoing monitoring of Business Associates Agreements and third party data sharing/use agreements. • Plans and conducts audits and reviews to assess departmental and business unit compliance with HIPAA and contractual requirements and accreditation standards. • Assist with the development and provision of HIPAA privacy and security training, education and awareness. Initiate, facilitate and promote	• Bachelors degree or equivalent experience • 3 years experience in healthcare compliance or information privacy compliance. • Knowledge of HIPAA, HITECH and other healthcare privacy laws • Appropriate knowledge of information privacy and/or security, preferably including CIPP certification • Auditing experience • Knowledge and understanding of legislative/regulatory process and the technology environment regarding privacy • Proficiency with PC-based applications, thorough knowledge of Microsoft Office Suite (including Access, Excel, PowerPoint & Word), MS Visio

Role	Responsibilities	Skill Set
	activities to foster privacy and security awareness within Molina Healthcare. • Maintain current knowledge of applicable federal and state privacy laws and accreditation standards, and monitors advancements in information privacy technologies to ensure organizational adaptation and compliance. • Fosters a team environment. • Works cooperatively and collaboratively with co-workers and HIPAA Project Team members.	and MS Project. • Ability to learn new information systems and software programs. • Ability to assess and mitigate risks and, if required, independently review controls. • Strong written and verbal communication skills. • Strong analytical, organizational, and project management skills. • Independent judgment and initiative in identifying and resolving problems. • Effective interpersonal and negotiation skills.
Implementa-tion Project Manager	• The Implementation Project Manager leads the Vendor's project management activities for the MMIS implementation.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 5 years required below can be substituted for a degree. • PMP certification or industry recognized project management certification preferred.
Infrastructure Lead	• Establishes and Maintains telecommunications and connectivity. • Oversees network administrators, technicians, and operators. • Develops Value Added Networks (VANS) and the Eligibility Verification System (EVS). • Investigates, evaluates, recommends and implements upgrades to hardware and software to according to state requirements. • Prepares and maintains documentation for current network platform, backup, and printing procedures. • Develops and maintains Disaster Recovery Plan and leads testing activities.	• Bachelor's degree or equivalent experience. • Strong knowledge of networks, security, and IT infrastructure • Skilled at communicating technical information to non technical users • 6 years experience with LANS and Networks. • 2 years supervisory and management experience.
Interface Lead	• Provides day-to-day direction to the Interface Team. • Defines and validates the customer business requirements and solution requirements for interfaces. • Develops the data mappings for the inbound and outbound data interfaces. • Designs the integration of data between the Health PAS solutions.	• Bachelor's degree or equivalent experience. • Strong knowledge of interfaces, including data mapping, requirements definition, data integration, and testing. • Skilled at communicating technical information to non technical users

Role	Responsibilities	Skill Set
	• Supports testing for the interface processes. • Tracks and reports the progress of interface tasks.	• 6 years experience with system interfaces. • 2 years supervisory and management experience.
Interface Specialist	• The Interface Specialist manages all interface development and implementation activities for Medical/Dental and POS.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 3 years required below can be substituted for a degree.
LAN/Desktop Support Analyst	• Provides technical support of hardware, systems, subsystems and/or applications for local MMS customers and/or employees. • Reviews, analyzes, and evaluates information technology systems operations. • Applies basic diagnostic techniques to identify problems, investigate causes and recommend solutions to correct common failures and support of PCs and applications. • Responsible for personal computers and desktops and for disposal of obsolete equipment. • Supports on-call as required on a rotating basis 24/7.	• Associate's Degree or equivalent experience • 3 - 5 years computer experience • Knowledge of Windows 2000/2003/2008 Server administration • Knowledge of 2005 R2 Virtual Server • Computer room/network/phone and printer support skills • Personal computer hardware and applications support skills.
Letter/Report Manager	• Analyzes, models, designs, develops and implements at least one Integrated Solutions component for Medicaid sites including the Letter / Report Manager. • Designs, develops and implements customized functionality for at least one Integrated Solutions component to accommodate business processes related to that Integrated Solutions component. • Identifies the need for and develops new Integrated Solutions functionality to accommodate new business processes and procedures as they are introduced to the solution. • Assists and mentors peers with understanding Integrated Solution components, technical architecture, custom development, and operations support. • Represents the Integrated Solution as a new implementation lead or existing customer support lead, potentially managing junior Integrated Solutions resources.	• Bachelor's degree or equivalent experience • Combined 5-10 years of health care, system engineering, and project management experience. • Business Analysis and Modeling knowledge, applying technical solutions to business processes • FileNET configuration of document classes, indices and distribution queues (Storage Manager) • Possesses knowledge of one or more of the following: Venetica (Process Manager), Cincom (Letter Manager), ASG Cypress (Report Distribution Manager), Apropos AVRS, Call Center Toolsets (Contact Manager) • Knowledge of Microsoft Structured Query Language (SQL), VB Script, Visual Basic for Applications (VBA) Java Script, HTML and extensive knowledge of Markup

Role	Responsibilities	Skill Set
		Language (XML), and Active Server Pages (ASP • Knowledge of Project Management • Excellent verbal and written communication skills.
Mailroom/ Claims Supervisor	• Responsible for supervising Mailroom staff and monitoring daily operations according to department's policies and procedures. • Delegates and prioritizes task assignments of claims and mailroom staff. • Updates departmental desktop procedures. • Maintains productivity to ensure staff meets production standards.	• High School Diploma or GED • Working knowledge of mailroom operations • 5 years supervision/lead in a claims processing environment.
Mailroom: Inbound Mail Staff: Data Entry	• Enters claims data into system. • Follows appropriate policies and procedures to ensure proper payment of claims. • Meets established production requirements consistently • Maintains an accuracy rate of 98% or better. • Contributes a positive attitude to the team in order to meet department goals. • Supports all departmental initiatives in improving overall efficiency. • Meets all attendance policy requirements.	• High School Diploma or GED • 1 – 2 years general office experience • Knowledge of Microsoft Office products • General knowledge of personal computer • Good verbal and written communication skills.
Mailroom: Inbound Mail Staff: Scanner	• Generates, reviews, and distributes reports from OADES BIC system, as well as OADES 824 from SQL Db. • Generates report for Mailroom production for OPS 55. • Monitors OADES workflows for stopped processes. Troubleshoots and resets batches that fail to process through workflow. • Monitors and reports on multiple Data Entry Vendors. • Maintains logs and tracks paper claims for retention at offsite warehouse. Also obtains appropriate state approvals for destruction of stored claims. • Maintains inventory of forms and supplies utilized in the Mailroom. • Operates and cleans mailroom equipment. • Meets established production and quality standards. • Supports all departmental initiatives in improving overall efficiency.	• High School diploma or GED • 3+ years general office experience; preferably mailroom • Good working knowledge of scanner hardware and software • Ability to lift up to 50 lbs • Basic knowledge of Microsoft Office Outlook • Ability to abide by Molina's policies • Maintain regular attendance based on agreed-upon schedule.
Mailroom: Inbound Mail Staff:	• Opens and sorts all incoming mail. • Screens medical claim forms for pertinent information.	• High School diploma or GED • 2+ years general office experience; preferably

Role	Responsibilities	Skill Set
Screener/ Coder	• Batches medical claim forms by claim type. • Completes Code Sheets for Third Party Liability and/or Medicare Crossover claims. • Prepares, for mailing, Return to Provider (RTP) letters for returning claims with missing information required to enter into the claims payment system. • Prepares Remittance Advices weekly for mailing to providers. • Meets established production and quality standards. • Supports all departmental initiatives in improving overall efficiency.	mailroom • Ability to lift up to 50 lbs • Basic knowledge of Microsoft Office Outlook • Ability to abide by Molina's policies • Maintain regular attendance based on agreed-upon schedule.
Mailroom: Outbound Mail Staff	• Prepares, stuffs, weighs and posts all outgoing mail • Prepares and stages items for off-site storage • Operates and cleans mailroom equipment. • Meets established production and quality standards. • Supports all departmental initiatives in improving overall efficiency.	• High School diploma or GED • 3+ years general office experience; preferably mailroom • Good working knowledge of postal equipment • Ability to lift up to 50 lbs • Basic knowledge of Microsoft Office Outlook • Ability to abide by Molina's policies • Maintain regular attendance based on agreed-upon schedule.
Medical/ Dental Ad Hoc Reporting Specialist	• 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.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 3 years required below can be substituted for a degree.
Medical/ Dental Application Manager	• 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.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 5 years required below can be substituted for a degree.
Medical/ Dental Project Manager	• The Project Manager leads the Vendor's project management activities for Medical/ Dental inclusive of integration management with POS.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 5 years required below can be

Role	Responsibilities	Skill Set
		substituted for a degree. • PMP certification or industry recognized project management certification preferred.
Medical/ Dental Quality Manager	• The Quality Manager oversees all quality assurance functions and responsibilities including deliverable review, accuracy of reports, system enhancement documentation, and review of test results.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 3 years required below can be substituted for a degree.
Medical/ Dental Systems Manager	• 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.	• Bachelor's degree preferred in Computer Science, Information Systems or related field. • 4 years of directly relevant experience in addition to the 8 years required below can be substituted for a degree.
Medical Review	• Review forms sent in for sterilization and hysterectomy for accuracy, completeness and meeting federal regulations and guidelines. • Enters authorizations into the system for approval or denial, or return to provider for corrections. • Review and process claims for edit 225 for emergency transportation. Review encompasses medical necessity and appropriate information provided. • Communicate with providers regarding concerns about claims that have denied due to the sterilizations, and hysterectomy, and other medical related questions. • Index prior authorizations and 'Return to Provider' (RTP) letters into the PET system. • Maintains a weekly and monthly logs for number of RTP, and Authorizations entered into the QNXT system • Review multiple ER visits per day, per member for medical necessity. • Provides assistance to customer service for denials and guidelines followed for medical necessity. • Consistently meets established production and quality standards. • Contributes a positive attitude to the team in order to meet department goals. • Assists with special projects. • Supports all departmental initiatives in improving overall efficiency.	• Registered Nurse with active WV license • Medical knowledge related to appropriate patient care • Thorough understanding of CPT/HCPCS and ICD9 coding procedures and guidelines • Excellent verbal and written communication skills • General PC skills and Microsoft Outlook skills.

Role	Responsibilities	Skill Set
Member Buy-In	• Responsible for timely and professional interaction with providers including escalating recurring or critical issues to appropriate Team Lead or Manager in a timely fashion. • Ability to navigate through the system with efficiency. • Must be able to meet and retain all quality and production standards set by management and/or customer. • Excellent time management when handling special projects that include but are not limited to member mail, LTC calls, Nursing Home, Hospice, and mild research.	• High school diploma or GED • Excellent organizational skills • Familiarity with Data Input • Knowledge of Microsoft Office • The ability to work independently with little supervision • Excellent verbal and written communication skills.
Member Payment Data Entry	• Enters member buy-in data into system while interpreting coding and understanding medical terminology in relation to diagnoses and procedures. • Follows adjudication policies and procedures to ensure proper payment of claims. • Meets established production requirements consistently • Maintains an accuracy rate of 98% or better. • Contributes a positive attitude to the team in order to meet department goals. • Supports all departmental initiatives in improving overall efficiency. • Meets all attendance policy requirements.	• High School diploma or GED • 1 – 2 years general office experience • Knowledge of Microsoft Office products • General knowledge of personal computer • Good verbal and written communication skills.
Member Payment Financial Analyst	• Analyzes financial information related to member payment. • Develops financial requirements specifications using industry best practices ensuring that the requirements and related business rules are complete, consistent, concise, comprehensible, traceable, feasible, unambiguous, and testable. • Facilitates peer reviews of financial requirements documents. • Participates in peer reviews of work products derived from financial requirements specifications to ensure that the requirements were interpreted correctly. • Manages changes to base line financial requirements using established project change control processes and tools. • Assists in the creation of objectives, agendas and other meeting materials in preparation for financial workshops.	• Bachelor's degree preferred; or equivalent combination of education and additional years of directly relevant experience. • 3 years direct experience with Flexi Financial System • 2 years client-facing experience • 2 years Medicaid/Medicare experience • Excellent analytical skills, ability to evaluate information to reconcile conflicts, decompose high-level information into details, and distinguish user requests • Ability to lead requirements workshops and make "real-time" changes to artifacts • Ability to effectively communicate features and requirements to stakeholders and technical staff • Excellent organizational,

Role	Responsibilities	Skill Set
		interpersonal and verbal and written communication skills.
Member Services Representa-tive	• Ability to handle heavy inbound call volume with knowledge to address more complex concerns from Provider Community. • Responsible for timely and professional interaction with providers including escalating recurring or critical issues to appropriate Team Lead or Manager in a timely fashion. • Ability to navigate through the system with efficiency. • Must be able to meet and retain all quality and production standards set by management and/or customer. • Excellent time management when handling special projects that include but are not limited to member mail, LTC calls, Nursing Home, Hospice, and mild research.	• High school diploma or GED • Minimum of 3 to 5 years Customer Service/Call Center experience in medical claims • Excellent organizational skills • Familiarity with Data Input • Knowledge of Microsoft Office • The ability to work independently with little to no supervision • Excellent verbal and written communication skills • Must possess knowledge and skill to support and enable less experienced staff.
Member Services Supervisor	• Directs the assigned department on policy and procedures related to claims/providers/ members. • Manages a team of Representatives that includes recruitment, development, and motivation of staff. • Initiates and communicates a variety of personnel actions that includes employment, termination, performance reviews, • Salary reviews, and disciplinary actions. • Facilitates meetings with the customer/client and the necessary management team to discuss provider/member issues; offers suggestions for improvement and/or changes; assists with the implementation of changes. • Assists providers with problem solving and resolution of more complex claims and other issues; advises providers of new • Protocols, policies and procedures and website data. • Proactively resolves problems to insure compliance with contract terms and resolve problems due to system issues to build trust and strong business relations with all providers; analyzes data to assess the scope of the problem, plan an appropriate approach and measure results. • Researches and coordinates the resolution of provider claims. • Researches and analyzes call center data and create reports for results and recommendations. • May work collaboratively with the Quality Improvement Department to review the	• Bachelor's degree or equivalent experience • Five (5) or more years of supervisory experience in a Call Center Operations environment • Four (4) or more years experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of health care policy and direction. • Strong analytic and problem solving abilities. • Through direct interactions with providers, builds positive and collaborative relationships • Leadership qualities • Ability to multi task in a high paced environment • Excellent verbal and written communication skills.

Role	Responsibilities	Skill Set
	accuracy, completeness and verification of provider/member calls in the Call Tracking documentation and QNXT system; ensures that provider data that is entered into the provider module is complete and accurate.	
Modification and Enhance-ment Tester	• Creates and executes test cases and documents results of test execution. • Generates test data. • Documents defects from test case execution. • Supports individual DDIs or other Test Center work as needed. • Supports assigned solution components requirement set. • Tracks defects and code drops related to assigned solution component; helps ensure their completion and incorporation into all related documentation. • Attends and supports weekly status meetings with test team to ensure an understanding of their thoughts and observations.	• Bachelors degree and/or equivalent experience • 4+ years test experience • Knowledge of the contents of the work plan as well as the Requirements Traceability Matrix • Thorough knowledge of Medicaid and HPAS components • Excellent interpersonal and verbal and written communication skills.
MMIS Sr. Technical Resource	• Responsible for participating on the Turnover Team to coordinate activities related to the turnover of the MMIS to the state or a new vendor.	• For the Turnover Phase, a resource will be selected from existing WV MMIS staff. • An SME in Health PAS applications and business processes.
NOC Engineer	• Responsible for expert-level maintenance and upgrades of servers in a manner that will maintain a secure, steady and reliable system performance and to plan for any additional projects. Research and install new systems. • Ensure the smooth running of all systems. • Ensure adherence to software licensing laws • Ability to provide innovative solutions to problems presented. • Provide secure access to the network for remote users. • Ensure the security of data from internal and external attack. • Provide users with appropriate support and advice. • Keep up to date with the latest technologies. • Employ security solutions, including firewall, anti-virus, and intrusion detection systems. • Ensure proper operation of all network hardware such as switches, hubs, and cabling. • Conduct research on network products, services, protocols, and standards in support of network procurement and development efforts. • Practice network asset management, including	• 3+ years experience with network and internetwork topologies, Server and User administration, TCP/IP protocols, storage and server fault tolerance, virtualization, and firewall and router administration • May manage user access to Production and Test environments.

Role	Responsibilities	Skill Set
	maintenance of network component inventory and related documentation and technical specifications information. • Ensure system connectivity of all servers, PCs, and applications. • Create and maintain documentation as it relates to system configuration, mapping, processes, and service records. Bachelor's degree or equivalent experience.	
Nursing Home Resolution Analyst	• Process claim forms, adjudicates for allocation of deductibles, co-pays, co-insurance maximums and provider reimbursements. • Follow adjudication policies and procedures to ensure proper payment of claims. • Resolve pends based on Medicaid rules and regulation established for final processing. • Resolve call tracking claim resolution, and/or adjustments • Process claim adjustments through Reversal/Replacement requests submitted by providers. • Manually price claims as required by Medicaid rules and system limitations as defined by policy and departmental procedures. • Create authorizations with QNXT Prior Authorization module as required by Medicaid rules and as defined by policy and departmental procedures. • Meet established production requirements consistently • Maintain an accuracy rate of 98% or better. • Contribute a positive attitude to the team in order to meet department goals. • Support all departmental initiatives in improving overall efficiency.	• High School diploma or GED • 3-5 years claims processing experience • Limited knowledge of Microsoft Office Outlook • General knowledge of PC • Good working knowledge of medical claims systems • Knowledge of CPT/HCPCS and ICD9 coding procedures and guidelines • Good verbal and written communication skills.
Operations Resource	• Responsible for participating on the Turnover Team to coordinate activities related to the turnover of the MMIS to the state or a new vendor.	• For the Turnover Phase, a resource will be selected from existing WV MMIS staff. • An SME in West Virginia MMIS operations.
Pharmacy Analyst, Tester, Software Engineer	• May leads POS team on technical tasks: analyzing work requests from customer for pharmacy applications changes, assessing risks, assigning tasks, assisting team in developing technical solutions, and mentoring other team members in applications and technical skills. Performs development tasks when needed. • Responds rapidly to production real-time POS problems: participates in POS on-call rotation, provides support for other POS on-call	• Bachelors degree or equivalent experience • 5+ years in real-time transaction processing, application programming, relational database programming, and client-server programming • Ability to establish close working relationships with

Role	Responsibilities	Skill Set
	personnel, analyzes production problems, and proposes solutions. • Analyzes production transactions and system data to understand system behavior and improve system operation. • Promotes continuing high quality of software and documentation by reviewing software, documents, and team activities for compliance with the quality processes and practices developed by the POS team. Proposes process improvements as needed.	customers and internal staff, understanding their needs and perspectives • C, Unix, SQL, pharmacy applications, real-time processing, statistics, Source code control, MS Office Suite • Ability to understand real-world application of process quality concepts • Excellent verbal and written communication skills.
Pharmacy Business Analyst	• Participates and leads on technical tasks: analyzing work requests from customer for pharmacy applications changes, assessing risks, assisting team in developing technical solutions, and mentoring other team members in applications and technical skills. • Implements Change Requests and Trouble reports to the pharmacy applications. • Responds rapidly to production real-time POS problems: participates in POS on-call rotation, provides support for other POS on-call personnel, analyzes production problems, and proposes solutions. • Analyzes production transactions and system data to understand system behavior and improve system operation. • Promotes continuing high quality of software and documentation by reviewing software, documents, and team activities for compliance with the quality processes and practices developed by the POS team. Proposes process improvements as needed.	• Bachelor's degree or equivalent experience • 3 to 5 years in real-time transaction processing, application programming, relational database programming, and client-server programming • Close working relationships with customers and internal staff. Understanding of their needs and perspectives • Multiple software and hardware environments, pharmacy applications, real-time processing, statistics, Source code control, MS Office Suite • Excellent verbal and written communication skills.
Pharmacy ETL	• Provides guidance to site management including cost analysis. Also provides guidance to other MMS teams. • Provides guidance to other MMS teams regarding Pharmacy ETL questions and issues. • Provides guidance to the Infrastructure team for Pharmacy ETL application server architecture requirements and disk capacity/performance needs. • Mentors other team members in areas of expertise. • Develops and manages packages and applications. • Packages ETL packages for deployment to development, test, and production environments. • Identifies, develops, and documents processes	• Bachelors degree or equivalent experience • 3 to 5 years analysis experience • 3 to 5 years Pharmacy ETL design and/or development experience, • 3 to 5 years database experience in SQL environment • 3 to 5 years with ETL tools such as SSIS, Informatica, DataStage or Ab Initio • Analytical skills in a SQL environment • ETL design and development knowledge • Database knowledge utilizing

Role	Responsibilities	Skill Set
	and procedures. • Automates processes where appropriate. • Participates in the ETL on-call rotation. • Ensures that assigned tasks are completed on or ahead of schedule. Prioritizes assigned tasks appropriately. • Informs the team lead and Central Engineering management of project issues; escalate issues in a timely manner, and ask for assistance when needed. • Communicates effectively with a variety of audiences including management, peers, and members of other MMS teams. Tailors the message to the audience. • Understands our Pharmacy processes and procedures, communicates processes and procedures to other groups, and enforces adherence to processes and procedures. • Solves complex issues in innovative ways.	tools such as SSIS, Informatica, DataStage, or Ab Initio. • Excellent verbal and written communication skills.
Pharmacy Manager	• The Pharmacy Manager is responsible for planning, developing, testing, implementing and maintaining the West Virginia MMIS Pharmacy, including POS, and assisting with management of the MMIS Pharmacy POS Replacement DDI and Certification including all sub-phases.	• Bachelor's degree preferred in Computer Science, Information Systems or related field. • 4 years of directly relevant experience in addition to the 4 years required below can be substituted for a degree.
Pharmacy Technician	• Responsible for responding to pharmacy point of sale questions • Assists pharmacy providers with questions regarding BMS policy for pharmacy services • Provides resolution to pharmacy point of sale claims that, based on BMS policy and clinical needs, require an override • Reviews the WV preferred drug list for accuracy and completeness • Responsible for keeping the National Drug Codes current within the WV MMIS	• High School Diploma or GED • Possess a current, valid Board of Pharmacy license • Working knowledge of WV MMIS • Knowledge of BMS pharmacy policies • 5 years of Medicaid experience with 3 of those years specific to WV Medicaid.
Pharmacy Test Analyst	• Analyze, test and maintain Point of Sale pharmacy applications based upon business requirements and customer policies • Test software and database upgrades for quality and effectiveness • Present application upgrades/changes to the customer via email & teleconference • Develop test documentation to track quality assurance of software upgrades/changes • Develop and maintain test cases/scripts for software upgrades/changes • Coordinate and maintain Medicaid pharmacy claim application business rules	• Associate's degree or equivalent experience • 2 – 3 years experience with application experience • Experience with automated and manual testing • Ability to work well with others • Ability to multi-task and prioritize • Close working relationships with internal staff. • Multiple software and hardware environments, pharmacy

Role	Responsibilities	Skill Set
	• Create and run ad hoc reports for state Medicaid officials using SQL • Serve as technical liaison between customers and software developers regarding customer requested application changes • Research and resolve problem Medicaid claims.	applications, real-time processing, statistics, Source code control, MS Office Suite • Excellent verbal and written communication skills.
PMO Analyst	• Conducts independent analysis of the schedule for the design, development and implementation of the WV MMIS replacement • Analyzes the process and methodologies used by the various technical and operational teams for the WV MMIS replacement project to confirm that risks, issues and opportunities have been addressed • Reviews the deliverables associated RTMs, BSD, and other design artifacts • Broad knowledge of and exposure to project management disciplines to support PMO activities	• Bachelors degree or equivalent • 5-8 years leading service delivery teams • 5 years experience with automated tool suites • 1-3 years PMO experience • Excellent MS Office skills including Excel, PowerPoint, Access, Word • Thorough knowledge of automated tool support including Rational Tool Suite and Risk Radar • Familiarity with MS Project Server administration, and MS SQL Server queries and reporting • Understanding of MS networking technologies • Adherence to Project Management Institute best practices • Ability to handle multiple, high priority assignments concurrently.
PMO Health PAS-OnLine Content Management	• Provides 24/7 web portal support that involves upkeep and maintenance. • Performs portal augmentations such as functionality upgrades, documentation postings or updates, and web page portal message postings for provider/vendor/clearinghouse users. • Publishes reports to the web portal (remittance advices, 835s, etc.). • Portal troubleshooting with server and web portal user accounts and Sun One Application services. • Monitors and resolves issues with the File Transfer Agent (FTA), FTS/Biztalk Scheduled Tasks, and XJ Series portal shell scripts. • Processes and resolves 837 errors and electronic adjustments on a QCSI/a Qtrans level via the Resubmitter program. • Performs Trading Partner EDI X12 testing for	• Associate's degree or equivalent experience • 4010 EDI Knowledge • eServices XJ Series Web Portal Knowledge • X12 Transactions Compliancy • HTML and DHTML Fundamentals • Basic Networking • Sun One Application • Adobe InDesign • File Transfer Agent (FTA) • MS SQL • MS Office • Biztalk • Instream • QNXT • DRG Calculations

Role	Responsibilities	Skill Set
	users seeking to upload HIPPA compliant files via the web portal. • Provides daily/weekly EDI transaction reports such as Crossover Error, Summary and Metrics to e-Services.	• Excellent verbal and written communication skills.
PMO Health PAS-InterComm Engineer	• Subject Matter Expert for SharePoint Server. • Coordinates with SharePoint team lead. • Administers user/group access and permissions. Supports user access/usage issues. • Creates and administers internal team sub-sites. • Coordinates with Architecture and Infrastructure in software requirements review, preliminary and critical design, integration readiness review, and software acceptance review for team sites. • Presents oral briefings to project team, management and customers. • Conducts portal training as needed. • Coordinates with site ops to identify and resolve issues which could affect SharePoint portals, • Supports customer interface to shared portals. • Creates solutions to enhance user experience and functionality. • Provides SharePoint design work, documentation, and best practices consulting. • Create customer documentation.	• Bachelors degree or equivalent experience • 3 to 5 years SharePoint administration • 2+ years SQL query experience • Good knowledge of Microsoft Applications (i.e. Word, Excel, InfoPath, and Designer) • Thorough understanding of MS networking, application, and database technologies • Excellent verbal and written communication skills • Ability to manage multiple assignments and shift priorities.
PMO Manager	• Originates the appropriate planning concepts and tools used for planning, scheduling, and tracking projects. • Establishes the project management infrastructure, including development of project plans, schedules, resource requirements, and change orders. • Maintains the project management plans; including issue management plan, a risk management plan, a quality management plan, a change and configuration management plan. • Monitors the work activities against with the approved work plan. • Controls project requirements, scope, and change management issues.	• Bachelor's degree or equivalent experience • 6-8 years project management experience • 1-3 years PMO experience • 5 yrs strategic planning experience • 5 yrs SDLC experience • Excellent MS Office skills including Excel, PowerPoint, Access, Word • Excellent MS Project client and server skills • Thorough understanding of MS networking technologies • Excellent attention to detail and follow-up skills • Broad business management background including resource management, policy determination, financial impact analysis • Analytical ability to identify

Role	Responsibilities	Skill Set
		issues and develop solutions • Excellent verbal and written communication skills.
PMO QA Lead	• Conducts independent analysis of the schedule for the design, development and implementation of the WV MMIS replacement • Audits the process and methodologies used by the various technical and operational teams for the WV MMIS replacement project • Audits the deliverables and associated RTMs, BSD, and other design artifacts to ensure thoroughness and accuracy • Develops the process for identifying, tracking and reporting the risks, issues and opportunities associated with the WV MMIS replacement project. • Broad knowledge of and exposure to project management disciplines to support PMO activities • Proactively facilitates business process improvements	• Bachelors degree or equivalent experience • 5 to 8 years leading service delivery teams • 5 years experience with automated tool suites • 1 to 3 years PMO experience • Excellent MS Office skills including Excel, PowerPoint, Access, Word • Thorough knowledge of automated tool support including Rational Tool Suite and Risk Radar • Familiarity with MS Project Server administration, and MS SQL Server queries and reporting • Understanding of MS networking technologies • Adherence to Project Management Institute best practices • Ability to handle multiple, high priority assignments concurrently.
POS Ad Hoc Reporting Analyst	• Creates reports to meet user requirements using Microsoft SQL Reporting Services. • Writes and maintains database stored procedures. • Writes documentation for best practices, lessons learned, release notes, DDI documents. • Performs other duties as assigned by the Team Lead and Analytics Manager. • Provides peer review and unit test reports. • Successfully completes training courses set forth by Analytics team manager. • Maintains SharePoint sites. • May work independently or cooperatively with other software developers. • May function as a technical consultant or researcher.	• Bachelor's degree or equivalent experience • 3 years experience SSRS report development • Strong knowledge of SQL 2005/2008 • Familiar with relational database concepts, and client-server concepts • Knowledge of Medicaid IT systems Strong SQL 2005 and Microsoft Reporting Services or Crystal Reports experience • SSIS or DTS experience • Developing knowledge of a MITA area and CMS requirements • Experience with Rational tools • Excellent organizational and oral/written communication skills.

Role	Responsibilities	Skill Set
		• Strong analytical, technical, and interpersonal skills required. • Must be highly motivated and results-oriented.
POS Deputy Account Manager	• 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. The Deputy Account Manager assists with oversight the MMIS Replacement DDI and Certification and all sub-phases.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 6 years required below can be substituted for a degree.
POS Help Desk	• Responds to pharmacy point of sale questions • Assists pharmacy providers with questions regarding BMS policy for pharmacy services • Provides resolution to pharmacy point of sale claims that, based on BMS policy and clinical needs, require an override • Provides data layouts/responds to questions regarding pharmacy point of sale claims submission	• High School Diploma or GED • Working knowledge of WV MMIS • Knowledge of BMS pharmacy policies • 5 years of Medicaid experience with 3 of those years specific to WV Medicaid.
POS Project Manager	• The Project Manager leads the Vendor's project management activities for POS inclusive of integration management with Medical/Dental.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience in addition to the 5 years required below can be substituted for a degree. • PMP certification or industry recognized project management certification preferred.
POS Quality Manager	• 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.	• Bachelor's degree or equivalent experience • 4 years of directly relevant experience can be substituted for a degree.
POS Sr. Technical Resource	• Responsible for participating on the Turnover Team to coordinate activities related to the turnover of the MMIS to the state or a new vendor.	• For the Turnover Phase, a resource will be selected from existing WV MMIS staff. • An SME in West Virginia MMIS POS operations.

Role	Responsibilities	Skill Set
POS Systems Manager	• Manage day to day client interaction planning and implementation, additions, changes and major modifications in support of pharmacy applications. • Initiates and implements improvements in all areas of IT responsibility. • Serves as the main point of contact on all pharmacy technical and subject matters • Relay relevant information to customers and staff in a timely manner • Motivate the team to work together, utilizing each team member to his/her fullest potential • Sets and manages internal client expectations • Communicates effectively with state and internal clients to identify needs and evaluate alternate business solutions • Continually seeks opportunities to increase customer satisfaction and deepen client relationships • Lead internal teams and task groups • Be accessible when unexpected circumstances require prompt attention	• Bachelors degree or equivalent experience • 10+ years in one or more business aspects of information systems development. Hands-on experience of applications programming • MS Project, MS Office Suite, SQL, Technical knowledge of pharmacy architecture and applications • Excellent verbal and written communication skills.
Provider Payment Systems Analyst	• Assists in conducting Requirements to COTS Specification workgroups • Acts as a Gap Systems Analyst, using the prescribed gap process for collecting and documenting the full set of requirements during a Gap workshop with the customer in order to develop requirements specifications artifacts to ensure that requirements are complete • Prepares prototypes, artifacts and deliverables, and demonstration of product configuration • Complete, after each workshop, artifacts and unit test tasks as well as updates to deliverable documents • Supports conversion and interface activities • Supports operations staff in researching configuration and processing issues	• Bachelor's Degree or equivalent experience • Intermediate QNXT product knowledge and best practices • Advanced Medicaid industry knowledge • Microsoft SQL Server knowledge • Excellent verbal and written communication skills.
PRIMS Software Engineer	• Performs ongoing support of the PRIMS projects, including user interface and database modifications, application and database performance tuning, and ad hoc report creation • Serves as technical lead on any PRIMS implementation, including database design and development, application/GUI design and development, data conversion and migration planning and development, and system testing • Advises on all technical matters for PRIMS projects • Trains new technical staff on application	• Bachelor's Degree or equivalent experience • Minimum of 5 years SQL development/administration experience • Minimum 5 years reporting tools experience • Minimum 5 years Medicaid Drug Rebate experience • Ability to establish and maintain positive and effective work relationships with coworkers,

Role	Responsibilities	Skill Set
	maintenance and improvements • Monitors day-to-day activities of technical staff working on application and serves as primary technical contact with other engineering groups supports PRIMS operations.	clients, members, providers, customers, and other stakeholders.
Provider/ Member Services Manager	• Manages and provides direct oversight of the activities of one or more of the following functions: Call Center, Enrollment and Electronic Data Interchange areas within the Provider Relations Department. Assists in the development of internal Desktop Processes and Policies and Procedures. Develops and implements training programs and educational materials for the assigned department and other internal staff. • Directs the assigned department on policy and procedures related to claims/providers/members. • Manages a team of Representatives that includes recruitment, development, and motivation of staff. • Initiates and communicates a variety of personnel actions that includes employment, termination, performance reviews, • Salary reviews, and disciplinary actions. • Facilitates meetings with the customer/client and the necessary management team to discuss provider/member issues; offers suggestions for improvement and/or changes; assists with the implementation of changes. • Assists providers with problem solving and resolution of more complex claims and other issues; advises providers of new • Protocols, policies and procedures. • Proactively resolves problems to insure compliance with contract terms and resolve problems due to system issues to build trust and strong business relations with all providers; analyzes data to assess the scope of the problem, plan an appropriate approach and measure results. • Researches and coordinates the resolution of provider claims. • Researches and analyzes call center data and create reports for results and recommendations. • May work collaboratively with the Quality Improvement Department to review the accuracy, completeness and verification of provider/member calls in the Call Tracking documentation and QNXT system; ensures that provider data that is entered into the provider module is complete and accurate.	• Bachelor's degree or equivalent experience • 5 or more years of supervisory experience in a Call Center Operations environment • 4 or more years experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of health care policy and direction. • Strong analytic and problem solving abilities. • Through direct interactions with providers, builds positive and collaborative relationships • Leadership qualities • Ability to multi task in a high paced environment • Excellent verbal and written communication skills • Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA) • Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers.

Role	Responsibilities	Skill Set
Provider Enrollment Supervisor	• Supervises and provides direct oversight of the activities of the Provider Enrollment unit. • Assists in the development of internal desktop processes and policies and procedures in conjunction with the manager. • Maintains appropriate call center reporting statistics and quality improvement practices. • Researches, reports and analyzes enrollment data including functions of the call center and creates reports for results, monitoring and recommendations.	• Bachelor's Degree or equivalent experience • 3 to 5 years of leadership/supervisory experience in a Call Center Operations environment • 4+ years experience in claims and/or benefits interpretation and provider networking.
Provider Field Representa-tives	• Proactively resolves problems to insure compliance with contract terms and resolve problems due to system issues to build trust and strong business relations with all providers; analyze data to assess the scope of the problem, plan an appropriate approach and measure results. • Develops implements and maintains operational content used to train providers and their office staff and/or billing vendors. • Coordinates and conducts education activities involving providers, Provider Services and other vendors with the objective to modify inefficient claim filing behaviors. • Conducts field visits to provider's offices proactively and in response to business issues including, but not limited to, claims processing, policy application and reimbursement issues. • Attends and supports appropriate Provider and Vendor Committee meetings. Participates and attends Community or Provider sponsored events representing the company or the customer/client. • Responds to provider issues in writing, telephonic and in the provider's office. This includes issues related to all aspects of claims filing, reimbursement, and dispute resolution as defined in customer/client contract, application of payment or medical policies. • Must be able to meet and retain all quality and production standards set by management and/or customer. • Excellent time management when handling special projects.	• Associate's Degree or equivalent experience • Minimum three (3) years of Customer Service experience • Minimum of two (2) years of Medical Claims Processing background • Excellent verbal and written communication skills • Effective analytical skills • Experience with Microsoft Office and internet navigation • A current Driver's License with good driving record • Ability to work a flexible schedule • Excellent organizational skills • Through direct interactions with providers, builds positive and collaborative relationships • Leadership qualities • Ability to multi task in a high paced environment.
Provider Services Lead	• Directs the assigned department on policy and procedures related to call center/correspondence/field inquiries. • Supervises the team including recruitment, development and motivation of staff. • Initiates personnel actions including	• Bachelors degree or equivalent experience • 3-5 years of leadership/supervisory experience in a Call Center Operations environment

Role	Responsibilities	Skill Set
	employment, terminations, performance/salary reviews and disciplinary actions. • Facilitates meetings with the teams to discuss issues/suggestions for improvement and assists the manager with the implementation of changes. • Resolves problems to insure compliance and customer satisfaction. • Builds trust and strong business relationships internally & externally. • Researches, reports and analyzes call center/correspondence/field data and creates reports for results, monitoring and recommendations. • Works collaboratively with all monitoring functions to assure accuracy and quality of information.	• 4+ years of experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of health care policy and direction • Good knowledge and understanding of Medicaid policies and procedures • Good working knowledge of the Medicaid policies, medical billing, authorization processes, and enrollment • Ability to build positive and collaborative relationships • Leadership qualities • Ability to multi-task in a high paced environment • Excellent verbal and written communication skills • Excellent customer service skills • Excellent organizational and analytical skills.
Provider Services Representa-tives	• Ability to handle heavy inbound call volume with knowledge to address more complex concerns from Provider Community. • Responsible for timely and professional interaction with providers including escalating recurring or critical issues to appropriate Team Lead or Manager in a timely fashion. • Ability to navigate through the system with efficiency. • Must be able to meet and retain all quality and production standards set by management and/or customer. • Excellent time management when handling special projects that include but are not limited to member mail, LTC calls, Nursing Home, Hospice, and mild research.	• High School diploma or GED • Minimum of 3 to- 5 years Customer Service/Call Center experience in medical claims • Excellent organizational skills • Familiarity with Data Input • Knowledge of Microsoft Office • The ability to work independently with little to no supervision • Excellent verbal and written communication skills • Must possess knowledge and skill to support and enable less experienced staff.
Provider Services Supervisor	• Directs the assigned department on policy and procedures related to claims/providers/members. • Manages a team of Representatives that includes recruitment, development, and motivation of staff. • Initiates and communicates a variety of personnel actions that includes employment, termination, performance reviews, • Salary reviews, and disciplinary actions.	• Bachelor's degree or equivalent experience • Five (5) or more years of supervisory experience in a Call Center Operations environment • Four (4) or more years experience in claims and/or benefits interpretation and provider networking • Substantive knowledge of

Role	Responsibilities	Skill Set
	• Facilitates meetings with the customer/client and the necessary management team to discuss provider/member issues; offers suggestions for improvement and/or changes; assists with the implementation of changes. • Assists providers with problem solving and resolution of more complex claims and other issues; advises providers of new • Protocols, policies and procedures and website data. • Proactively resolves problems to insure compliance with contract terms and resolve problems due to system issues to build trust and strong business relations with all providers; analyzes data to assess the scope of the problem, plan an appropriate approach and measure results. • Researches and coordinates the resolution of provider claims. • Researches and analyzes call center data and create reports for results and recommendations. • May work collaboratively with the Quality Improvement Department to review the accuracy, completeness and verification of provider/member calls in the Call Tracking documentation and QNXT system; ensures that provider data that is entered into the provider module is complete and accurate.	health care policy and direction. • Strong analytic and problem solving abilities. • Through direct interactions with providers, builds positive and collaborative relationships • Leadership qualities • Ability to multi task in a high paced environment • Excellent verbal and written communication skills.
QA Auditor	• Assists in creating deliverables and documentation. • Assists with quality assurance reviews for each project deliverable; including internal peer reviews and project management reviews. • Helps prepare the final deliverables for submission to the State. • Assists in addressing comments from the State pertaining to project deliverables. • Ensures that the testing processes are adhering to the procedures documented in the test plans. • Reports quality review findings. • Participates in the Corrective Action Plan activities.	• Bachelor's degree or equivalent experience • 2 years conducting training for internal and external clients • 2 years experience with assigned deliverables.
QA Trainer	• Assists with quality assurance reviews for each project deliverable; including internal peer reviews and project management reviews. • Performs internal quality control functions • Participates in the development of training materials and curricula. • Provides feedback to staff regarding errors/problems identified and correction action required.	• High school diploma GED • Technical Writing and Documentation Control experience • Practical knowledge of document control management systems • Excellent writing and editing skills

Role	Responsibilities	Skill Set
	• Ensures that the testing processes are adhering to the procedures documented in the test plans. • Reports quality review findings. • Participates in the Corrective Action Plan activities. • Participates in training facilitation.	• Experience with Word, Excel and Adobe • Detail oriented and organized • Excellent verbal and written communication skills.
Rebate Analyst	• Conducts analysis of proposed changes to the drug rebate system • Responsible for providing data to the BMS related to drug rebate activities • Assists BMS with analysis of proposed changes • Assists with the documentation and requirements, specifications and testing efforts for drug rebate changes	• High School Diploma or equivalency • Working knowledge of the Federal drug rebate regulations and guidelines • 5 years of Medicaid experience with 3 of those years specific to WV Medicaid.
Receptionist	• Operates telephone console with professionalism including forwarding calls and taking messages • Greets visitors and notifies employees of guests' arrival • Maintains visitor register and security passes • Performs confidential work of an administrative nature under the direction of the department head • Establishes and maintains official documents and records in appropriate files. • Serves as a back up to Site Administrative personnel • May handles mail/FedEx distribution to appropriate parties; orders supplies for site. • Assist other units as time permits	• High School diploma or GED • 3 to 5 years administrative experience • Maintain a working relationship with site, client and visitor personnel • Proficient in Word and Excel • Excellent verbal and written communication skills.
Registered Nurse	• Review forms sent in for sterilization and hysterectomy for accuracy, completeness and meeting federal regulations and guidelines. • Enters authorizations into the system for approval or denial, or return to provider for corrections. • Review and process claims for edit 225 for emergency transportation. Review encompasses medical necessity and appropriate information provided. • Communicate with providers regarding concerns about claims that have denied due to the sterilizations, and hysterectomy, and other medical related questions. • Index prior authorizations and 'Return to Provider' (RTP) letters into the PET system. • Maintains a weekly and monthly logs for number of RTP, and Authorizations entered into the QNXT system • Review multiple ER visits per day, per member	• Active license as a Registered Nurse in West Virginia and a minimum of a Bachelor of Science degree, Master's Degree preferred. • 2 years experience in medical knowledge related to appropriate patient care • Thorough understanding of CPT/HCPCS and ICD9 coding procedures and guidelines • Excellent verbal and written communication skills • General PC skills and Microsoft Outlook skills.

Role	Responsibilities	Skill Set
	for medical necessity. • Provides assistance to customer service for denials and guidelines followed for medical necessity. • Consistently meets established production and quality standards. • Contributes a positive attitude to the team in order to meet department goals. • Assists with special projects. • Supports all departmental initiatives in improving overall efficiency.	
Release Management	• Define, document, and follow the specific process for each of the CR categories. A change management plan document must be maintained and followed. • Establish and follow a prioritization business rules, project scope, and implementation timeline. • Monitor CR tracking in RQMS system and maintain updates to tracking information • Establish and follow criteria for scope changes, statements of work, cost estimates, and invoicing. • Report to site leadership on CR performance measurements. • Develop strong customer relationships based on mutual respect and rigorous business rules. • Work with site leadership and finance to ensure timely invoicing of billable CRs and report profitability of these CRs monthly. • Hold all resources accountable for on-time and on-budget delivery of CRs.	• Bachelor Degree or equivalent experience • 5 years experience in project management, software implementation, or system change management • Strong client-facing and relationship skill service skills required including proven ability to manage and disposition conflict resolution • Demonstrated ability to work effectively in a matrix organization and to get things done without direct authority. Comfortable working in a geographically disperse environment. • Demonstrated written and verbal communication skills with customer, off-site support groups, and internal department heads • Healthcare claims processing experience strongly preferred.
Release/ Sprint Foreman	• Define, document, and follow the specific release/sprint process. • Establish and follow prioritization business rules, project scope, and implementation timeline. • Report to site leadership on release/sprint performance measurements. • Develop strong customer relationships based on mutual respect and rigorous business rules. • Hold all resources accountable for on-time and on-budget delivery of sprints.	• 5 years experience in project management, software implementation, or system change management • Strong client-facing and relationship service skills required • Demonstrated ability to work effectively in a matrix organization and to perform without direct authority. Comfortable working in a geographically disperse environment. • Demonstrated written and

Role	Responsibilities	Skill Set
		verbal communication skills with customer, off-site support groups, and internal department heads • Healthcare claims processing experience strongly preferred.
Reports Manager	• The Reports Manager is responsible for managing the report development and 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 • Preparing and issuing instructions concerning generation, completion, and distribution of reports according to new or revised practices, procedures, or policies of reports management. • Defines a full software development lifecycle for the Analytics team, including full testing methodology, detailed plans for conducting unit testing, detailed deployment plans with checklists describing how to deploy the work products, and source control. • Works with the projects and the workforce manager to plan project staffing needs for the department 6 - 12 months out including new or diminished business opportunities. • Drives team efficiency: looks for and documents ways to increase the efficiency through continuous improvement goals and process maturation taking into account budget impacts. • Maintains management/technical skills that can be utilized in the field to solve complex problems. • Maintains a Best Practices document available to all team members on SharePoint.	• Bachelors degree or equivalent experience • 10 years work experience preferable in claims processing environment and/or healthcare environment • 3 years management or team leadership experience • Strong knowledge of SQL 2005/2008 SSRS report development • Familiar with relational database concepts, and SDLC concepts Strong knowledge of SQL 2005, Microsoft Reporting Services and Crystal Reports • Ability to effectively assign tasks to staff and to prioritize tasks according to project needs • Solid understanding of Health PAS architecture and processing • Self-motivated, takes initiative to identify, communicate, and resolve potential issues • Knowledge of Rational and TFS • Strong knowledge and hands-on experience with developing and implementing reports and software, using structured software life-cycle methodologies • Excellent problem solving, organizational and oral/written communication skills • Strong analytical, technical, interpersonal and relationship management skills • Must be highly motivated and results-oriented and work effectively with members of multiple departments • Good software development and customer service skills.

Role	Responsibilities	Skill Set
	• Tasks developers, manages staff for workloads. • Develops & implements reports with repeatable processes to satisfy federal CMS reporting requirements. • Maintains best practices for report distribution and archiving that complies with federal & state statutes. • Continuous improvements of established reports in production to ensure best performance. • Creates reports to meet user requirements using Microsoft SQL Reporting Services and Crystal Reports. • Provides documentation for best practices, lessons learned, release notes, DDI documents. • Maintains Share Point sites.	
Senior Database Administrator	• Oversees Health PAS database administration, backups, and recoveries, verifying the security and integrity of the database. • Creates and maintains database schema definition, performance tuning, and capacity planning. • Collaborates with other systems and operations units to maximize the value of the data and determine the impact of changes on Health PAS. • Verifies that databases and data dictionaries are updated according to specified schedules. • Executes development scripts to update the database. • Works with team members to resolve database questions or problems. • Coordinates systems resource availability with database analysts, system and application programmers, and other users. • Maintains industry-recognized policies, procedures, and standards relating to database management.	• Bachelor's degree or equivalent experience • 5 years hands-on relational database experience • 2 years as a SQL Server database administrator in a production environment. Familiarity and comfort with ordinary maintenance tasks such as moving tempdb, migrating databases, changing server configuration parameters, dropping/adding users and logins. • Solid understanding of relational theory and how it applies to production environments. • Advanced to expert level SQL Server 2005/2008 administration and tuning skills • Experience with large databases up to 2 terabytes in size and a solid understanding of the effects of various factors on the health and performance of large, transactional SQL Server databases • Excellent problem solving skills • Ability to lead complex database-related technical tasks, identify and resolve potential issues, and drive tasks to successful completion on or ahead of schedule.

Role	Responsibilities	Skill Set
Senior Systems Analyst by function: - Care/ Utilization Management - Claims/TPL/ COBA - Finance - Provider/ Contracts/ Benefits - Member	• Responsible for analyzing customer directed system changes • Updates changes to the configurable data tables • Responsible for conducting system test to confirm configuration changes work as planned • Responsible for completing post implementation review of production (configuration) changes • Assists BMS with analysis of proposed changes	• High School Diploma or equivalency • Working knowledge of WV MMIS • Knowledge of BMS medical policies • Knowledge of COTS products that are integrated with the WV MMIS • 5 years of Medicaid experience with 3 of those years specific to WV Medicaid.
Senior Systems Application Analyst (Claims, Member, Provider, Reporting)	• Applies extensive technical expertise with full knowledge of Health PAS solution including all components • Leads the Requirements to COTS Specification meetings and produces required artifacts and deliverables • Participates in the design, development and deployment of technical solutions, integrating various COTS products and custom software components • Exercises considerable latitude in determining technical objectives of assignment without direction • Guides the successful completion of major programs and may function in a project leadership role • Displays the ability to analyze programs, including performance, diagnosis and troubleshooting • Analyzes business workflow and system need for conversion and migrations and assists in data mapping • Coordinates requirements, specifications, design and testing efforts for projects • Prepares user documentation • Performs unit test plan, scripts and rigorous test per requirements	• Bachelor's Degree or equivalent experience • Master's Degree preferred • 5 years software application development experience • 5 years analysis and problem solving expertise • Development expertise within the healthcare arena • QNXT database structure knowledge • Excellent verbal and written communication skills.
Senior Tester	• Attends RCS sessions. • Responsible for the creation of the system test cases. • Schedule and coordinates walkthrough of test case results with state. • Performs Accessibility. • Performance and Stress testing. • Creates and executes test cases and documents results of test execution.	• Bachelor's degree or equivalent experience • 7+ years testing experience • Knowledge of the contents of the work plan as well as the Requirements Traceability Matrix • Strong knowledge of Medicaid and HPAS components • Excellent interpersonal and

Role	Responsibilities	Skill Set
	• Generates Test data. • Documents defects from test case execution. • Provides guidance to junior testers. • Acts as owner of assigned solution components requirement set. • Tracks defects and code drops related to assigned solution component; ensures their completion and incorporation into all related documentation. • Oversees/manages specific DDI sub-initiatives as required. • Attends and supports weekly status meetings with test team to ensure an understanding of their thoughts and observations.	verbal and written communication.
Service Delivery Manager	• Manages all aspects of very large system implementation projects of significant complexity or multiple large-scale projects • Conceptualizes project approaches and solutions that meet client needs • Develops detailed project plans, communication plans, schedules, role definitions, risk management, and assumptions; manages to plans • Estimates resource requirements based on project scope • Manage scope and client expectations to deliver projects that meet and excel client expectations • Identifies and resolves complex project/program tasks and issues; proactively puts plansin place to prevent future issues • Leads or facilitates complex, multi-session client meetings • Forecasts risk areas and develops mitigation strategies • Participates in developing methods and tools to support improved implementation success and repeatability	• Bachelor's Degree or equivalent years of experience • Master's Degree in Business preferred • 8 years large system implementation experience • 5 to 7 years healthcare/payer experience • Strong healthcare and public sector knowledge and experience • Direct experience implementing configurable applications that support health plan/payer processes • Strong understanding of technology trends and solutions • Ability to use and develop repeatable methods, processes, and tools that support implementation of new technologies • Excellent verbal and written communication skills.
Solution/ Integration Developer	• Analyzes, models, designs, develops and implements at least one Integrated Solutions component for Medicaid sites. • Designs, develops and implements customized functionality for at least one Integrated Solutions component to accommodate business processes related to that Integrated Solutions component. • Identifies the need for and develops new Integrated Solutions functionality to accommodate new business processes and procedures as they are introduced to the	• Bachelor's degree or equivalent experience • 5+ years experience health care, system engineering, and project management experience. • Business Analysis and Modeling knowledge, applying technical solutions to business processes • FileNET configuration of document classes, indices and

Role	Responsibilities	Skill Set
	solution. • Assists and mentors peers with understanding Integrated Solution components, technical architecture, custom development, and operations support. • Assists all other Molina Medicaid groups involved in integration efforts across the practice that involve Integrated Solution components. • Identifies and prescribes technical solution requirements in support of the MMS Business Development group's efforts in writing proposals and responding to RFPs and RFIs, etc. • Represents the Integrated Solution as a new implementation lead or existing customer support lead, potentially managing junior Integrated Solutions resources.	distribution queues (Storage Manager) • Possesses knowledge of one or more of the following: Venetica (Process Manager), Cincom (Letter Manager), ASG Cypress (Report Distribution Manager), Apropos AVRS, Call Center Toolsets (Contact Manager) • Knowledge of Microsoft Structured Query Language (SQL), VB Script, Visual Basic for Applications (VBA) Java Script, HTML and extensive knowledge of Markup Language (XML), and Active Server Pages (ASP • Knowledge of Project Management • Excellent verbal and written communication skills.
Solution Leads/SME	• Analyzes, models, designs, develops and implements Integrated Solutions components for Medicaid sites. • Designs, develops and implements customized functionality to accommodate business processes related to Integrated Solutions components. • Identifies the need for and develops new Integrated Solutions functionality to accommodate new business processes and procedures as they are introduced to the solution. • Assists and mentors peers with understanding Integrated Solution components, technical architecture, custom development, and operations support. • Assists all other Molina Medicaid groups involved in integration efforts across the practice that involve Integrated Solution components. • Identifies and prescribes technical solution requirements in support of the MMS Business Development group's efforts in writing proposals and responding to RFPs and RFIs, etc. • Represents the Integrated Solutions group as a new implementation lead or existing customer support lead, managing junior Integrated Solutions resources.	• Bachelors degree or equivalent experience • Combined 8 years of health care, system engineering, and project management experience. • Business Analysis and Modeling knowledge, applying technical solutions to business processes • FileNET configuration of document classes, indices and distribution queues (Storage Manager) • Possesses knowledge of one or more of the following: Venetica (Process Manager), Cincom (Letter Manager), ASG Cypress (Report Distribution Manager), Apropos AVRS, Call Center Toolsets (Contact Manager) • Knowledge of Microsoft Structured Query Language (SQL), VB Script, Visual Basic for Applications (VBA) Java Script, HTML and extensive knowledge of Markup Language (XML), and Active Server Pages (ASP • Knowledge of Project Management

Role	Responsibilities	Skill Set
		• Excellent verbal and written communication skills.
Sterilization/ Hysterectomy Staff	• Review and/or enter S/H information from Physician Certification Statements. • Review forms received for sterilization and hysterectomy for accuracy, completeness and meeting federal regulations and guidelines. • Communicate with providers regarding concerns about claims that have denied due to the sterilizations, and hysterectomy, and other medical related questions. • Consistently meets established production and quality standards. • Contributes a positive attitude to the team in order to meet department goals. • Assists with special projects. • Supports all departmental initiatives in improving overall efficiency.	• Medical knowledge related to appropriate patient care • Thorough understanding of CPT/HCPCS and ICD9 coding procedures and guidelines • Excellent verbal and written communication skills • General PC skills and Microsoft Outlook skills.
Systems Architect	• Identifies the standards and technologies for implementing Health PAS solutions and enabling performance qualities, such as availability, scalability, recoverability, etc. • Selects the appropriate architecture and technologies for solutions and interfaces between software components that make up a solution area. • Evaluates and selects server hardware, software configuration, and ongoing job control for a specific solution area. • Supports the Applications architect in selecting application frameworks. • Plans acceptance test criteria for solutions and assists test teams conducting integration and acceptance testing. • Balances quality issues (cost vs. robustness) for solution designs and assists in parametric cost estimations. • Monitors performance benchmarks for solutions provided by customer service level agreements • In conjunction with the Project Architect, sizes the applications and selects the hardware, software and configuration to use • Participates in the drafting of service level agreements. • Establishes processes to monitor existing systems for performance problems and drafts environment roll-out migration plans • Participates in tuning and troubleshooting software applications and solutions. • Assists technical support teams in defect	• Bachelor's degree or equivalent experience • 5 - 8 years solution architecture design • 3 - 5 years of software modeling experience (e.g. RUP, Agile, UML) • 3 - 5 years of leading development teams • Ability to architect high-volume transaction processing systems and understands the effects of various factors on the health and performance of applications making up larger solutions; ability to conduct design reviews • Software modeling and visual representation skills • Ability to survey emerging technologies and evangelize new technologies, standards and methodologies that will have a positive impact on cost and performance • Solid understanding of Health PAS architecture and processing and of how software architecture and design relates to larger project objectives • Self-motivated, takes initiative to identify, communicate, and

Role	Responsibilities	Skill Set
	management. • Assists in strategic sales efforts from a technical perspective. • Provides technical leadership and guidance to the Product Development team. • Trains fellow architects and engineers in new or unfamiliar software designs and programming techniques. • Works with the Enterprise Architect to roll out solutions to the sites and facilitate solution training and adoption. • Assists delivery teams with solving complex technical issues. • Establishes, documents, and rolls out software architecture processes and procedures. • Provides recommendations, alternatives, and guidance to Product Development team leads, and other MMS teams regarding software product questions and issues. • Communicates effectively with a variety of audiences including management, programmers, and members of other MMS teams. Tailor the message to the audience. • Communicates software architecture policies and procedures to the Product Development and other MMS teams, and enforces adherence to processes and procedures.	resolve potential issues • Excellent problem solving skills and excellent verbal and written communication skills.
Technical Architect Lead	• Facilitates the analysis and documentation of the to-be business process workflow and identifying where efficiencies can be gained through business process reengineering. • Oversees the entire Health PAS architecture team. • Responsible for completing the system and data architecture of the Health PAS environments to support the integration of the components. • Ensures the integrity of the system through the development phases. • Establishes the development, test, and production environments in support of the implementation. • Makes certain that the technical requirements and design meets the customer requirements consistent with the Health PAS software architecture and underlying technologies. • Establishes and enforces development methodologies, processes and procedures.	• Bachelor's Degree or equivalent experience • 3 - 5 years experience with leading or managing technical resources systems • Thorough knowledge of the Health PAS system • Excellent written and oral communication skills.
Tech Support Desk	• Responsible for providing the technical support of telephony systems, for local MMS customers and/or employees. • Applies basic diagnostic techniques to identify	• Associate's Degree or equivalent experience • 3 - 5 years experience with

Role	Responsibilities	Skill Set
	problems, investigate causes and recommend solutions to correct common failures and support of local telephony systems • Orders and sets up new staff equipment. • Provides upgrades of phone systems to Molina Standards.	telephony systems.
Test Lead	• Coordinates all testing activities including the creation and execution of test cases and data. • Attends RCS sessions. • Schedules and coordinates walkthrough of test case results with state. • Generates Test data. • Prioritizes and coordinates the resolution of defects from test case execution.	• Bachelor's Degree or equivalent experience • Knowledge of the contents of the work plan as well as the Requirements Traceability Matrix • Strong knowledge of Medicaid and HPAS components.
Test Manager	• Defines and documents testing process modifications. • Manages and coordinates Testing Environments and tools for all phases of testing • Coordinates the testing of requirements for small to large projects. • Interfaces with QA, Program management stakeholders, client management, client test teams and other client defined points of contact to ensure ongoing satisfaction with delivery of Test Center services. • Acts as onsite liaison to client for all things related to Project testing • Identifies requirements for training of test center staff • Oversees/manages specific DDI sub-initiatives as required • Communicates Project initiatives, status, tasks and responsibilities to test team to ensure their understanding.	• Bachelor's degree or equivalent experience • 7-10 years in testing environment • 2-3 years supervisory/management experience • Strong HPAS Application knowledge • Proficiency with majority of MS Office product set • Strong follow through and active listening skills • Strong project and task scoping and management skills • Good interpersonal skills and meeting facilitation ability • Understanding of overall architecture of HPAS solution • Good ability to identify issues with direction, executing plans • Excellent verbal and written communication skills.
Tester	• Creates and executes test cases and documents results of test execution. • Generates Test data. • Documents defects from test case execution. • Supports individual DDIs or other Test Center work as needed. • Supports assigned solution components requirement set. • Tracks defects and code drops related to assigned solution component; helps ensure their completion and incorporation into all related documentation.	• Bachelors degree or equivalent experience • 4+ years test experience • Knowledge of the contents of the work plan as well as the Requirements Traceability Matrix • Thorough knowledge of Medicaid and HPAS components • Excellent interpersonal and verbal and written

Role	Responsibilities	Skill Set
	• Attends and supports weekly status meetings with test team to ensure an understanding of their thoughts and observations.	communication skills.
Trainer	• Responsible for developing training curricula, training materials and facilitating training sessions for Medical/Dental and POS. • Reviews policies, procedures, work instructions, forms, etc. for format consistency. Edit as applicable. • Maintains revision control and a tracking spreadsheet for all controlled documents. • Assists other departments in the creation of documents. • Trains staff on document control policies and procedures. • Proofreads and edits documentation and correspondence to the state and other external entities. • Carries out the duties of a Quality Assurance Analyst as requested. • Assumes responsibilities of other QA team members as needed due to absence.	• Bachelor's Degree or equivalent experience • Excellent writing and editing skills • Experience with Word, Excel and Adobe • Detail oriented and organized • Excellent verbal and written communication skills • Excellent presentation and facilitation skills.
Turnover Manager	• The Turnover Manager is responsible for planning, coordinating, and managing all tasks related to the turnover of this contract to the State or a new vendor.	• Bachelor's Degree or equivalent experience • Excellent planning and coordination skills • Excellent written and verbal communication skills

An outline of the roles and responsibilities within an organization are critical to the success of a project, allowing all team members to understand who oversees each area of the project.

B RESUMES [4.1.8]

This entire section contains confidential and proprietary information and has been redacted.

C BUSINESS AND TECHNICAL REQUIREMENTS [Appendix E]

Molina offers the BMS technology and services that align with the BMS "To Be" vision goals and objectives. Molina's goal is to enable the BMS to comply with mandatory changes, to introduce flexibility in program design to better manage costs and increase collaboration among intrastate agencies, and to facilitate the use of state and regional information exchange. Molina's Health PAS, consisting of integrated, COTS components, and its associated business processes, aligned with the MITA standards, can facilitate West Virginia's move into the future while meeting the goals and objectives of the MMIS re-procurement project.

Molina provides the completed RFP Appendix E, Business and Technical Requirements, matrix in **Figure C-1**.

Figure C-1: Molina's Response to RFP Appendix E, Business and Technical Requirements

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
1 (ME)	**1. Member Management (ME)**			
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:	X		
ME.3	Web portal	X		
ME.4	By telephone to the Provider Help Desk	X		
ME.5	Automated Voice Response System (AVRS)	X		
ME.6	Electronic inquiry through a 270 transaction	X		
ME.7	Other as specified by the BMS during the DDI phase		X[1]	
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).	X		
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.	X		
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.	X		
ME.11	The Vendor is expected to transmit an interface file to RAPIDS and FACTS so that required Mountain Health	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
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).	X		
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.	X		
ME.15	The MMIS is expected to accept the Medicaid ID assigned by the eligibility source or through the Master Data Management (MDM) solution.	X		
ME.16	Ability to accept and maintain eligibility to pay for services provided for Members who are not Title XIX or Title XXI Members.	X		
ME.17	The system should allow authorized users to manually enter Member eligibility information.	X		
ME.18	Ability to automatically apply data validation edits during manual entry of Member eligibility information.	X		
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.	X		
ME.21	Enrollment broker is to have direct (role-based) user-access to the MMIS.	X		
ME.22	The Vendor is to maintain appropriate benefits package for services for enrolled Member.	X		
ME.23	Ability to support flexible administration of benefits from multiple programs so that a Member may receive a customized set of services.	X		
ME.24	Ability to report on duplicate Member records using multiple criteria (e.g., name, SSN) in order to reconcile duplicate enrollment records.	X		
ME.25	Ability to capture and display from eligibility source head-of-household name.	X		
ME.26	Capture and display case number in each individual Member record.	X		
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.		X	
ME.28	Ability to store, track and display eligibility source data including but not limited to eligibility codes, termination reason codes, termination dates, etc.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
ME.29	Generate monthly PAAS rosters to be submitted to the PAAS providers monthly.	X		
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).		X	
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:	X		
ME.33	RAPIDS (Recipient Automated Payment and Information Data System)	X		
ME.34	FACTS (Families and Children Tracking System)	X		
ME.35	TPL vendor/s as specified by BMS	X		
ME.36	Enrollment broker/s as specified by BMS	X		
ME.37	Other systems as specified by the BMS during DDI		X[1]	
ME.38	Ability to support the following functionality in regards to processing updates to the Member data set:	X		
ME.39	Automatically edit fields for reasonableness, validity, format and consistency with other data present in update transaction.	X		
ME.40	Transaction reconciliation reporting for file/data reconciliation with external data sources (e.g., totals and detail information, difference reports, change reports).	X		
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.	X		
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.	X		
ME.43	Error correction/synchronization error reporting - report all failed synchronization.	X		
ME.44	Ability to perform the following functions:	X		
ME.45	Maintain identification of all applicants eligible for Medicaid benefits.	X		
ME.46	Allow for timely updating of the data base to include new Members and all changes to existing Member records.	X		
ME.47	Maintain positive (active, as opposed to passive) control over all data pertaining to Medicaid Member eligibility.	X		
ME.48	Build and maintain a computer file of Member data to be used for claims processing, administrative reporting, and surveillance and utilization review.	X		
ME.49	Able to distribute eligibility data to other processing agencies.	X		
ME.50	Provide file space for, and record whenever available, the Social Security Number of each eligible Member.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
ME.51	Contain and use the data necessary to support Third Party Liability recovery activities.	X		
ME.52	Role-based security providing confidential access for individuals or groups.	X		
ME.53	Ability to provide external eligibility sources daily access to approved Member eligibility data.	X		
ME.54	Ability to support on-line data presence, validity, format, and relationship edits for manually entered updates.	X		
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.	X		
ME.56	Ability to identify recipients with multiple ID numbers for cross referencing, and for unduplicated counts of recipients for reporting purposes.	X		
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).	X		
ME.58	Enrollment broker can automate or be able to directly enter information that would be maintained in the Member record.	X		
ME.59	Ability to allow enrollment brokers to enter Member choice (PCP or HMO) directly into the MMIS.	X		
ME.60	Ability to allow enrollment brokers to enter notes, comments, etc., into MMIS.	X		
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.	X		
ME.62	Ability to automatically update and edit eligibility information based on information received in Vital Statistics file.	X		
ME.63	Ability to interface with the Department of Corrections to receive incarceration file.		X	
ME.64	Send data to RAPIDS for review of Member termination.	X		
ME.65	Provide an automated link to claims for the Member under current and historical names and ID numbers and display the data.	X		
ME.66	Ability to track and display all Member current and historical names and ID numbers.	X		
ME.67	Provide update capability for all Member data for designated BMS staff and make update separate from inquiry	X		
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.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
ME.69	Allow direct navigation access to a Member's historical claims, PAs, referrals, and case histories.	X		
ME.70	Ability to maintain current and historical eligibility data to support the following:	X		
ME.71	Basic program eligibility verification	X		
ME.72	Special program eligibility verification	X		
ME.73	ID card production	X		
ME.74	Claims processing	X		
ME.75	Premium processing	X		
ME.76	Prior authorization processing	X		
ME.77	Reporting	X		
ME.78	Other activities as specified by the BMS during the DDI phase		X[1]	
ME.79	Ability to maintain a Member data set that contains all data elements, including (but not limited to):	X		
ME.80	Name	X		
ME.81	Residence and mailing address(es)	X		
ME.82	Phone numbers (home, cell, etc.)	X		
ME.83	E-mail address	X		
ME.84	Gender	X		
ME.85	Date of Birth (DOB)	X		
ME.86	DHHR County Office ID	X		
ME.87	Member ID number	X		
ME.88	Unique and/or universal Member identifiers from the eligibility systems	X		
ME.89	Social Security Number (SSN)	X		
ME.90	Medical Health Insurance Claim (HIC) Number (Medicare Number)	X		
ME.91	Race	X		
ME.92	Ethnicity	X		
ME.93	Head of household detail (including but not limited to name, Member ID, SSN)	X		
ME.94	Rate code or MAS/BOE ("aid category")	X		
ME.95	**Long Term Care**	X		
ME.96	Nursing Home name and Provider ID the Member resides in	X		
ME.97	Effective/Term dates for stay	X		
ME.98	Resource amounts	X		
ME.99	Resource amounts effective and term dates	X		
ME.100	Other as specified by the BMS during the DDI phase		X[1]	
ME.101	Ability to establish unique, date-specific benefit packages for each program applicable to a Member to ensure correct benefit application.	X		
ME.102	Ability to maintain periods of Medicare eligibility with	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	flexible segments.			
ME.103	Ability to maintain client (member) identification numbers to twelve (12) or more digits.	X		
ME.104	Ability to cross-reference current and historical Member identification numbers for all eligibility sources.	X		
ME.105	Maintain and cross-reference Member name changes, including name change date and effective date.	X		
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.	X		
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.	X		
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.	X		
ME.109	**4. Inquire Member Eligibility**			
ME.110	The Vendor is expected to maintain a Medicaid Eligibility Verification System (MEVS).	X		
ME.111	The Vendor is expected to provide each Medicaid Eligibility Verification System (MEVS) vendor daily access to approved Member eligibility data.	X		
ME.112	The Vendor is expected to provide an Automated Voice Response System (AVRS) which accesses the MEVS information.	X		
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.	X		
ME.114	Ability to electronically generate eligibility verification reports based on supplied list (there may be an associated cost to the provider).	X		
ME.115	The system should maintain a log of all telephone and electronic inquiries to eligibility inquiry systems.	X		
ME.116	**5. Perform Population & Member Outreach**			
ME.117	Ability to track Member outreach communications detail, including:	X		
ME.118	Target population	X		
ME.119	Quality measure/s addressed	X		
ME.120	Purpose (e.g., implement programs like enrollment campaigns for waiver programs or other plan/benefits change, privacy notice)	X		
ME.121	Date/s of distribution	X		
ME.122	Method/s of distribution	X		
ME.123	Other as defined by the BMS during DDI		X[1]	

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
ME.124	**6. Manage Applicant & Member Communication**			
ME.125	Ability to generate and distribute Member-related correspondence, reports and associated documents.	X		
ME.126	Ability to attach Member-related correspondence documents to the Member record.	X		
ME.127	Periodically generates Member satisfaction surveys.	X		
ME.128	The system is expected to receive and track summary level mailing data from the enrollment broker for reporting purposes.		X	
ME.129	**7. Manage Member Grievance & Appeal**			
ME.130	Ability to track PA denials in MMIS.	X		
ME.131	Provide the ability for BMS to manually flag denied prior authorizations under appeal.	X		
ME.132	Provide the ability for BMS to run a report of all denied prior authorizations flagged as under appeal.	X		
ME.133	Provide the ability for BMS to display a report of all denied prior authorizations flagged as under appeal.	X		
ME.134	The system should support workflow for the appeals and grievances processes.	X		
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.	X		
2	**Provider Management (PM)**			
PM.1	**1. Enroll Provider**			
PM.2	Ability to enroll Providers eligible to provide Medicaid services.	X		
PM.3	Ability to enroll non-traditional Medicaid Providers to support payment of services in the MMIS. For example, taxi/transportation and respite.	X		
PM.4	Ability to enroll non-Medicaid Providers on behalf of different program or different agency or others as defined by BMS.	X		
PM.5	The Vendor is expected to maintain control over all data pertaining to Provider enrollment (including paper batches and electronic data).	X		
PM.6	Ability to generate unique tracking numbers for Provider enrollment applications and updates.	X		
PM.7	Ability to give Providers secure temporary access to the enrollment process and once approved for enrollment, permanent access to the online system.	X		
PM.8	The system should allow Providers the ability to complete and submit enrollment applications and updates in a secure online environment.	X		
PM.9	Ability to automatically assign Providers a temporary username/password for the online enrollment process.	X		
PM.10	Ability to automatically generate to the submitter a receipt	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
PM.12	Ability to allow Providers to access their own information and group owners to access information for all Providers in the group.	X		
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.	X		
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.	X		
PM.15	Ability to allow Providers to view and send online alerts and notifications generated by BMS or Vendor staff.	X		
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).	X		
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.	X		
PM.18	Ability to alert appropriate staff that a Provider enrollment application has pended for a certain amount of days as defined by BMS.	X		
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).	X		
PM.20	Ability to maintain hard and soft (electronic) copies of required Provider enrollment documentation, as defined by the BMS.	X		
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.	X		
PM.22	Ability to purge enrollment tracking data based on parameters defined by the BMS.	X		
PM.23	Ability to enroll only those Providers who agree to abide by the rules and regulations of the State Medicaid program.	X		
PM.24	Ability to identify and assign Provider applications and updates by Provider types, as defined by BMS.	X		
PM.25	Ability to identify and assign Provider enrollment application status, as defined by BMS (e.g., Initial/New, Resubmitted with Modifications, Cancellation).	X		
PM.26	Ability to identify and display the applicant type, as defined by BMS (e.g., Rendering Provider, Billing Agent, Pay to	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	Affiliations).			
PM.27	Ability to track the date enrollment forms are received for each Provider application.	X		
PM.28	Ability to automatically identify and terminate a duplicate enrollment request or update, and give the Provider a meaningful error message.	X		
PM.29	Ability to save partially completed Provider enrollments for a given number of days (to be defined by BMS).	X		
PM.30	Ability to notify applicants of partially submitted applications.	X		
PM.31	Ability to conduct re-verification of currently enrolled Provider, based on BMS-specified conditions.	X		
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:	X		
PM.33	Applicant type	X		
PM.34	Provider type	X		
PM.35	Other as identified by BMS during DDI		X[1]	
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.	X		
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.	X		
PM.38	Ability to hold application in pending status until pre-approving entity gives authorization to proceed.	X		
PM.39	Ability to cross-reference license and sanction information with other State and/or Federal agencies.	X		
PM.40	Ability to verify certification in other states for participating out-of-state Providers.	X		
PM.41	Ability to track, display, and maintain verification of enrollment application/record information, including:	X		
PM.42	Provider Identifiers (e.g., NPI, SSN, EIN)	X		
PM.43	Sanction status (e.g., HIPDB, NPDB, boards, criminal background checks)	X		
PM.44	Credentials (e.g., licensure specialty boards, school, affiliations)	X		
PM.45	Other as identified by BMS during DDI		X[1]	
PM.46	Ability to use an expedited enrollment process to enroll Out of Network Providers for a limited period of time.	X		
PM.47	Ability to allow approved users to manually reactivate inactive Providers.	X		
PM.48	Ability to automatically reactivate inactive Providers, according to criteria defined by BMS.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PM.49	Ability to track and report a Provider's enrollment activity from receipt of application to final disposition.	X		
PM.50	Ability to assign unique Provider number when enrollment is approved.	X		
PM.51	Ability to track and support BMS-established review schedule to ensure Providers continue to meet program eligibility requirements.	X		
PM.52	Ability to maintain and display history and audit trails for online changes and updates.	X		
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.	X		
PM.54	**2. Provider Contracts**			
PM.55	Ability to define procedures and diagnoses a Provider is allowed to render under a Provider's license.	X		
PM.56	Ability to define types of Provider contracts.	X		
PM.57	Ability to support flexible rules-based logic (as specified by BMS and Federal guidelines) to define Provider contracting parameters.	X		
PM.58	Ability to define and easily update (per BMS) the procedures or services a Provider is allowed to provide under a contract.	X		
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.	X		
PM.60	Ability to 'model' or create a new contract from an existing contract.	X		
PM.61	Ability to track and support BMS-established review schedule to ensure Providers continue to meet program eligibility requirements.	X		
PM.62	Ability to maintain and display history and audit trails for online changes and updates.	X		
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.	X		
PM.64	**3. Disenroll Provider**			
PM.65	Ability to allow Providers to submit online request for termination of their Provider agreement.	X		
PM.66	Ability to identify Provider disenrollment request status, as defined by BMS (e.g., initial, duplicate, resubmitted with modifications).	X		
PM.67	Ability to validate that disenrollment meets State rules, as defined by the BMS.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PM.68	Ability to allow users with appropriate authorization to terminate providers.	X		
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).	X		
PM.70	Ability to process disenrollment requests for all application status types (e.g., Initial/New, Modification, Cancellation, Update).	X		
PM.71	Ability to disenroll Providers after a certain period of inactivity (to be defined by BMS).	X		
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.	X		
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).	X		
PM.75	Ability to log and track all Provider information requests, including:	X		
PM.76	Name of requesting party	X		
PM.77	Date of inquiry	X		
PM.78	Parameters used in system query	X		
PM.79	User name (of user querying system)	X		
PM.80	Validation of Authorization detail	X		
PM.81	Date/time information queried in system	X		
PM.82	Date/time information sent to requester	X		
PM.83	Other as identified by BMS during DDI		X[1]	
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.	X		
PM.85	Ability to display free-form narrative in chronological or reverse chronological sequence.	X		
PM.86	**5. Manage Provider Communication**			
PM.87	Ability to generate and distribute Provider-related correspondence, information requests, and notifications, including:	X		
PM.88	Enrollment applications	X		
PM.89	Enrollment rejection notifications	X		
PM.90	Billing instructions	X		
PM.91	Relevant State policy information	X		
PM.92	Request for information to support enrollment/contracting process	X		
PM.93	Mailing labels	X		
PM.94	Program memorandum	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PM.95	Notifications of pending expired Provider eligibility	X		
PM.96	Other as identified by BMS during DDI	X		
PM.97	Ability to maintain a record (including an audit trail) of all communication sent to Providers.	X		
PM.98	Ability to maintain a record (including an audit trail) of all communication received from Providers.	X		
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.	X		
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.	X		
PM.101	The BMS is to have the ability to view and update the Provider Inquiry Log.	X		
PM.102	Ability to track and report Provider inquiries regarding billing and submission practices.	X		
PM.103	Ability to allow Provider correspondence to be generated or suppressed according to BMS defined parameters.	X		
PM.104	Ability to allow users to choose between standard/routine Provider correspondence, or to develop customized correspondence.	X		
PM.105	Ability to track and notify Providers of date-dependent events, as defined by BMS (e.g., review dates).	X		
PM.106	Ability to refer Providers to appropriate licensing board (according to criteria defined by BMS).	X		
PM.107	Ability to allow users to view Provider labels, letters, and listings online or on paper.	X		
PM.108	Ability to suppress Provider's ID number from labels, envelopes and other correspondence, as required.	X		
PM.109	Ability to suppress Member's ID number from labels, envelopes and other correspondence, as required.	X		
PM.110	Provider notifications should be linked to related documentation in the system.	X		
PM.111	**6. Manage Provider Appeal**			
PM.112	Ability to support appeals for prospective and current Providers.	X		
PM.113	Ability to track Provider appeal detail, including:	X		
PM.114	Issue detail	X		
PM.115	Filing party	X		
PM.116	Reviewer/s	X		
PM.117	Process status (initial, second, expedited, withdrawn, disposed)	X		
PM.118	Review/hearing date/time	X		
PM.119	Hearing ruling	X		
PM.120	Disposition	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PM.121	Other as specified by the BMS during DDI		X[1]	
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.	X		
PM.123	Ability to display free-form narrative in chronological or reverse chronological sequence.	X		
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	X		
PM.125	Ability to support grievance/appeals process work flow, including automatic notification to appropriate parties (as defined by the BMS).	X		
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.	X		
PM.128	Ability to identify and display the source of any data that is obtained from an external source.	X		
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).	X		
PM.130	Ability to provide role-based access to authorized users to perform mass updates to Provider data, based on flexible selection criteria.	X		
PM.131	Ability to provide role-based access to authorized users, allowing online update and inquiry capabilities of the Provider information files.	X		
PM.132	Ability to provide online, real-time, role-based access to the Provider information using a variety of secure methods, including:	X		
PM.133	Web	X		
PM.134	WAN/LAN	X		
PM.135	Point-of-service devices	X		
PM.136	Other as specified by the BMS during the DDI phase		X[1]	
PM.137	Ability to integrate with the following systems to allow users to access and/or enter/edit Provider data:	X		
PM.138	Medicaid Provider Web Portal	X		
PM.139	Automated Voice Response System (AVRS)	X		
PM.140	Electronic Document Management System (EDMS)	X		
PM.141	Other systems as specified by the BMS during DDI		X[1]	
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).	X		
PM.143	Ability to identify the NPIs of prescribers for Pharmacy purposes.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PM.144	Ability to identify crossover-only Providers.	X		
PM.145	The Vendor should update Provider information as follows:	X		
PM.146	Perform authorized updates on a daily (or otherwise specified) basis with online updates.	X		
PM.147	Perform updates using full transaction files received.	X		
PM.148	Perform mass Provider updates as directed by BMS.	X		
PM.149	Ability to provide authorized users access to current Provider information (e.g., P.A.s and referrals, Claims, correspondence).	X		
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:	X		
PM.151	Medicaid Provider ID	X		
PM.152	Provider name	X		
PM.153	National Provider Identifier (NPI)	X		
PM.154	Medicare number	X		
PM.155	Social Security Number (SSN)	X		
PM.156	Phone number		X	
PM.157	Employer Identification Number (EIN)/Taxpayer Identification Number (TIN)	X		
PM.158	Federal Drug Enforcement Agency (DEA) number	X		
PM.159	Previous Identifier(s) (so that all data is historically maintained)	X		
PM.160	Phonetic search		X	
PM.161	Other identifiers used by the BMS		X[1]	
PM.162	Ability to provide authorized users limited role-based access to archived Provider data.	X		
PM.163	Ability to uniquely identify each Provider, allowing for the association of multiple standardized and user-defined identifiers and qualifiers, including:	X		
PM.164	National Provider Identifier (NPI)	X		
PM.165	Former Medicaid ID number	X		
PM.166	Federal Drug Enforcement Agency (DEA) number	X		
PM.167	National Council of Prescription Drug Programs (NCPDP) number	X		
PM.168	Other as identified and/or defined by BMS during DDI		X[1]	
PM.169	Ability to maintain an online cross-reference of BMS-assigned identifier to all other identifiers maintained for a Provider.	X		
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.	X		
PM.171	Ability to identify when multiple BMS-assigned Provider	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	numbers are assigned to a single Provider.			
PM.172	Ability to maintain CLIA information.	X		
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).	X		
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.	X		
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).	X		
PM.176	Ability to identify the Provider Program(s) the Provider is participating in, including but not limited to:	X		
PM.177	State Plan Medicaid	X		
PM.178	Ryan White Program	X		
PM.179	Juvenile Services Benefit Plan	X		
PM.180	Tiger Morton Benefit Plan	X		
PM.181	Mental Retardation/Developmentally Disabled (MRDD) waiver	X		
PM.182	Aged Disabled waiver	X		
PM.183	Children's Health Insurance Plan (CHIP)	X		
PM.184	Breast and Cervical Cancer Program	X		
PM.185	Birth to Three Benefit	X		
PM.186	Other as defined by the BMS	X		
PM.187	Ability to associate multiple service locations to the same Provider base identifier.	X		
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.	X		
PM.189	Ability to maintain group affiliations and managed care enrollment.	X		
PM.190	Ability to affiliate individual Providers to their group(s) (i.e., program(s)).	X		
PM.191	Ability to associate a group with all individual Providers.	X		
PM.192	Ability to associate an unlimited number of Providers with a single group.	X		
PM.193	Ability to define Providers and Provider groups that share common ownership.	X		
PM.194	Ability to identify the type of Provider ownership	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	arrangement.			
PM.195	Ability to transfer Provider ownership without re-entry of duplicate information.	X		
PM.196	Ability to identify, cross reference, and link one Provider owner to many rendering Providers and one rendering Provider to many owners.	X		
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.	X		
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).	X		
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.	X		
PM.200	Ability to maintain corporate names with a naming structure for corporations that do not have first and last names.	X		
PM.201	Ability to track and maintain licensing, credentialing, sanction and certification information that includes:	X		
PM.202	Type, specialty, and sub-specialty	X		
PM.203	Taxonomy	X		
PM.204	Certification begin and end dates	X		
PM.205	Certification type code	X		
PM.206	Certifying agency	X		
PM.207	Certifying state	X		
PM.208	Verification type	X		
PM.209	Verification date	X		
PM.210	Verification due date	X		
PM.211	License ID	X		
PM.212	Sanctioning agency	X		
PM.213	Sanctioning state	X		
PM.214	Sanction begin and end dates	X		
PM.215	Other as defined by BMS during DDI		X[1]	
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).	X		
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).	X		
PM.218	Ability to enter, store, display and access Provider data, including:	X		
PM.219	Provider Number	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PM.220	Provider name	X		
PM.221	Facility name	X		
PM.222	Billing name	X		
PM.223	Provider license number	X		
PM.224	IRS name	X		
PM.225	Provider type - with the flexibility to accommodate and maintain non-medical Providers on the Provider master and affiliates.	X		
PM.226	Provider title	X		
PM.227	Multiple mailing addresses	X		
PM.228	Multiple practice addresses	X		
PM.229	Ownership information	X		
PM.230	Change in ownership information	X		
PM.231	Long-term care facility data, including:	X		
PM.232	Number of beds by licensed level of care	X		
PM.233	OHFLAC certification/re-certification	X		
PM.234	Physical address and contact information of the facility	X		
PM.235	Other as identified by BMS during DDI		X[1]	
PM.236	Payment address	X		
PM.237	County number	X		
PM.238	Multiple phone numbers	X		
PM.239	Fax number	X		
PM.240	Multiple e-mail addresses	X		
PM.241	Web site url	X		
PM.242	Drug Enforcement Agency (DEA) number - including historic data with effective and end dates	X		
PM.243	National Council for Prescription Drug Programs (NCPDP) number - including historic data with effective and end dates	X		
PM.244	Employer Identification Number (EIN)/Taxpayer Identification Number (TIN) and effective and term dates	X		
PM.245	Social Security Number (SSN)	X		
PM.246	Provider CLIA (Clinical Laboratory Improvement Amendments) number and related address	X		
PM.247	Medicare numbers	X		
PM.248	Managed Care Organization (MCO) affiliations	X		
PM.249	Group number	X		
PM.250	Specialty/sub-specialty data	X		
PM.251	License and certification data	X		
PM.252	Date of birth	X		
PM.253	Date of death	X		
PM.254	Gender	X		
PM.255	Language	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PM.256	Additional training or certification indicator	X		
PM.257	Restrictions on dispensing of specific drugs	X		
PM.258	Provider enrollment status codes with associated effective and end dates	X		
PM.259	Provider program eligibility with associated effective and end dates	X		
PM.260	Contractual terms, including:	X		
PM.261	Services contracted to provide	X		
PM.262	Performance measures		X	
PM.263	Reimbursement rates	X		
PM.264	Summary level payment data which is automatically updated after each claims processing payment cycle by the following:	X		
PM.265	Calendar week-to-date	X		
PM.266	Calendar month-to-date	X		
PM.267	Calendar year-to-date	X		
PM.268	State fiscal year-to-date	X		
PM.269	Federal fiscal year-to-date	X		
PM.270	1099 reported amount (current & prior year)	X		
PM.271	Ownership date	X		
PM.272	Physician Assured Access System (PAAS) indicator	X		
PM.273	Fee-for-service (FFS) indicator	X		
PM.274	Crossover indicator	X		
PM.275	Suspended/Suspension indicator	X		
PM.276	Suspended/Suspension effective and terminated dates	X		
PM.277	Primary Care Case Management (PCCM) indicator	X		
PM.278	Out-of-state Provider indicator	X		
PM.279	Rural, urban, or teaching hospital indicator	X		
PM.280	Electronic Funds Transfer (EFT) information	X		
PM.281	Electronic Claims Management (ECM) data	X		
PM.282	Billing restriction data, with applicable begin and end dates	X		
PM.283	Medical degree information.	X		
PM.284	Providers PCP panel information including:	X		
PM.285	Accepting new patient indicator	X		
PM.286	Age range	X		
PM.287	Gender	X		
PM.288	Authorized enrollment	X		
PM.289	Current enrollment/maximum enrollment and number left	X		
PM.290	Other as identified by BMS during DDI		X[1]	
PM.291	Ability to identify Provider 'on call' information to capture 'covering for' and 'covered by' Providers.	X		
PM.292	Ability to provide an free-form text narrative (length to be	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	determined by BMS) at the base-Provider level that:			
PM.293	Identifies the user, date, and time entered.	X		
PM.294	Provides the capability to display free form narrative in chronological or reverse chronological sequence.	X		
PM.295	Includes an associated user-defined special condition code/flag (for classification/reporting purposes).	X		
PM.296	Ability to report on the special condition code/flag.	X		
PM.297	Ability to define the relationship between a Provider and an EDI submitter as well as billing agent.	X		
PM.298	**8. Perform Provider Outreach**			
PM.299	Ability to track Provider outreach communications detail, including:	X		
PM.300	Target population	X		
PM.301	Issues or measure/s addressed (e.g., new immigrant population in need of language compatible Providers)	X		
PM.302	Purpose (e.g., corrections to billing practice, public health alerts, public service announcement)	X		
PM.303	Date/s of distribution	X		
PM.304	Method/s of distribution	X		
PM.305	Other as defined by the BMS during DDI		X[1]	
PM.306	Ability to perform Provider outreach to both prospective and current Providers.	X		
3	**Operations Management (OM)/OM1. Service Authorization**			
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.	X		
OM1.3	Ability to verify Member eligibility and PAAS participation during referral claim processing.	X		
OM1.4	Ability to verify PAAS referral during claim processing.	X		
OM1.5	Ability to conduct claims edits/audits for referral claims according to BMS business rules.	X		
OM1.6	**2. Authorize Services**			
OM1.7	The Prior Authorization component of the system should integrate with the Claims component.	X		
OM1.8	Claim processing performs Prior Authorization validation.	X		
OM1.9	The Prior Authorization component should be integrated with the web portal, AVRS, EDI and EDMS components.	X		
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.	X		
OM1.11	Ability to interface with MMIS to identify procedure codes	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	that require PA (medical utilization requirements).			
OM1.12	Ability to accommodate additions and updates of prior authorizations by interface.	X		
OM1.13	The Vendor is expected to support on-line entry and interface entry of prior authorization data with other prior authorization vendors.	X		
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.	X		
OM1.15	Ability to support submission of prior authorizations by other State agencies, other vendors, and BMS.	X		
OM1.16	Ability to allow users to submit a PA request on the Provider's behalf.	X		
OM1.17	Ability to accept and create PAs from MDS data for nursing facilities.	X		
OM1.18	Ability to accommodate future versions of the HIPAA electronic PA transactions.	X		
OM1.19	Ability to ensure all known and emerging BMS and Federal policy changes are reflected in the maintenance of the PA data repository.	X		
OM1.20	Ability to maintain and easily retrieve Provider-specific and Member-specific PA history.	X		
OM1.21	Ability to accept on-line, real-time inquiry, entry and update of PA requests, including initial entry of PA requests pending determination.	X		
OM1.22	Ability to allow Providers to submit PA requests electronically or through the web portal.	X		
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.	X		
OM1.24	Ability to allow for electronic submission of PA request attachments (e.g., EDI 275, HL7).	X		
OM1.25	Ability to allow PA request forms to be available online for download by users.	X		
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.	X		
OM1.27	Ability to integrate prior authorization-related correspondence, reports and associated documents with the EDMS component.	X		
OM1.28	Ability to support PA entries for medical services such as (but not limited to) the following:	X		
OM1.29	Vision	X		
OM1.30	Dental	X		
OM1.31	Durable Medical Equipment (DME)	X		
OM1.32	Surgical procedures	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM1.33	Other as defined by BMS during DDI		X[1]	
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.	X		
OM1.35	Ability to automatically provide PA staff (during PA process) with information when Member is a LTC facility resident/inpatient. Information should include:	X		
OM1.36	Level of Care (LOC)	X		
OM1.37	LOC effective dates	X		
OM1.38	Name of facility	X		
OM1.39	Medicaid Provider Number	X		
OM1.40	LTC facility date spans	X		
OM1.41	Spend-down amount	X		
OM1.42	Patient Liability Amount (PLA)	X		
OM1.43	PLA effective dates	X		
OM1.44	Ability to submit and approve retrospective authorizations.	X		
OM1.45	Ability to interface with MMIS and populate PA screens with PA information to be determined during design.	X		
OM1.46	Ability to generate a unique tracking number for PA requests.	X		
OM1.47	Ability to automatically notify submitter of successful submission and display the tracking number.	X		
OM1.48	Ability to assign a unique PA number as soon as the submitted request is approved.	X		
OM1.49	Ability to accept and retain the PA number submitted by the PA vendor.	X		
OM1.50	Ability to use tracking number to link attachments submitted by mail to electronic PA request.	X		
OM1.51	Ability to use tracking number to link attachments submitted electronically to electronic PA request.	X		
OM1.52	Ability to recognize both the NPI and former Medicaid ID number.	X		
OM1.53	The system should have the ability to capture and display PA data which includes, at minimum, the following:	X		
OM1.54	PA number	X		
OM1.55	Member ID	X		
OM1.56	Service code/s	X		
OM1.57	Procedure/NDC code	X		
OM1.58	Modifier codes	X		
OM1.59	Billing, rendering, and referring Provider information, including name, and Provider ID/NPI	X		
OM1.60	Dates of service	X		
OM1.61	Effective and term date of PA	X		
OM1.62	Requested effective date of PA	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM1.63	Units of service expressed as days, quantity per day, number of services, dollars, tooth number/letter, tooth surface	X		
OM1.64	Quantity used	X		
OM1.65	Miscellaneous codes w/ notes field (for contractors)	X		
OM1.66	Rates	X		
OM1.67	Member Rate code	X		
OM1.68	Dollar cap	X		
OM1.69	Local Provider information	X		
OM1.70	Limits (including calendar month limits)	X		
OM1.71	Room and board	X		
OM1.72	Waiver start date	X		
OM1.73	Manufacturer product number	X		
OM1.74	Status of the PA request (including pending, denied, approved, and modified)	X		
OM1.75	Date approved	X		
OM1.76	History of all actions taken on PA request, including amendments	X		
OM1.77	Date of last change, ID of person changing, and information changed for each PA record	X		
OM1.78	ID of authorizing person	X		
OM1.79	Other as defined by BMS during DDI		X[1]	
OM1.80	Ability to allow the identification of the principal procedure and date, and the inclusion of five additional procedures and dates.	X		
OM1.81	Ability to include descriptions of codes in the PA request.	X		
OM1.82	Ability to allow for expansion and addition of fields to the on-line PA request form.	X		
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:	X		
OM1.84	Identifies and displays the user, date, and time entered	X		
OM1.85	Provides the capability to display free form narrative in chronological or reverse chronological sequence	X		
OM1.86	Ability to accommodate flexible time span dates for PA (by calendar month, calendar year, rolling month, and other as defined by BMS).		X	
OM1.87	Ability to apply the method and hierarchy of PA processing criteria as defined by BMS.		X	
OM1.88	Ability to automatically approve certain PA requests based on information entered (as identified by BMS).	X		
OM1.89	Ability to perform comprehensive on-line and batch edits to ensure the integrity of prior authorization data.	X		
OM1.90	Ability to run edits on submitted PA requests, such as the following:	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM1.91	Relationship edits	X		
OM1.92	Field length/type	X		
OM1.93	Character type	X		
OM1.94	Ability to edit PAs on-line for the presence of required data to include:	X		
OM1.95	Valid Provider ID and eligibility	X		
OM1.96	Valid procedure and diagnosis codes	X		
OM1.97	Presence of required claim type-specific data on the PA	X		
OM1.98	Covered service	X		
OM1.99	Allowed dollar amounts/unit	X		
OM1.100	Other as defined by BMS during DDI	X		
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.		X	
OM1.102	Ability to reject PA request if it does not pass all edits.	X		
OM1.103	Ability to automatically notify the submitter of failed PA submission and identify which field(s) did not pass edits.	X		
OM1.104	Ability to automatically generate Provider alerts and notifications, to include:	X		
OM1.105	The need for additional information on an already submitted PA request		X	
OM1.106	Reminders of missing information		X	
OM1.107	System updates/policy changes	X		
OM1.108	Duplicate or possible duplicate requests		X	
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.		X	
OM1.110	Ability to identify and reject duplicate PAs across all PA types based on user configurable criteria including:		X	
OM1.111	Client identifier		X	
OM1.112	Rendering Provider identifier		X	
OM1.113	Service from and through dates		X	
OM1.114	Diagnosis code(s)		X	
OM1.115	Procedure code(s), revenue code(s)		X	
OM1.116	Other as defined by BMS during DDI		X[1]	
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).	X		
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.		X	
OM1.119	Ability to retain incomplete PA request submissions for a minimum number of days, to be defined by BMS, before	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
OM1.121	Ability to notify the Provider following the approval or denial of a PA.	X		
OM1.122	Ability to automatically generate approval or denial notices as soon as the determination has been made.	X		
OM1.123	Ability to support role-based override capabilities for individual edits by authorized user.	X		
OM1.124	Ability to identify those individuals who authorized and performed an override.	X		
OM1.125	Ability to accept PAs for a terminated Member for eligible dates of services.	X		
OM1.126	Ability to maintain PA active status when Member loses eligibility.	X		
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.	X		
OM1.128	Ability to allow staff to select the reason codes explaining the disposition of the request when a PA denies/approves.	X		
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).	X		
OM1.130	Ability to link to eligibility data when reviewing the PA request.	X		
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.	X		
OM1.132	Ability to auto-populate the PA number at the claim line level regardless of Provider submission.	X		
OM1.133	The system should allow Providers to view remaining/unused units authorized.	X		
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.	X		
OM1.135	Ability to provide PA search options, including search by PA number.	X		
OM1.136	Ability to return multiple PAs if more than one match is found.	X		
OM1.137	Ability to provide multiple users with simultaneous, on-line, role-based access to a PA request, but build in features	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
OM1.139	Ability to provide PA audit trail capability to:	X		
OM1.140	Track and report all PA related changes	X		
OM1.141	Identify the individual who modified the system data	X		
OM1.142	Record the date that the modification occurred	X		
OM1.143	Display an audit trail of all PA processing steps	X		
OM1.144	View on-line all PA audit trail information	X		
OM1.145	Other as defined by BMS during DDI		X[1]	
OM1.146	Ability to process the PA and limit the price for a service to the amount authorized on the PA.	X		
OM1.147	Ability to maintain the authorized PA price.	X		
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.		X	
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).		X	
OM1.150	Ability to approve service authorization requests for waiver services up to a specific dollar amount.		X	
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.		X	
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.).	X		
OM1.153	The system should allow users to call up PA requests with a linked or bundled relationship as a complete service package.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	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.	X		
OM1.155	Ability to automatically link the paid claim record with the PA record.	X		
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.	X		
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.	X		
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.	X		
OM1.159	Ability to allow for modification to the scope of services authorized and extend or limit the effective dates of authorization.	X		
OM1.160	Ability to update PA records based on claims processing to restore reversed units to the PA, during each PA request period.	X		
OM1.161	Ability to amend authorizations past the end date.	X		
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.	X		
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.		X	
OM1.164	The system should provide statistical and operational reporting capabilities.	X		
OM1.165	Ability to report and maintain web portal PA activity statistics.	X		
OM1.166	Ability to automatically generate a letter to the Provider for BMS entered authorizations. The letter is to include the PA number.	X		
OM1.167	Ability to provide PA-related correspondence functions to include the following:	X		
OM1.168	Template development and the ability for users to select desired correspondence from a list of available templates	X		
OM1.169	Display, print, and save PA-related correspondence via	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	the EDMS component of the MMIS			
OM1.170	Regenerate correspondence	X		
OM1.171	Allow users to suppress or allow auto generation of correspondence based on user configurable event-driven criteria	X		
OM1.172	Allow users to insert and override address information on correspondence	X		
OM1.173	Allow users to add free form text to individual or groups of PA correspondence	X		
OM1.174	Other as defined by BMS during DDI		X[1]	
OM1.175	Ability to automatically alert staff via email that letters/notifications have been generated.	X		
3.OM2.	**3. Operations Management (OM)/OM2. Payment Management, Claims/Encounter Adjudication**			
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.	X		
OM2.3	Ability to perform real-time adjudication of claims.	X		
OM2.4	Ability to process all standard claim types, including:	X		
OM2.5	Institutional (UB-04, 837-I)	X		
OM2.6	Professional (CMS-1500, 837-P)	X		
OM2.7	Dental (ADA, 837-D)	X		
OM2.8	Pharmacy (NCPDP current and future versions (electronic) or Universal claim form (paper))	X		
OM2.9	Ability to provide a Claims Processing component that offers the following functionality:	X		
OM2.10	Claim Entry and Editing	X		
OM2.11	Claim Auditing	X		
OM2.12	Claims Inquiry	X		
OM2.13	Claims Tracking	X		
OM2.14	Batch Control	X		
OM2.15	Quality Control	X		
OM2.16	Pricing	X		
OM2.17	Claim Output	X		
OM2.18	Suspense (pend) Correction	X		
OM2.19	Interface with POS system	X		
OM2.20	Third Party Liability	X		
OM2.21	Month-End Processing	X		
OM2.22	1099 Adjustments	X		
OM2.23	Claims History File	X		
OM2.24	Attachments	X		
OM2.25	Claim Forms	X		
OM2.26	Automated procedure code editing which allows	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	acceptance of nationally recognized modifiers			
OM2.27	Claim Disposition (for all claim types, according to BMS and Federal processing rules)	X		
OM2.28	Electronic Media Claims	X		
OM2.29	Claim Payment	X		
OM2.30	Accounts Payable Management	X		
OM2.31	Accounts Receivable Management	X		
OM2.32	Provider Credits and Adjustments Processing	X		
OM2.33	Explanation of Medical Benefits (EOMB) Processing	X		
OM2.34	Diagnosis Related Group (DRG) Processing	X		
OM2.35	Resource Based Relative Value Scale (RBRVS) Processing	X		
OM2.36	APC (Ambulatory Patient Classification) Processing (OPPS, out-patient prospective processing system)	X		
OM2.37	Prior Authorization (PA) Processing	X		
OM2.38	Refund Function at Header and Line Level (for all medical, dental and pharmacy claims)	X		
OM2.39	Gross payment for Med/Dent and Pharmacy POS	X		
OM2.40	Adpay for Med/Dent and Pharmacy POS	X		
OM2.41	Manage Member Incentive Programs	X		
OM2.42	Produce Check Files	X		
OM2.43	Produce Remittance Advice	X		
OM2.44	Other as defined by BMS during DDI		X[1]	
OM2.45	Ability to accept all HIPAA formatted electronic claims submissions.	X		
OM2.46	The system should not accept non-HIPAA compliant codes or characters into the system.	X		
OM2.47	Ability to identify Members with other insurance (including, but not limited to, Medicare Part A, B, and D).	X		
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.	X		
OM2.49	Ability to identify and process pay-and-chase claims (including subrogation). Capture other insurance allowed and payable amounts.	X		
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.	X		
OM2.51	Ability to process claims for populations that are not Title XIX.	X		
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,	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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).	X		
OM2.54	Ability to provide a free-form text narrative (length/number of characters to be approved by BMS) on the claim record that:	X		
OM2.55	Identifies the user, date, and time entered	X		
OM2.56	Provides the capability to display free form narrative in chronological or reverse chronological sequence	X		
OM2.57	Includes an associated user-defined special condition code/flag	X		
OM2.58	Ability to report on the special condition code/flag.	X		
OM2.59	Other as defined by BMS during DDI		X[1]	
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.	X		
OM2.62	Ability to capture and store adjudication details to include payments, contracts, discount adjustments, and patient liability.	X		
OM2.63	Ability to capture and store the data that is derived during claims processing functions.	X		
OM2.64	Ability to use historical records of client eligibility for claims processing functions.	X		
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.	X		
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.	X		
OM2.68	Ability to maintain accurate and complete registers and audit trails of all processing.	X		
OM2.69	Ability to provide claims audit trail capability to:	X		
OM2.70	Track and report all claim related changes	X		
OM2.71	Identify the individual who modified the claim data	X		
OM2.72	Record the date that the modification occurred	X		
OM2.73	Display an audit trail of all processing steps	X		
OM2.74	View on-line all claims audit trail information	X		
OM2.75	Other as defined by BMS during DDI		X[1]	
OM2.76	Records and edits that all required attachments, per the reference records or edits, have been received and	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	maintained for audit purposes.			
OM2.77	Ability to retain and display as part of the claim record the billing agent submitter/ID number.	X		
OM2.78	**4. Claims Inquiry**			
OM2.79	Ability to respond to queries concerning Member eligibility and benefit status.	X		
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.	X		
OM2.81	Ability to provide online, real-time claims inquiry by search criteria including:	X		
OM2.82	Member ID and/or name	X		
OM2.83	Rendering Provider ID and/or name, including NPI	X		
OM2.84	Billing Provider ID and/or name	X		
OM2.85	PA or referral	X		
OM2.86	Dates of service, paid, denied, pended	X		
OM2.87	HCPCs, CPT, DRG, revenue, and/or NDC codes	X		
OM2.88	Combination of any of the above	X		
OM2.89	Other inquiry criteria as determined by the BMS during DDI		X[1]	
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.	X		
OM2.92	Ability to provide a selection screen when multiple PAs match the auto assignment criteria.	X		
OM2.93	Ability to link PAs to claims based on PA identifiers submitted with the claim.	X		
OM2.94	Ability to allow multiple PAs to be linked to a specific claim.	X		
OM2.95	Ability to provide a claims screen that displays all PAs linked to a specific claim.	X		
OM2.96	Ability to update PA data during the adjudication process to reflect utilization of services including:	X		
OM2.97	Authorized unit, visit, and dollar amounts used	X		
OM2.98	Authorized unit, visit, and dollar amounts remaining	X		
OM2.99	Accumulators reset for claims reversals	X		
OM2.100	Other as defined by BMS during DDI		X[1]	
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.	X		
OM2.103	Ability to manage audits/edits to avoid hard-coding that is	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	not accessible to the user.			
OM2.104	Ability for the user to define and update business rules real-time.	X		
OM2.105	Ability to maintain and view business rule change history on-line.	X		
OM2.106	Ability to maintain status of business rules (development, testing, production).	X		
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.	X		
OM2.108	Ability to execute impact analysis testing of any proposed business rule change.	X		
OM2.109	**7. Edits/Audits**			
OM2.110	Ability to process claims according to a Member's program benefits.	X		
OM2.111	Ability to provide claim editing processes necessary to detect and correct (when possible and appropriate) erroneous data. The system should include:	X		
OM2.112	Real-time integration to MMIS claims adjudication processes	X		
OM2.113	User configurable functions	X		
OM2.114	Report generation features	X		
OM2.115	Up-to-date code sets and edit criteria	X		
OM2.116	Other as defined by BMS during DDI		X[1]	
OM2.117	The system is expected to incorporate the BMS's existing edits and audits.	X		
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.	X		
OM2.119	Ability to apply Medicare Correct Coding Initiative (CCI) edits to defined claim line items.	X		
OM2.120	Ability to edit Third Party Liability (TPL) claims to adhere to the cost avoidance adjudication rules specified in the Federal Regulations.	X		
OM2.121	Ability to establish edits specific to a TPL insurance policy.	X		
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:	X		
OM2.123	Dollar thresholds	X		
OM2.124	Member or Provider specific criteria	X		
OM2.125	Medical coding	X		
OM2.126	Other as defined by BMS during DDI		X[1]	
OM2.127	Ability to apply any claims processing function based on characteristics of the Provider (e.g., type, specialty, and individual or group enrollment).	X		
OM2.128	Ability to perform pre-payment claims audits using criteria	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	that includes:			
OM2.129	Comparison of diagnosis codes against billed services	X		
OM2.130	Unbundling of procedure codes, when bundling is more appropriate and vice versa	X		
OM2.131	Mutually exclusive procedures	X		
OM2.132	Duplicate or near duplicate payments	X		
OM2.133	Duplicate services	X		
OM2.134	Service limits	X		
OM2.135	Age and gender appropriate services	X		
OM2.136	Duplicate Medicare cross-over claims	X		
OM2.137	Consistent payment across various Provider types for the same services	X		
OM2.138	Breakdowns of savings based on changes to clinical rules	X		
OM2.139	Trends in historical data	X		
OM2.140	Rules review	X		
OM2.141	New visit frequency	X		
OM2.142	Incidental surgical procedures	X		
OM2.143	Pricing of multiple surgeries and multiple modifiers	X		
OM2.144	Add-on codes from multiple surgery editing	X		
OM2.145	Application of AMA guidelines as defined in the CPT for asterisked procedures	X		
OM2.146	Appropriate use of modifiers	X		
OM2.147	An automated clinical review process	X		
OM2.148	Other as defined by BMS during DDI		X[1]	
OM2.149	Ability to use data in any field on a claim to apply an audit.	X		
OM2.150	Ability to verify that all Providers submitting input are properly enrolled.	X		
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.)	X		
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.	X		
OM2.153	Ability to define date parameters to support adjudication of services.	X		
OM2.154	**8. Suspensions (Pends) and Exceptions**			
OM2.155	The Vendor is expected to perform online pended claims resolution.	X		
OM2.156	Ability to automatically suspend all transactions in error until corrections are made.	X		
OM2.157	Ability to perform exception control (desktop procedures).	X		
OM2.158	Ability to allow authorized users to override any edits/audits to manually adjudicate a claim when required for exception claim processing.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM2.159	Ability to capture the identity of the user who authorizes the exception payment.	X		
OM2.160	Ability to reprocess claims that have not been finalized for payment.	X		
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.	X		
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.	X		
OM2.163	Ability to define criteria for systematic claims reprocessing, with the ability to review and modify that selection of claims prior to reprocessing.	X		
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.	X		
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.	X		
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.	X		
OM2.167	Able to capture, display and report on encounter data.	X		
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.	X		
OM2.170	The Vendor is expected to allow for manual pricing of claims.	X		
OM2.171	Ability to price each claim line item according to the applicable pricing rules.	X		
OM2.172	Ability to display all service lines of a single claim.	X		
OM2.173	Ability to determine and display the number of units paid on a claim line.	X		
OM2.174	Ability to define Member co-payments at the claim line level.	X		
OM2.175	Ability to define Member co-payments at the claim header level.	X		
OM2.176	Ability to process claims including Member liability in the final payment amount.	X		
OM2.177	Ability to provide an automated process, approved by BMS, to acquire Medicare Rates, and ensure conformance with Federal requirements regarding Medicare pricing.	X		
OM2.178	Calculate Medicare and TPL coinsurance and deductible	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
OM2.180	Ability to accommodate pricing for payments that may exceed billed charges, including payment of encounter fees to:	X		
OM2.181	Rural Health Clinics (RHCs)	X		
OM2.182	Federally Qualified Health Clinics (FQHCs)	X		
OM2.183	DRGs	X		
OM2.184	Critical Access Hospitals (CAHs)	X		
OM2.185	Ability to calculate spend down and reimbursement amount after capturing and applying information captured in the patient pay field.	X		
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).	X		
OM2.187	Ability to view Benefit utilization information through the user interface (UI) for Benefit Plan accumulations.	X		
OM2.188	Ability to maintain a DRG file as determined by BMS. The DRG file should contain, at a minimum, elements such as:	X		
OM2.189	DRG code	X		
OM2.190	DRG description	X		
OM2.191	Add date	X		
OM2.192	Begin date	X		
OM2.193	End date	X		
OM2.194	DRG weight (relative value)	X		
OM2.195	Audit trail	X		
OM2.196	Average length of stay	X		
OM2.197	Other as defined by BMS during DDI		X[1]	
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:	X		
OM2.199	Anesthesia conversion factors (with the ability to accept and process by units and/or minutes based on BMS's choice)	X		
OM2.200	Anesthesia base rates	X		
OM2.201	Vaccine for Children (VFC) rates	X		
OM2.202	Multiple RBRVS Conversion Factors for the same period of time	X		
OM2.203	All other conversion factors as defined by BMS during DDI		X	
OM2.204	Ability to define date parameters to support pricing of services.	X		
OM2.205	Ability to capture and display rate codes defined by BMS.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	(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:	X		
OM2.207	Provider specific fee schedule	X		
OM2.208	Usual and Customary Rate (UCR)	X		
OM2.209	Per diems	X		
OM2.210	LTC facility room and board charges	X		
OM2.211	LTC coinsurance amount (uses "lesser than" calculation)	X		
OM2.212	Diagnosis Related Groups (DRGs)	X		
OM2.213	Medicare coinsurance/deductible and pricing methodology	X		
OM2.214	TPL pricing methodology	X		
OM2.215	Formulas	X		
OM2.216	Percentages	X		
OM2.217	Pricing by PA	X		
OM2.218	Other payment methods (as defined by BMS during DDI)		X[1]	
OM2.219	Ability to maintain pricing history per BMS specifications.	X		
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.	X		
OM2.221	Ability to generate pricing data for all Provider programs using selection parameters specified by the State.	X		
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.	X		
OM2.224	Ability to integrate with the EDMS component, for inbound imaging of claims and attachments, claims reporting, and correspondence.	X		
OM2.225	Ability to electronically match attachments to their associated claims.	X		
OM2.226	Ability to allow authorized users to manually modify the link between a claim and its associated attachments, PAs and image files.	X		
OM2.227	Ability to process related claims based on the presence of specific attachments, as defined by the user.	X		
OM2.228	Ability to accept unlimited number and types of attachments per claim.	X		
OM2.229	Ability to allow users to navigate to and view claims attachments from within the claim screens.	X		
OM2.230	Accepts Medicare crossover claims with Medicare Explanation of Benefits (EOB) claims attachments.	X		
OM2.231	Employs an electronic tracking mechanism to locate	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
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.	X		
3.OM3.	**3. Operations Management (OM)/OM3. Payment Management, Payment & Reporting**			
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).	X		
OM3.3	Ability to print and distribute paper Remittance Advice in accordance with BMS approved schedule.	X		
OM3.4	Ability to produce the paper Remittance Advice copies on demand.	X		
OM3.5	Ability to generate additional remittance voucher pages (X number of pages free, fee thereafter -- per Fiscal Agent pricing structure).	X		
OM3.6	Ability to allow Remittance Advice for zero pay and zero balance items.	X		
OM3.7	Ability to suppress Remittance Advice relating to adjustments performed for the purpose of correcting internal account or category codes.	X		
OM3.8	Ability to associate the warrant/ACH number with the claim.	X		
OM3.9	Ability to include warrant/ACH number in 835 Remittance Advice transaction.	X		
OM3.10	Ability to print warrant/ACH number on the Remittance Advice.	X		
OM3.11	Ability to include all claims and financial transactions (such as recoupments) on the paper Remittance Advice.	X		
OM3.12	Ability to distribute the Remittance Advice to multiple locations.	X		
OM3.13	Ability to report any withholdings to a Provider's payment on the Remittance Advice.	X		
OM3.14	Ability to generate reports summarizing payment and status transactions (HIPAA 820, 277).	X		
OM3.15	**2. Prepare Coordination of Benefits (COB)**			
OM3.16	Ability to capture and provide COB information online and in batch format.	X		
OM3.17	Ability to comply with the following Federal Third Party Liability (TPL) processing and HIPAA requirements,	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	including:			
OM3.18	Ability to store a unique identifier for individual health plans	X		
OM3.19	Other as defined by BMS during DDI		X[1]	
OM3.20	Ability to maintain a process to identify projected allowed amount for previously denied claims in order to estimate savings due to TPL.	X		
OM3.21	Ability to identify all payment costs avoided due to established TPL.	X		
OM3.22	Ability to use the HIPAA 837 transaction to facilitate TPL billing functions (i.e., using the 837 COB functionality).	X		
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.	X		
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.").	X		
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.	X		
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).	X		
OM3.30	Payment processing should be independent of other system activity.	X		
OM3.31	Ability to support a fixed payment schedule (as defined by BMS).	X		
OM3.32	Ability to support unscheduled payment generation (per BMS request).	X		
OM3.33	Ability to calculate payment amounts for claims, including:	X		
OM3.34	FFS Claims	X		
OM3.35	Pharmacy POS	X		
OM3.36	HCBS Provider claims	X		
OM3.37	MCO/Capitation	X		
OM3.38	Performance incentives (per BMS)	X		
OM3.39	Withholdings	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM3.40	Other as defined by BMS during DDI		X[1]	
OM3.41	Ability to base payment calculations on inputs that include:	X		
OM3.42	Patient Resource Amounts	X		
OM3.43	Spend-down amounts	X		
OM3.44	TPL payment adjustments	X		
OM3.45	Crossover payment adjustments	X		
OM3.46	Member payment Adjustments	X		
OM3.47	Ability to determine net payment amount	X		
OM3.48	Other as defined by BMS during DDI		X[1]	
OM3.49	Ability to support payroll processing (e.g., HCBS Providers), including withholding payments for payroll, and State and Federal taxes.	X		
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	X		
OM3.51	**6. Prepare Premium EFT/Check**			
OM3.52	Ability to calculate payment amounts for premium payments, including:	X		
OM3.53	MCO premium payments based on MCO contract data (reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package)	X		
OM3.54	PCCM premium payments based on BMS rules	X		
OM3.55	Other as defined by BMS during DDI		X[1]	
OM3.56	Ability to associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA.	X		
3.OM4.	**3. Operations Management (OM)/OM4. Payment Management, Capitation & Premium Preparation**			
OM4.1	**1. Prepare Health Insurance Premium Payment**			
OM4.2	Ability to support HIPP invoicing and payment processing.	X		
OM4.3	Ability to update Member records to reflect capitation payments made on his/her behalf.	X		
OM4.4	Ability to calculate premium assistance cost effectiveness based on historical claims payment information compared to insurance premiums for a Member.	X		
OM4.5	Ability to employ a user-configurable process to identify potential high cost Members.	X		
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.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM4.7	Ability to allow payment of premiums to multiple payees for a single Member.	X		
OM4.8	Ability to accommodate prospective and retrospective premium payments.	X		
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.	X		
OM4.10	Ability to store premium assistance payment tracking details such as warrant numbers.	X		
OM4.11	Ability to make adjustments to premium payments.	X		
OM4.12	Ability to integrate all premium assistance reporting and correspondence with the EDMS component.	X		
OM4.13	**2. Prepare Medicare Premium Payment**			
OM4.14	Ability to support Medicare Part A and B buy-in processing.	X		
OM4.15	Ability to receive appropriate Medicaid Member eligibility data from all sources of eligibility determination.	X		
OM4.16	Ability to receive State Data Exchange (SDX), Enrollment Data Base (EDB) file, and/or Beneficiary Data Exchange (BENDEX) eligibility files.	X		
OM4.17	Ability to perform a matching process against Member data.	X		
OM4.18	Ability to generate a two-part buy-in file, one for Medicare Part A and one for Medicare Part B.	X		
OM4.19	Ability to receive Medicare buy-in records and load on a monthly basis.	X		
OM4.20	Ability to send/receive buy-in files to/from CMS.	X		
OM4.21	Ability to automatically update eligibility information based on information received in the Medicare Enrollment Database (EDB) file.	X		
OM4.22	Ability to post buy-in changes to the appropriate Member record.	X		
OM4.23	Ability to produce buy-in reports as specified by BMS.	X		
OM4.24	Provides Buy-In Beneficiary information for program or management use, including:	X		
OM4.25	Transaction processed	X		
OM4.26	Errors identified	X		
OM4.27	Errors correction status	X		
OM4.28	Tracks Buy-In exceptions for those Beneficiaries who are identified as eligible, but whose premiums have not been paid.	X		
OM4.30	**3. Prepare Capitation Premium Payment**			
OM4.31	Ability to process adjustments to capitation (health plan premium) payments.	X		
OM4.32	Ability to process per-Member per-month (PMPM) capitation payment based on BMS-defined rate factors	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
OM4.34	Selects premium payment amount and generates PMPM payment (capitation, premium, case management fee).	X		
OM4.35	Ability to query Member-specific history of capitation payments for each applicable managed care program to which that Member belongs.	X		
OM4.36	Identifies individuals/enrollees who have terminated enrollment, disenrolled, or are deceased, and excludes those individuals from the monthly MCO capitation payment.	X		
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.	X		
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).	X		
OM4.39	Performs reconciliations of payments to MCO, PCP roster.	X		
OM4.40	Verifies correct transfer of capitation payment when Member disenrolls from one MCO and enrolls in another plan.	X		
OM4.41	Ability to generate capitation recoupments automatically, based on user-defined criteria.	X		
OM4.42	Ability to maintain Member-specific history of capitation payment activity for each applicable managed care program to which that client belongs.	X		
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.	X		
OM4.44	Process per-Member per-month (PMPM) for primary care gatekeeper services.	X		
3.OM5.	**3. Operations Management (OM)/OM5. Payment Information Management**			
OM5.1	**1. Manage Payment Information**			
OM5.2	Ability to provide a Payment Data Repository to track and maintain all payment detail, including:	X		
OM5.3	Claims and adjudication history (including payment)	X		
OM5.4	Premium and capitation payment history	X		
OM5.5	HCBS claims and payment history	X		
OM5.6	Other as defined by BMS during DDI		X[1]	
OM5.7	**2. Inquire Payment Status**			

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM5.8	Ability to receive claim status inquiries in a variety of medium, including:	X		
OM5.9	X12 276 and 277 Transactions through portal and in batch file process	X		
OM5.10	Mail	X		
OM5.11	Phone (Agent)	X		
OM5.12	Fax	X		
OM5.13	Phone (AVRS)	X		
OM5.14	Provider Enrollment Tracking System (PETS)	X		
OM5.15	Other as defined by BMS During DDI		X[1]	
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.		X	
OM5.17	Ability to respond to claim status inquiries in a variety of medium, including:	X		
OM5.18	X12 276 and 277 Transactions through portal and in batch file process	X		
OM5.19	Mail	X		
OM5.20	Phone (Agent)	X		
OM5.21	Fax	X		
OM5.22	Phone (AVRS)	X		
OM5.23	Other as defined by BMS During DDI		X[1]	
OM5.24	Ability to provide payment inquiry response in conformance with BMS, State, and Federal policies.	X		
OM5.25	Ability to deny requests not in compliance with BMS's information access/privacy policies and HIPAA guidelines.	X		
3.OM6.	**3. Operations Management (OM)/OM6. Member Payment Information**			
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.	X		
OM6.3	Ability to automatically generate a spend-down report identifying the Members whose spend-down indicator is "Yes."		X	
OM6.4	Ability to edit against the spend-down indicator and pend for "Yes."		X	
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.	X		
OM6.6	**2. Prepare Member Premium Invoice**			
OM6.7	Calculates and generates enrollment and premium notices to policy holders.	X		
OM6.8	Processes premium receipts from policy holders.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM6.9	Supports inquiries regarding premium collections.	X		
OM6.10	Produces premium collection reports.	X		
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).	X		
OM6.12	Ability to generate an invoice to the Member for program premiums.	X		
OM6.13	Ability to define premium rates and associate to specific benefit offerings.	X		
OM6.14	Ability to identify through Member eligibility the applicable premium rate determination in order to generate invoices for premium payment.	X		
OM6.15	Ability to prepare member premium invoices on a set schedule (as specified by the BMS).	X		
OM6.16	Ability to capture all data necessary to meet BMS, State, and Federal premium reporting requirements.		X	
OM6.17	Ability to integrate premium billing invoices and associated reporting with the Electronic Document Management System (EDMS) component.	X		
OM6.18	Ability to maintain an audit trail of all transactions.	X		
3.OM7.	**3. Operations Management (OM)/OM7. Cost Recoveries**			
OM7.1	**1. Manage Recoupment**			
OM7.2	Ability to support multiple recoupment options, rules and terms for recovery of all overpayments.	X		
OM7.3	Ability to net against current or future payments to recover overpayments using a lump sum, percentage or repayment plan.	X		
OM7.4	Ability to assess and collect interest per business rules (as defined by BMS).	X		
OM7.5	Ability to post checks to outstanding receivable balances.	X		
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).	X		
OM7.7	Ability to track the status of recoupment by Provider through all stages of the collection and appeals processes.	X		
OM7.8	Ability to create bank deposit.	X		
OM7.9	**2. Manage Estate Recovery**			
OM7.10	Ability to identify Members subject to estate recovery.	X		
OM7.11	Ability to interface with TPL vendor files.	X		
OM7.12	Ability to automatically generate a unique case identifier upon referral for Estate Recovery Case Management. Identifier methodology to be specified by BMS.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
OM7.13	Ability to automatically create the Case Management record (from the initial case review data) upon referral to Case Management.	X		
OM7.14	Ability to track and maintain Case Management data at the individual case level, including:	X		
OM7.15	Case number	X		
OM7.16	Case status (e.g., open, suspended, closed)	X		
OM7.17	Actions taken	X		
OM7.18	Outcomes including monetary recoveries	X		
OM7.19	Listing of case contacts/affected parties	X		
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.	X		
OM7.21	Significant case documentation/evidence (e.g., medical records, Member interview findings, Provider credential verification)	X		
OM7.22	Other as defined by BMS during DDI		X[1]	
OM7.23	Ability to integrate and analyze data from external sources (e.g., vendors) in multiple media types.	X		
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).	X		
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.	X		
OM7.27	Edits additions and updates to the Beneficiary insurance information to prevent the addition of duplicate policies.	X		
OM7.28	Provides a mechanism to identify outdated TPL information.	X		
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.	X		
OM7.30	Allows only authorized staff members to do manual deletes and overrides of alerts/edits.	X		
OM7.31	Ability to report TPL resources against paid claims history retroactively for five (5) years to identify recoverable funds.	X		
OM7.32	Manages accounts receivable and claims adjustments as TPL related invoices are paid.	X		
OM7.33	Provides data storage and retrieval for Third Party Liability (TPL) information; supports TPL processing and update of the information.	X		
OM7.34	Ability to support entry of free-form text field that allows	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
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.		X	
OM7.37	Ability to track post-payment recovery and adjustment of paid claims, including account receivable entries.	X		
OM7.38	**4. Manage Drug Rebate**			
OM7.39	Ability to support non-traditional drug rebates (i.e., DME, other state drug rebate programs).	X		
OM7.40	Ability to generate CMS 64 reporting related to drug rebate.	X		
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).	X		
OM7.42	Ability to maintain all fields provided by CMS quarterly drug rebate file including historical data as determined by BMS.	X		
OM7.43	Ability to generate statement of accounts.	X		
OM7.44	Ability to generate quarterly utilization file for transfer back to CMS.	X		
OM7.45	Ability to generate drug rebate invoices for different rebate programs.	X		
OM7.46	Ability to compare National Drug Code (NDC) unit rebate amounts supplied by the manufacturer directly with the same information supplied by CMS.	X		
OM7.47	Ability to exclude drug expenditures (e.g., claims from the 340B pharmacies) from rebate invoicing.	X		
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.	X		
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.	X		
OM7.50	Ability to flag, withhold and correct invalid claims data before it reaches invoice generation.	X		
OM7.51	Ability to assess interest according to Federal requirements.	X		
OM7.52	Ability to automatically set up Accounts Receivables at the NDC level for drug manufacturers invoiced for all rebate programs.	X		
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		X	

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
OM7.55	Ability to record and track manufacturer disputes of drug rebate invoices at the NDC detail level.	X		
OM7.56	Ability to associate the claims with NDC level detail related to a manufacturer's dispute.	X		
OM7.57	Ability to report on all drug rebate programs individually and collectively.	X		
OM7.58	Ability to provide drug manufacturers access through the Web Portal to upload data (as approved by BMS).		X	
OM7.59	Ability to manage reversal/adjustment claims for invoicing purposes.	X		
OM7.60	Ability to import, maintain and modify historical rebate claims, pricing and payment data.	X		
OM7.61	Ability to support and apply conversion factors.	X		
OM7.62	Ability to post payment data at the deposit, check, invoice and line item levels.	X		
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.	X		
OM7.64	**5. Manage Settlement**			
OM7.65	Ability to process and distinguish settlement amounts owed and payments due Provider for reporting purposes.	X		
OM7.66	The system should allow Providers access to cost settlement information via the portal (similar to Medicare).		X	
OM7.67	The system is expected to generate all required cost settlement reporting.	X		
OM7.68	Ability to apply check payment to an open receivable.	X		
OM7.69	Ability to track the status of settlement by Provider through all stages of the collection and appeals processes.	X		
OM7.70	Ability to generate cost settlement information reports online via the Provider Portal. Specifics of the report to be agreed-upon during DDI.	X		
OM7.71	Ability to internally generate all required cost settlement reporting. Specifics of the report to be agreed-upon during DDI.	X		
4	**4. Program Management (PG)**			
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.	X		
PG.3	Ability to calculate rates utilizing the designated fee	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
PG.5	Ability to assign budget neutrality.	X		
PG.6	Ability to assess the fiscal impact of updating rates by testing against previously paid claims.	X		
PG.7	Ability to use the pricing files such as Medicare Physician Fee Database (MPFDB) File to update Reference data without manual intervention.	X		
PG.8	Ability to automatically update Provider rate tables through an electronic means (e.g., Excel, ODBC compliant database).	X		
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).	X		
PG.10	Ability to associate Provider-specific reimbursement contracts with the Providers. Ability to accommodate various pricing files, UCR, custom fee RBRVS, PPS.	X		
PG.11	System can receive an electronic update of Medicare rates for Federally Qualified Health Centers (FQHC).	X		
PG.12	Ability to pend claims awaiting approval of fee, rate and code updates.	X		
PG.13	Ability to accommodate retroactive application of rates.	X		
PG.14	Upon any change in rates, the system can provide automatic notification to an appropriate distribution list.	X		
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)).	X		
PG.16	Ability to extract information that supports rate setting functions.	X		
PG.17	System should capture and apply Member resource amount or spend-down amount for claims adjudication.	X		
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).	X		
PG.20	Ability to produce and distribute 1099 files, documents and reports as required by the IRS.	X		
PG.21	Ability to produce copies of 1099s.	X		
PG.22	Ability to generate corrected tax 1099s.	X		
PG.23	Ability to automatically adjust 1099 amounts from repayments of claims.	X		
PG.24	Ability to automatically adjust 1099 amounts from repayments of claims paid out and repaid in the same calendar year.	X		
PG.25	The system has the ability to produce test 1099 list and	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
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.	X		
PG.29	Ability to provide online access to accounting information based on the user's role.	X		
PG.30	Ability to provide access to financial transactions and specifically related claims or other related or source information.	X		
PG.31	Provide online inquiry of financial records based on a variety of criteria that may include:	X		
PG.32	Payee or payer identifiers and names	X		
PG.33	Payment, service, and processing dates	X		
PG.34	Claim identifiers to be defined by BMS		X	
PG.35	Remittance identifiers and dates	X		
PG.36	Ability to capture cost report information in a prescribed electronic format for financial analysis and settlement.	X		
PG.37	Ability to query the mapping from the data elements in MMIS to a State-defined reporting/financial account code.	X		
PG.38	Ability to maintain a date-effective map from the data elements in MMIS to a State-defined reporting/financial account code.	X		
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.	X		
PG.40	Ability to assign a valid State financial system account code prior to final payment (e.g., State fund, Medicaid, etc.).	X		
PG.41	Ability to calculate and apply interest on accounts receivable/payable account balances, as defined by the user.	X		
PG.42	Ability to maintain date-effective interest rates.	X		
PG.43	Ability to adjust interest payments when a claim that was originally paid with interest is adjusted.	X		
PG.44	Ability to apply different interest rates.	X		
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).	X		
PG.46	Ability to reconcile account code balances between the system and the State financial system.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PG.47	Provides method for lump-sum reimbursement, such as Disproportionate Share Hospital (DSH).	X		
PG.48	Ability to withhold A/R from current payments.	X		
PG.49	Ability to generate A/R aging.	X		
PG.50	Provides and maintains the capability to process standard financial transactions including recoupments and payouts which cover more than one claim/service.	X		
PG.51	**4. Perform Accounting Functions - Adjustments**			
PG.52	Ability to associate a transaction control number (TCN) with all claim credits and adjustments.	X		
PG.53	Ability to reverse a previously paid claim.	X		
PG.54	Ability to associate a reason code with all claim credits and adjustments.	X		
PG.55	Ability to maintain the record of the original claim when a claim credit is generated.	X		
PG.56	Ability for reversal and replacement claims to retain same log date.	X		
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.	X		
PG.58	Ability to link adjustments or replacement claims to immediate predecessor or original claims.	X		
PG.59	Ability to associate all supporting documentation for gross adjustments to the transaction control numbers (TCNs) assigned to the gross adjustment.	X		
PG.60	Ability to assign specified functions at line level (e.g., ignore, warn, pend, pay, deny).	X		
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.	X		
PG.62	Ability to image claim adjustments requests from Providers (including faxes).	X		
PG.63	Ability to process returned warrants or EFTs. Functionality should include:	X		
PG.64	Re-establishment of all claims into a to-be paid status	X		
PG.65	Reinstate units and dollars for prior authorized services	X		
PG.66	Ability to place Provider on hold until bank account information updated	X		
PG.67	Other as defined by BMS during DDI		X[1]	
PG.68	Ability to receive and maintain all managed care retroactive and current eligibility enrollment spans and trigger retroactive adjustment claims.	X		
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.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PG.70	Ability to allow adjustments payments for retroactive eligibility.	X		
PG.71	Ability to allow adjustments due to third-party prior payment and alert the cost avoidance unit.	X		
PG.72	Ability to display both contracted agreement amount and actual payment amount.	X		
PG.73	Ability to establish weekly payment reductions or increases based on the following:	X		
PG.74	IRS levy/lien	X		
PG.75	Child Support	X		
PG.76	Other conditions as defined by BMS during DDI		X[1]	
PG.77	Ability to process mass adjustments that may include multiple Providers.	X		
PG.78	Ability to provide easily customizable, parameter-driven mass adjustment selection and review process.	X		
PG.79	Ability to establish and provide a sandbox environment that provides the functionality to create, test, modify and store fiscal impact scenarios.	X		
PG.80	Ability to provide internal communication capabilities (notification/explanation) tied to mass adjustments when necessary (e.g., policy initiated mass adjustments).	X		
PG.81	Ability to deny or hold payments for review or release for immediate payment.	X		
PG.82	Accept electronic reversal and replacement claims and/or adjustment claims.	X		
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.	X		
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:	X		
PG.86	Payment release by Provider Type	X		
PG.87	Payment release by TCN	X		
PG.88	Payment release by Provider ID	X		
PG.89	Payment release by Claim Type (e.g., capitation, fee-for-service, POS)	X		
PG.90	Other as defined by BMS during DDI		X[1]	
PG.91	Ability to generate separate payment files for other payers using the WV MMIS (e.g., Juvenile Justice).	X		
PG.92	Ability to generate a user-defined gross payment to a Provider in lieu of a payment based on adjudicated claims.	X		
PG.93	Ability to generate multiple or expedited payments outside of the normal payment cycle.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
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.	X		
PG.95	Ability to generate a paper remittance file, an electronic remittance voucher file and a print image form.	X		
PG.96	Ability to accommodate multiple or changing tax IDs within the payment and enrollment components of the MMIS.	X		
PG.97	Identifies Providers with credit balances resulting from claim reversal.	X		
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.	X		
PG.99	Ability to net a Provider's payment against the balance in that Provider's accounts receivable account, as defined by the user.	X		
PG.100	Ability to maintain user approved repayment plans for Providers.	X		
PG.101	Ability to assign recoupments to a specific treating/servicing Provider to accommodate changes in employment.	X		
PG.102	Ability to distribute payments to a specified location regardless of the distribution location of the Remittance and Status Advice (RA).	X		
PG.103	Ability to cease a Provider's payment at the individual performing Provider or corporation level, as defined by the user.	X		
PG.104	Ability to associate the service rendered to the Provider who receives payment.	X		
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).	X		
PG.106	**6. Perform Accounting Functions - Accounts Receivable**			
PG.107	Ability to establish a receivable and distinguish between principle and interest balances.	X		
PG.108	Ability to establish a receivable and net against any current disbursement.	X		
PG.109	Ability to update or modify an established A/R invoice.	X		
PG.110	Ability to query A/R invoices.	X		
PG.111	Ability to post checks to outstanding receivable balances.	X		
PG.112	Ability to define the types of entities (e.g., individual Provider, organization, corporation, etc.) responsible for an A/R account.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PG.113	Ability to establish repayment plans that extend over multiple periods.	X		
PG.114	Ability to support multiple settlement options, rules and terms for recovery of all overpayments.	X		
PG.115	Ability to modify (add, delete, change, pend) any item in the A/R account.	X		
PG.116	Ability to maintain on-line inquiry to current and historical financial information with access by Member, Provider, manufacturer or other entity identification.	X		
PG.117	Ability to provide for a flexible, parameter-based, on-line query capability for financial information.	X		
PG.118	Ability to accept liens and/or orders to withhold from State and Federal entities.	X		
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).	X		
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.	X		
PG.121	Ability to create a bank deposit transmittal and/or summary.	X		
PG.122	Ability to maintain A/R aging Receivable file of all receivables regardless of current activity.	X		
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.	X		
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.	X		
PG.127	The Vendor is expected to implement corrective action plans to address performance issues (i.e., when performance falls below acceptable threshold).	X		
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.	X		
PG.130	System automatically maintains data integrity and verifies/reconciles data against the source systems, including payment data, and accounts for discrepancies.	X		
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	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
PG.133	Ability to accommodate reporting across all Medicaid services and Social Service payments regardless of service delivery method and financing mechanism.	X		
PG.134	Ability to schedule any report to be run at varying levels of immediacy, frequency, or user-defined condition.	X		
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.	X		
PG.136	Ability to produce all reports as defined by the BMS Master Reports List (see Procurement Library).	X		
PG.137	Ability for BMS authorized users to create ad-hoc reports.	X		
PG.138	Ability to report according to current and future HEDIS administrative reporting guidelines.	X		
PG.139	Provides the ability to report on unduplicated counts such as Members, Providers, and services.	X		
PG.140	Provides the ability to report based on a Member enrollment hierarchy established by the BMS.	X		
PG.141	Ability to display to the user the number of pages that will be printed before the user proceeds with printing a report.	X		
PG.142	Monitor the progress of claims processing activity and provide summary reports which reflect the current status of claims.	X		
PG.143	Present claims processing and payment information that demonstrates compliance with Federal prompt payment rules.	X		
PG.144	Analyze areas of program expenditure to determine cost benefit.	X		
PG.145	Analyze the frequency, extent, and type of Provider and other claims processing errors.	X		
PG.146	For reporting purposes, assigns to all claim line details line, and subline categories that correspond to the CMS 64.	X		
PG.147	Analyze Provider claim filing for timeliness, fiscal controls and ranking.	X		
PG.148	Maintains comprehensive list of standard reports and their intended use (business area supported).	X		
PG.149	Maintains a list of users of each standard report.	X		
PG.150	Retains and maintains access to reports for the period of time specified by the BMS report owner.	X		
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.	X		
PG.152	Ability to generate reports on service limitations and	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
PG.154	Provide a means of obtaining various listings of the Procedure, Diagnosis, and Formulary File.	X		
PG.155	Generate various listings of the claims processing suspense file.	X		
PG.156	Provides the Statistical Report on Medical Care: Eligibles, Members, Payments and Services (Form CMS-2082).	X		
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:	X		
PG.159	Provider enrollment	X		
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	X		
PG.161	Payment processing	X		
PG.162	Adjustments	X		
PG.163	Prior authorizations (PA)	X		
PG.164	Maintain Procedure, Revenue, Drug, Diagnosis, and DRG data	X		
PG.165	Maintain Modifier data	X		
PG.166	Maintain Medicare Action Code data	X		
PG.167	Maintain Resource Based Relative Value Scale (RBRVS) data	X		
PG.168	Maintain Provider Charge file data	X		
PG.169	Maintain free-form text memo information (Each entry is expected to include identification of user and date/time entered.)	X		
PG.170	Maintain System Parameter data	X		
PG.171	Maintain Edit Code data	X		
PG.172	Identify service frequency limitations	X		
PG.173	Drug Rebate processing	X		
PG.174	Drug Rebate file data	X		
PG.175	Labeler file	X		
PG.176	Drug Rebate Claim file	X		
PG.177	NDC Summary file	X		
PG.178	Produce various reports	X		
PG.179	Other activities as specified by the BMS during the DDI phase		X[1]	

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PG.180	Provides user-friendly navigation among the various reference files.	X		
PG.181	Provides on-line inquiry capability to all current reference data.	X		
PG.182	Provides on-line inquiry capability and archive access to historical reference data as defined by the BMS Data Retention Policy.	X		
PG.183	Provides BMS-designated on-line role-based access for approval/update/edit of reference file data tracked through the Change Request process.	X		
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.	X		
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.	X		
PG.186	Table design should be flexible to ensure that the MMIS is able to readily accommodate changes.	X		
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.	X		
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).	X		
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).	X		
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.	X		
PG.191	Ability to support the transition to future versions of code sets (e.g., ICD-11).	X		
PG.192	All reference file updates are expected to be tested by Vendor and approved by BMS prior to moving data to production.	X		
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.	X		
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.	X		
PG.195	Ability to assure updates do not overlay or otherwise make historical information inaccessible. Should maintain back-	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
PG.197	Ability to maintain effective dates for all code sets.	X		
PG.198	Ability to add values or update any code set attributes.	X		
PG.199	Ability to maintain a map of procedure codes to diagnosis codes to define valid/invalid combinations.	X		
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.	X		
PG.201	Ability to associate National Drug Codes (NDCs) with their therapeutic indicators.	X		
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.	X		
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.	X		
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.	X		
PG.205	Ability to maintain a map of Revenue codes to CPT procedure codes to apply claims processing functions based on the CPT code.	X		
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.	X		
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.	X		
PG.209	Ability to maintain and update effective and end dates for all benefit plans.	X		
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.	X		
PG.211	Ability to easily add, delete, or modify benefit plan(s) and/or its related components.	X		
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.	X		
PG.213	Ability to allow an existing benefit plan and its associated components to be copied and renamed (to facilitate the	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	creation of a new plan).			
PG.214	Ability to support a hierarchy of program rules to determine which program the claim will be paid.	X		
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:	X		
PG.217	International Classification of Disease (ICD)-9/10-CM diagnosis and procedure codes	X		
PG.218	Approved versions of Health Common Procedure Coding System (HCPCS) procedure codes	X		
PG.219	Procedure code data status (active/inactive) code segments with effective begin and end dates for each segment	X		
PG.220	History of full descriptions for procedure codes	X		
PG.221	History of short descriptions for procedure codes	X		
PG.222	Effective and term dates for all items	X		
PG.223	Diagnostic Related Groups (DRG)	X		
PG.224	NDC drug codes	X		
PG.225	HIPAA mandated code sets	X		
PG.226	HL 7 LOINC code sets		X	
PG.227	Current Dental Terminology (CDT) procedure codes	X		
PG.228	Current Procedure Terminology (CPT) procedure codes	X		
PG.229	Indicators associated with selected parameters for use in claims processing (to determine include, exclude, disregard)	X		
PG.230	Multiple modifiers and the percentage of the allowed price applicable to each modifier	X		
PG.231	Revenue Center Codes (RCC)	X		
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	X		
PG.233	Provider charge file legacy custom rates	X		
PG.234	Managed care program covered benefits exclusion plans	X		
PG.235	Relative value units	X		
PG.236	Edit/audit criteria and disposition tables	X		
PG.237	Business rules	X		
PG.238	Ambulatory Payment Classifications (APCs)	X		
PG.239	Base units for American Society of Anesthesiologists (ASA) codes	X		
PG.240	Coding values that indicate if a procedure is covered by Medicaid or other programs	X		
PG.241	Authorized specialty and taxonomy	X		
PG.242	Required Clinical Laboratories Improvement Amendments	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	(CLIA) certification type			
PG.243	PA requirements (e.g., always required, sometimes required, never required)	X		
PG.244	Valid/invalid Place Of Service (POS) limitations	X		
PG.245	Recipient age/gender restrictions	X		
PG.246	Contraindicated edits	X		
PG.247	Pre and post-operative days	X		
PG.248	Once-in-a-lifetime indicator	X		
PG.249	Never events (TBD) HAC	X		
PG.250	Two digit place of service	X		
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	X		
PG.252	Aid category, rate code, RAPIDS program code, or MAS/BOE code	X		
PG.253	Family planning indicator (method defined by BMS)	X		
PG.254	Emergency indicator	X		
PG.255	Claim type	X		
PG.256	Diagnosis code requirements including the list of valid/invalid diagnosis codes and if diagnosis is required (header/line) for claims adjudication	X		
PG.257	Units of service	X		
PG.258	Review indicator	X		
PG.259	Tooth number or letter	X		
PG.260	Tooth surfaces	X		
PG.261	EPSDT indicator	X		
PG.262	Anesthesia base values	X		
PG.263	Duplicate check	X		
PG.264	Indicator of TPL actions, such as cost avoidance, benefit recovery or pay, by procedure code.	X		
PG.265	Indication of MCO carve-outs	X		
PG.266	Procedures manually priced or manually reviewed	X		
PG.267	Limits of the procedure	X		
PG.268	Indication of non-coverage by third-party payers	X		
PG.269	Information such as accident-related diagnosis codes for possible TPL, Federal cost-sharing	X		
PG.270	Indicators for surgical, bi-lateral surgical, and endoscopy procedures	X		
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)	X		
PG.272	Payment Type (one-time, repetitive, invoiced)	X		
PG.273	Post-operative day(s) parameter used for determining bundling policy for surgical claims/visits	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PG.274	Indicate if referring Provider number is required for the procedure code	X		
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)	X		
PG.276	Non-reportable indicator	X		
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.	X		
PG.279	Vendor is expected to procure the Drug Reference database for use in claims processing.	X		
PG.280	Ability to import CMS drug rebate file and use it for claims processing as directed by BMS.	X		
PG.281	Provides a notification to BMS that drug code and pricing changes need manual review.	X		
PG.282	Automatically implements drug code and pricing changes upon approval of BMS.	X		
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.	X		
PG.284	Ability to maintain a Drug Data Set which is expected to contain the following:	X		
PG.285	Eleven digit NDC	X		
PG.286	Brand name	X		
PG.287	Generic name	X		
PG.288	Name of manufacturer and labeler codes	X		
PG.289	Add date	X		
PG.290	Begin date	X		
PG.291	Effective date	X		
PG.292	CMS termination date	X		
PG.293	Obsolete date	X		
PG.294	Specific therapeutic class codes and descriptions	X		
PG.295	Route of administration	X		
PG.296	Identification of strength, units, quantity, and dosage form (powder, vial, liquid, cream, capsule) on which price is based	X		
PG.297	Standard packaging indicators, size and description	X		
PG.298	Previous NDC	X		
PG.299	Minimum dosage units and days	X		
PG.300	Maximum dosage units and days	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PG.301	Generic indicator	X		
PG.302	Generic code number (GCN)	X		
PG.303	Generic sequence number (GSN)	X		
PG.304	DEA code	X		
PG.305	Unlimited date-specific pricing segments which include all prices needed to adjudicate drug claims records in accordance with BMS policy	X		
PG.306	Indicators for multiple dispensing fees	X		
PG.307	Identification of CMS Drug Rebate, Medical Assistance Administration (MAA) Rebate program status and corresponding dates	X		
PG.308	CMS unit of measure	X		
PG.309	Quantity field for pharmacy claims (allow for decimal units)	X		
PG.310	Indicators for controlled drug, over-the-counter (OTC)	X		
PG.311	DESI/LTE indicator (drug efficacy study index, less than effective)	X		
PG.312	Preferred drug list status	X		
PG.313	Indicators for schedule assigned to controlled drugs	X		
PG.314	Drug Utilization Review (DUR) functions (e.g., high dose, low dose, drug to drug interaction)	X		
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	X		
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	X		
PG.317	Other as defined by BMS during DDI		X[1]	
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:	X		
PG.320	Revenue code date-specific pricing segments, including, effective begin and end dates, and allowed amount for each segment	X		
PG.321	Revenue code status code segments with effective begin and end dates for each segment	X		
PG.322	Indicators associated with selected parameters to designate whether the code should be included, excluded, or disregarded in claims processing	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PG.323	Complete narrative descriptions of revenue codes.	X		
PG.324	Indication of TPL actions, such as cost avoidance, benefit recovery, or pay, by revenue code	X		
PG.325	Indication of non-coverage by third-party payers	X		
PG.326	Information such as accident-related indicators for possible TPL, Federal cost-sharing indicators, Medicare coverage, and allowed amounts	X		
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.	X		
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).	X		
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:	X		
PG.331	Fee schedule	X		
PG.332	Maximum allowable fee per service (note: some situations require paying Federal portion of fees)	X		
PG.333	Percent of charge (billed amount) pricing	X		
PG.334	Multiple rates for all Providers and Provider types (as identified by BMS)	X		
PG.335	Interim and final rates, per Provider	X		
PG.336	Per diem rates for BMS-specified Provider types	X		
PG.337	Capitated rates for MCOs and PCCM services	X		
PG.338	Case-by-case pricing (by report, manually priced, etc.)	X		
PG.339	PA pricing fee schedule	X		
PG.340	PA pricing case-by-case	X		
PG.341	Enhanced or adjusted incentive payments as determined by BMS-defined pricing rules (e.g., dental pediatric incentive, HPSA pricing)	X		
PG.342	Per diem rates, assigned to each LTC Provider with a corresponding date span for pricing	X		
PG.343	Anesthesia pricing	X		
PG.344	LTC facility daily rate, room and board charges	X		
PG.345	LTC Prospective Payment System (PPS) rates	X		
PG.346	LTC nursing rate	X		
PG.347	Case mix adjusted rates for long term care facilities	X		
PG.348	Payment rates and effective dates for each rate, per facility	X		
PG.349	Consumer-specific pricing based on consumer location (i.e., hospice), monthly cost caps per consumer (i.e., for	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	waiver programs)			
PG.350	Medicare pricing or payment rates	X		
PG.351	Procedure code modifier pricing	X		
PG.352	Drug cost plus dispensing fee per prescription	X		
PG.353	Different rates for transplants and organ acquisition costs	X		
PG.354	Assistant-at-Surgery pricing	X		
PG.355	Package size pricing	X		
PG.356	Individual consideration pricing (e.g., hospital outliers)	X		
PG.357	Ambulatory Surgical Center (ASC) group pricing as determined by BMS	X		
PG.358	VFC (Vaccines for Children program) pricing and rates by procedure code	X		
PG.359	National Drug Code (NDC) (used for pricing hospital claims)	X		
PG.360	Transportation pricing	X		
PG.361	Non-specified formula pricing	X		
PG.362	Other as defined by BMS during DDI		X[1]	
PG.363	Ability to maintain the following hospital-specific inpatient and outpatient rate data, by effective date(s) including:	X		
PG.364	Inpatient DRG rate components	X		
PG.365	Inpatient and outpatient cost to charge ratios	X		
PG.366	Other hospital specific payment components such as per diems, percentages	X		
PG.367	Ability to accommodate multiple outpatient hospital reimbursement methodologies based on business rules provided by BMS, including:	X		
PG.368	Outpatient prospective payment	X		
PG.369	Per discharge/visit	X		
PG.370	Percent of charge	X		
PG.371	Fee-For-Service (FFS) procedure code prices for outpatient hospital care	X		
PG.372	Line level and revenue center code pricing	X		
PG.373	Other as defined by BMS during DDI		X[1]	
PG.374	Ability to accommodate multiple inpatient hospital reimbursement methodologies based on business rules provided by BMS, including:	X		
PG.375	DRG	X		
PG.376	Per discharge/visit	X		
PG.377	Per diem	X		
PG.378	Percent of charge	X		
PG.379	Line level and revenue center code pricing	X		
PG.380	Other as defined by BMS during DDI		X[1]	

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
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:	X		
PG.383	Age	X		
PG.384	Gender	X		
PG.385	Family planning indicator	X		
PG.386	Prior authorization indicator	X		
PG.387	EPSDT indicator	X		
PG.388	TPL trauma and emergency trauma codes	X		
PG.389	Inpatient length of stay criteria	X		
PG.390	Accident/trauma indicator	X		
PG.391	Begin date	X		
PG.392	End date	X		
PG.393	Add date	X		
PG.394	Description of the diagnosis	X		
PG.395	Primary and secondary diagnosis code usage	X		
PG.396	Indicators associated with selected parameters to designate whether they should be: included, excluded, or disregarded in claims processing	X		
PG.397	Covered	X		
PG.398	Not covered	X		
PG.399	Effective dates for all items	X		
PG.400	Indication of non-coverage for certain eligibility groups	X		
PG.401	Indication of non-coverage by managed care organizations	X		
PG.402	Cross reference to procedure codes	X		
PG.403	Performance, utilization, and program integrity reviews	X		
PG.404	Participation in Member care management	X		
PG.405	Other as specified by the BMS during the DDI phase		X[1]	
5	**5. Care Management (CM)**			
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.	X		
CM.3	Ability to access and query data from other governmental entities (outside of BMS) in order to:	X		
CM.4	Design and improve programs for potential as well as existing Medicaid Members	X		
CM.5	Coordinate decision-making and program development across agencies and offices in support of common care management goals	X		
CM.6	Query data and extract reports to analyze effectiveness of	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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	X		
CM.8	Ability to use MMIS data to support population health analyses.	X		
CM.9	Ability to receive population health data from various external entities. Data should include:		X	
CM.10	Census data		X	
CM.11	Vital statistics		X	
CM.12	Immigration data		X	
CM.13	Public health data		X	
CM.14	Statewide Health Information Exchange		X	
CM.15	National Health Information Network		X	
CM.16	Other as defined by BMS during DDI		X[1]	
CM.17	Ability to track and maintain detail for population health initiatives, including:	X		
CM.18	Originator/source of inquiry	X		
CM.19	Data source/s used	X		
CM.20	Strategy (or strategies) developed in response to data analysis	X		
CM.21	Changes to benefits	X		
CM.22	Changes to reference data	X		
CM.23	Record of communication materials	X		
CM.24	Time period/case schedule of review	X		
CM.25	Other as defined by BMS during DDI		X[1]	
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.	X		
CM.27	Ability to display free-form narrative in chronological or reverse chronological sequence.		X	
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).	X		
CM.30	Ability to use claims history information to support care management program eligibility determination (e.g., Disease Management and Disability Determinations).	X		
CM.31	Ability to use historical data to identify potential participants for specific programs, including historical data from the following:	X		
CM.32	Medicaid Waiver program case management - Home and Community Based Services (HCBS) and other	X		
CM.33	Disease management	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
CM.34	Catastrophic cases	X		
CM.35	Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	X		
CM.36	Population management	X		
CM.37	Other as defined by BMS during DDI		X[1]	
CM.38	Ability to support flexible rules-based logic (as specified by BMS) to determine care management program eligibility criteria for:	X		
CM.39	Individual Member	X		
CM.40	Family	X		
CM.41	Target populations	X		
CM.42	Other as defined by BMS during DDI		X[1]	
CM.43	Ability to generate a high-cost Member report to determine potential participation in a care management program.	X		
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:	X		
CM.45	Target population characteristics (e.g., Member age, location, specific medical conditions)	X		
CM.46	Data requirements (e.g., time period)	X		
CM.47	Data elements presented in reporting (e.g., procedure codes, diagnosis codes)	X		
CM.48	Other as defined by BMS during DDI		X[1]	
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.	X		
CM.50	Ability to support flexible rules-based logic (as specified by BMS) to determine program/s appropriate for each Member.	X		
CM.51	Ability to track and maintain Member treatment (care) plans and Health Improvement Plans, including the following detail:	X		
CM.52	Member detail (name, ID, etc.)	X		
CM.53	Identifies care needs as specified in the Health Improvement Plan	X		
CM.54	Care Management Program (e.g., EPSDT, Disease Management)	X		
CM.55	Provider type/s	X		
CM.56	Provider detail of Provider/s associated with case (name PIN, contact info, etc.)	X		
CM.57	Patient-Centered Medical Home (PCMH)	X		
CM.58	Program starting and end dates	X		
CM.59	Care setting	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
CM.60	Services to be delivered	X		
CM.61	Services delivered detail (including cost & date)	X		
CM.62	Frequency of service/s	X		
CM.63	Expected results	X		
CM.64	Review detail, including dates	X		
CM.65	Other as identified by the BMS during DDI		X[1]	
CM.66	Ability to provide role-based access (defined by BMS) to Member treatment plans.	X		
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.)		X	
CM.68	Ability to set a program maximum number of unduplicated participants (as specified by BMS) for care management programs.		X	
CM.69	Ability to create a waiting list when the maximum number of unduplicated participants has been reached for a program.		X	
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.		X	
CM.71	Ability to automatically generate a notice/alert (defined by BMS) when unduplicated enrollment reaches a BMS-specified percentage of maximum enrollment.		X	
CM.72	Ability to manually override program maximum enrollment.		X	
CM.73	**3. Manage Case**			
CM.74	Ability to track and report the number of unduplicated participants in all care management programs.	X		
CM.75	Ability to accept and update care management screening data fields from claim and encounter data at least weekly.	X		
CM.76	Ability to track and maintain program Provider qualification requirements for each care management program.	X		
CM.77	Ability to match the care management periodicity schedule with FFS billing, managed care encounter data, and Health Outcome Measures.	X		
CM.78	Ability to automatically deny participation for Providers not meeting care management program qualification requirements.	X		
CM.79	Ability to monitor program data to determine if the services approved in the plan of care are provided.	X		
CM.80	Ability to provide on-line role-based access (as assigned/decided by BMS) to case management data, including:	X		
CM.81	Program data and imaged documentation	X		
CM.82	Member information (e.g., hospitalizations, LTC facility, pharmacy, PA information, State Plan services)	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
CM.83	Claims data	X		
CM.84	Historical case, claims and enrollment data	X		
CM.85	Eligibility information	X		
CM.86	Benefit packages	X		
CM.87	Provider information (e.g., outpatient services, waiver services by type, waiver services by Provider and by Member)	X		
CM.88	Case notes	X		
CM.89	Case activity codes	X		
CM.90	Other as defined by BMS during DDI		X[1]	
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.	X		
CM.92	Ability to provide Case Managers role-based access (as assigned/decided by BMS) to case management data. Case Managers can be defined as any of the following:	X		
CM.93	BMS staff	X		
CM.94	Nurses	X		
CM.95	Other State agencies	X		
CM.96	Contractors	X		
CM.97	Social workers	X		
CM.98	Other entities as defined by BMS		X[1]	
CM.99	Ability to maintain Member-level EPSDT records with functionality that:	X		
CM.100	Includes user configurable periodicity schedules	X		
CM.101	Maintains tracking data, by Member, including notification and screening dates, screening results, referral details	X		
CM.102	Stores summary and detail EPSDT activities and services	X		
CM.103	Generates initial and follow-up EPSDT notices, based on periodicity schedules	X		
CM.104	Track immunization records and status for children from birth to age eighteen (18)	X		
CM.105	Track services provided as a result of EPSDT	X		
6	**6. Program Integrity Management (PI)**			
PI.1	**1. Manage Case**			
PI.2	Ability to automatically generate a unique case identifier upon referral for Case Management. Identifier methodology to be specified by BMS.	X		
PI.3	Ability to automatically create the Case Management record (from the initial case review data) upon referral to Case Management.	X		
PI.4	Ability to track and maintain Case Management data at the individual case level, including:	X		
PI.5	Case number	X		
PI.6	Case Manager	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PI.7	Case status (e.g., open, suspended, closed)	X		
PI.8	Type of review/investigation	X		
PI.9	Initiating agency	X		
PI.10	Reason for inquiry/review	X		
PI.11	Review time period/case schedule	X		
PI.12	Actions taken	X		
PI.13	Providers placed on a hold and review status, the reason for hold and review status, and dates of hold and review	X		
PI.14	Outcomes including monetary recoveries, such as recoupments	X		
PI.15	Listing of case contacts/affected parties	X		
PI.16	Disposition (e.g., corrective action, Medicaid program membership termination)	X		
PI.17	Chronology of significant case activity (e.g., dates of phone calls to Providers, dates of records/information received from Provider/Member/attorney), including description	X		
PI.18	Significant case documentation/evidence (e.g., medical records, Member interview findings, Provider credential verification)	X		
PI.19	Referrals	X		
PI.20	Recoupments	X		
PI.21	Location of treatment	X		
PI.22	Other as defined by BMS during DDI		X[1]	
PI.23	Ability to track and maintain case detail, including:	X		
PI.24	Unique case identifier	X		
PI.25	Case description	X		
PI.26	OQPI (Office of Quality and Program Integrity) staff investigating the case	X		
PI.27	Date received	X		
PI.28	Source of case	X		
PI.29	Status (e.g., under review/results pending, closed, referred to Case Management)	X		
PI.30	Other as defined by BMS during DDI		X[1]	
PI.31	Ability for the user to enter free-form text in a field and display narratives in chronological or reverse chronological order. Each entry is expected to include identification of user and date/time entered.	X		
PI.32	Ability to automatically generate a unique system identifier for all cases under initial review. This identifier should indicate "under review" status, and is expected to be different from the Case Number assigned upon referral to Case Management.	X		
PI.33	Ability to integrate and analyze data from external sources (e.g., vendors) in multiple media types.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
PI.34	Ability to contain finalized claims, finance, and clinical data reconciled to PCN (Payment Control Number).		X	
PI.35	Ability to generate and track SUR/Fraud questionnaire letters to Members and Providers according to specific criteria, with the ability to change the criteria real-time.	X		
7	**7. Pharmacy Point-of-Sale (POS)**			
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.	X		
POS.3	The Pharmacy POS is expected to support all pharmacy functions, files and data elements necessary to meet the requirements in this RFP.	X		
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.	X		
POS.5	Ability to support the following inputs:	X		
POS.6	Claims history data	X		
POS.7	Member data	X		
POS.8	National Provider Identifier (NPI) validation	X		
POS.9	Provider data	X		
POS.10	Reference file data	X		
POS.11	Drug utilization review (DUR) reporting parameters	X		
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	X		
POS.13	HIPAA compliant electronic Prior Authorization requests and hard copy Prior Authorization requests	X		
POS.14	Online prescription data from Providers for Prospective Drug Utilization Review (ProDUR)	X		
POS.15	Automated preferred drug data file updates	X		
POS.16	ProDUR criteria	X		
POS.17	Other as defined by BMS during DDI		X[1]	
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.	X		
POS.19	Ability to perform print screen on all Pharmacy POS screens directly from the system.	X		
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.).	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
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.	X		
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).	X		
POS.23	The Pharmacy POS is expected to maintain batch controls and audit trails on all pharmacy claims processing activities.	X		
POS.24	The Pharmacy POS is expected to assign a unique control number to every claim at the time when the record is processed.	X		
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.	X		
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.	X		
POS.27	The Pharmacy POS is expected to provide audit trail capabilities for any changes to the system.	X		
POS.28	Ability to set minimum and maximum quantity limits on each drug with no additional charge.	X		
POS.29	At a minimum, ability to support paid, denied, duplicate pay, duplicate reverse, rejected, reversed and rejected reversed claims.	X		
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.	X		
POS.32	The system should support a notes functionality -- in regard to help desk activity	X		
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.	X		
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.	X		
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.	X		
POS.37	Ability to allow the Pharmacy POS real-time access to Pharmacy and Medical/Dental claims databases.	X		
POS.38	Ability to support interfaces with external systems,	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	including (but not limited to):			
POS.39	Retro DUR vendor	X		
POS.40	DSS/DW (Decision Support System/Data Warehouse)	X		
POS.41	CMS and/or their agents	X		
POS.42	Commercial drug file vendor	X		
POS.43	Other as defined by BMS during DDI (the Vendor is expected to exhibit a willingness to support BMS defined interfaces)		X[1]	
POS.44	Ability to support the following online processing of pharmacy claims through networks provided by contracted switch vendors:	X		
POS.45	Transmission and online real-time processing of pharmacy claims	X		
POS.46	Real-time access to Member and Provider eligibility information	X		
POS.47	Prior Authorization processing	X		
POS.48	Third Party Liability (TPL) processing and response	X		
POS.49	Respond to Drug Utilization Review (DUR) alerts	X		
POS.50	Notification of co-payment requirements	X		
POS.51	Other as defined by BMS during DDI		X[1]	
POS.52	Pharmacy POS should support an eligibility transaction through network Providers to provide or support Provider queries on eligibility.	X		
POS.53	**4. Drug File**			
POS.54	The Pharmacy POS drug file is expected to have the capability to indicate preferred drug status.	X		
POS.55	The Pharmacy POS drug file is expected to have the capability to indicate prior authorization requirements.	X		
POS.56	Ability to develop, implement and maintain the BMS's customized drug database.	X		
POS.57	Ability to, at a minimum, support all data elements provided by a commercial drug file vendor for each drug.	X		
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.	X		
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.	X		
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.	X		
POS.61	Ability to overwrite data transferred from commercial drug file vendor.	X		
POS.62	The Pharmacy POS is expected to have the ability to protect manual changes from automatic updates from the	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	drug database vendor.			
POS.63	Ability to allow user-defined Drug file data elements in addition to those provided by commercial drug file vendor.	X		
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.	X		
POS.65	Ability to manually update term dates of drugs.	X		
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.	X		
POS.67	Ability to view all database elements that are found in the drug file records.	X		
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.	X		
POS.69	Ability to maintain history of the deleted NDCs from the drug reference file.	X		
POS.70	Ability to generate report of changes made on Drug Reference File (including date of change), including date, time, reason and user ID.	X		
POS.71	Ability to import the CMS drug file and reconcile with the drug database file according to BMS established criteria.	X		
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.	X		
POS.74	Ability to monitor and track all claims processing activities.	X		
POS.75	Ability to process all claims in a real-time mode via POS technology.	X		
POS.76	Ability to allow system users to define which fields are displayed as part of a POS claim screen.	X		
POS.77	The Pharmacy POS is expected to support the universal claim form for paper submittals.	X		
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.	X		
POS.79	Ability to accept DEA on paper claim (either NPI or DEA is acceptable as a prescriber identifier on paper only).	X		
POS.80	Ability to support multiple transactions within 1 transmission from a Provider, based on current NCPDP standards.	X		
POS.81	On-line access to Member claim profile information that includes, but not be limited to:	X		
POS.82	Drugs with descriptions	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
POS.83	Narrative denial reasons	X		
POS.84	Other as defined by BMS		X[1]	
POS.85	Ability to limit benefits on a Member-by-Member basis, per BMS approval, for limitations such as therapeutic categories, optional services and others defined as BMS.	X		
POS.86	The Pharmacy POS should respond with reject codes for each transaction within a transmission as defined by NCPDP standard.	X		
POS.87	Ability to deny any claim without valid eligibility information on file.	X		
POS.88	Ability to verify Member eligibility using demographic data as determined by BMS.	X		
POS.89	Ability to identify Medicaid vs. Non-Medicaid Members.	X		
POS.90	Ability to support a pharmacy lock-in capability for each Member when necessary. Lock-in to one pharmacy Provider.	X		
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.		X	
POS.92	Ability to capture and display HMO plan information (fields for display to be defined by BMS).	X		
POS.93	Ability to edit all FFS claims submitted for Members identified to have third-party coverage, including Medicare, according to BMS policies.	X		
POS.94	Ability to process claims when Date of Service does not exceed 12 months from the date the prescription was written.	X		
POS.95	Ability to set a maximum day supply as defined for BMS.	X		
POS.96	Ability to allow exceptions to the maximum day supply.	X		
POS.97	Ability to support the current NCPDP standard "Reversal" message which is to effectively 'debit' the named claim.	X		
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.	X		
POS.100	The Pharmacy POS should perform real-time edit/audit processing.	X		
POS.101	Ability to modify edits and audits as necessary or as defined by the BMS when policy or coverage changes are implemented.	X		
POS.102	Ability to perform adjudication of unique claims (i.e. by-pass edits/audits) as specified by the BMS.	X		
POS.103	Ability to deny or override claim edits and audits in accordance with BMS determined guidelines.	X		
POS.104	Ability to identify and exclude from coverage certain National Drug Code (NDC) numbers as required by the BMS.	X		
POS.105	Ability to restrict a Provider to specific drugs they can	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
POS.107	Ability to limit dollar amounts as defined by BMS.	X		
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.	X		
POS.109	Ability to edit controlled substance claims in accordance with Federal regulations.	X		
POS.110	Ability to limit coverage by age, gender, quantity, and edits going backwards and forwards, and other as determined by BMS.	X		
POS.111	Ability to apply the Federal rebate requirements.	X		
POS.112	Ability to approve for payment exceptions to the Federal rebate requirements as defined by BMS.	X		
POS.113	Ability to edit and deny on certain NDC levels or therapeutic classes for drugs contraindicated during pregnancy.	X		
POS.114	Ability to limit drugs based on diagnosis or drug history.	X		
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.	X		
POS.116	Ability to recognize a preferred brand and not require the submission of a DAW code, as determined by BMS.	X		
POS.117	Ability to allow the BMS to define use criteria for use of DAW codes.	X		
POS.118	**7. Claims Processing - Benefit Plans**			
POS.119	Ability to configure claims processing benefit plans, as defined by the BMS.	X		
POS.120	Ability to process pharmacy claims using plan limitations as defined on the date of service.	X		
POS.121	Ability to support limits on scripts per month following benefit coverage rules (as defined by BMS).	X		
POS.122	Ability to apply, at the minimum, the primary, secondary coverage hierarchy (as defined by BMS) to claims processing.	X		
POS.123	Ability to block coverage of a benefit for certain Members as determined by BMS.	X		
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).	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
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.	X		
POS.127	Ability to edit to ensure that TPL has been satisfied in accordance with BMS policies.	X		
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.	X		
POS.129	Ability to accept TPL information in a submitted claim, per NCPDP standards.	X		
POS.130	Capable of tabulating the one or more TPL payments towards the Medicaid cost of the claim.	X		
POS.131	Ability to not wrap around the Medicare Part D Benefit.	X		
POS.132	Ability to capture the reject reason for the denial by the primary payer.	X		
POS.133	Ability to recognize the co-payment requirement from the primary insurance and calculate the Medicaid payment per BMS requirements.	X		
POS.134	Ability to deny hospice claims unless for a non-hospice covered drug. Hospice is considered a third-party payer.	X		
POS.135	Ability to support reject codes submitted from a Provider for each TPL submitted per NCPDP standard.	X		
POS.136	**9. Claims Processing - Compounds Requirements**			
POS.137	Ability to support the requirement that at least one ingredient is a covered legend drug.	X		
POS.138	Ability to edit for PA and quantity limits, and other edits as required by BMS, for each line of the compound.	X		
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.	X		
POS.140	Ability to support processing of compounds containing up to 25 ingredients per prescription.	X		
POS.141	Ability to price compound ingredients based on the individual prices of each ingredient quantity contained in the compound.	X		
POS.142	A compound drug containing a DESI (also known as Less than Effective Drug Efficacy Study Implementation -- LTE DESI) ingredient should be denied.	X		
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.		X	
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)	X		
POS.146	Ability to enforce 5 refills per prescription within 6 months	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
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.	X		
POS.149	**11. Drug Utilization Review (DUR)**			
POS.150	Ability to provide and support point-of-sale with prospective DUR edits.	X		
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.	X		
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.	X		
POS.153	Ability to provide online access to Prospective Drug Utilization Review (ProDUR) criteria/screening data files.	X		
POS.154	Ability to support the following requirements for ProDUR:	X		
POS.155	Support an edit process that should be parameter or table-driven and be flexible	X		
POS.156	Provide the capability to update system parameters without complex programming within one (1) business day of receipt of request	X		
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.	X		
POS.158	Other as defined by BMS during DDI		X[1]	
POS.159	**12. Drug Utilization Review (DUR) - Claims Review**			
POS.160	The DUR Clinical Modules should be configurable and customizable and provide edits per BMS policy. The modules should include (at a minimum):	X		
POS.161	Drug Drug Interaction (DD)	X		
POS.162	Therapeutic Duplication (TD)	X		
POS.163	Ingredient Duplication (ID)	X		
POS.164	Early Refill (ER) if applicable	X		
POS.165	Pregnancy Precaution (PG)	X		
POS.166	High Dosage (HD)	X		
POS.167	Maximum Duration (MX)	X		
POS.168	Breastfeeding Precaution (SX)	X		
POS.169	Low Dosage (LD)	X		
POS.170	Late Refill (LR)	X		
POS.171	Drug/Allergy alerts	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
POS.172	Ingredient/therapeutic duplication crossover	X		
POS.173	Other as defined by BMS during DDI		X[1]	
POS.174	RxDUR should have capability to modify the ON/OFF status of clinical modules.	X		
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.	X		
POS.176	Ability to capture and store chronic disease states in the Member file.	X		
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.	X		
POS.179	Ability to user-define text of messages to be returned to pharmacies.	X		
POS.180	Ability to user-define business rules which allow different messages under different circumstances.	X		
POS.181	Ability to apply alerts according to BMS specifications.	X		
POS.182	For each alert/denial, the ability to include, at a minimum, the following information (to the Provider):	X		
POS.183	Alert conflict type (e.g., drug allergy alert)	X		
POS.184	Alert severity (e.g., minor, major, etc.)	X		
POS.185	Available data related to the alert (e.g., other drug or condition in conflict).	X		
POS.186	Other as defined by BMS during DDI		X[1]	
POS.187	Ability to support a role-based override capability for all edits.	X		
POS.188	Ability to support special situations where State/Federal programs/exceptions exist with "soft edits" to allow Provider override.	X		
POS.189	Ability to support "hard edits" to prevent Provider override.	X		
POS.190	Ability to support a special "BMS Management Override" for paper claims where normal editing is bypassed.	X		
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.	X		
POS.192	Ability to user-define additional text to accompany standard NCPDP DUR reject codes and their associated return messages.	X		
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		X	

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
POS.195	Ability to produce a report, upon request, listing all ProDUR alerts encountered for specified Members, Providers, and/or prescribers.	X		
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.	X		
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.	X		
POS.199	Capability for modification of the default Screening Parameters.	X		
POS.200	Ability to rank the severity of adverse events.	X		
POS.201	Ability to modify the ranking of Severity Events.	X		
POS.202	Ability to establish initial Severity Rankings as specified by the BMS.	X		
POS.203	Ability to reject claims when certain drug combinations are used (as defined by BMS).	X		
POS.204	Capability of posting or not posting DUR events to the Provider, as determined by BMS.	X		
POS.205	**15. Drug Utilization Review (DUR) - Reporting**			
POS.206	Ability to generate the following reporting:	X		
POS.207	Alerts/claims denials by reason (e.g., therapeutic duplication, drug/drug interaction, excessive utilization)	X		
POS.208	Cost saving and cost tracking reports (e.g., savings amounts, co-pays).	X		
POS.209	Drug file update reporting (e.g., therapeutic class, update descriptions, low/high dose criteria)	X		
POS.210	Other as defined by BMS during DDI		X[1]	
POS.211	**16. Prior Authorization (PA) - Processing**			
POS.212	Ability to process PAs using the NCPDP standard guidelines.	X		
POS.213	Ability to utilize prior authorization information in claims processing.	X		
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.	X		
POS.215	Ability to provide edits in the claims processing system to identify drugs requiring prior authorization.	X		
POS.216	Ability to integrate with the BMS's Prior Authorization call center vendor (currently Rational Drug Therapy Program).	X		
POS.217	Ability to automatically generate and track prior	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	authorization using a unique identifier.			
POS.218	Ability to maintain prior authorization at the eligibility group level, program or plan.	X		
POS.219	Ability to edit for Prior Authorization in accordance with BMS policies and guidelines.	X		
POS.220	Ability to maintain a map of NDC code to diagnosis code to edit for valid/invalid combinations.	X		
POS.221	Ability to set PA requirements at various BMS determined levels (e.g., NDC, therapeutic class).	X		
POS.222	Ability to administer prior authorization processing in a real-time mode.	X		
POS.223	Ability to accept online real-time entry and update of prior authorization requests.	X		
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.)	X		
POS.225	Ability to apply the PA requirements effective on the date of service.	X		
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.	X		
POS.227	Ability to allow the BMS to specify criteria for requiring the Provider to supply a PA number before the transaction may be processed.	X		
POS.228	Ability to support emergency PA capability (as defined by BMS, using NCPDP standards).	X		
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.	X		
POS.230	Ability to provide on-line access to all prior authorization information.	X		
POS.231	Ability to accept on-line, real-time entry and update of PA determinations.	X		
POS.232	Ability to utilize prior authorization restrictions to include, but not limited to:	X		
POS.233	Drug data (e.g., NDC (9 to 11 digits), HIC, GCN sequence)	X		
POS.234	Member data	X		
POS.235	Provider data	X		
POS.236	Day specific, or span dates of the prior authorization	X		
POS.237	Frequency restrictions	X		
POS.238	Dollar/unit dispensing limitations	X		
POS.239	Other as defined by BMS during DDI		X[1]	
POS.240	Ability to link to eligibility data when reviewing the PA request.	X		
POS.241	Ability to automatically identify and update active or		X	

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	pended PA records when a reference file has been updated (e.g., drug code, drug category).			
POS.242	Ability to require and process PA for service to Member in LTC.	X		
POS.243	Ability to "grandfather" Members on identified services when a new PA requirement is identified.	X		
POS.244	Ability to add back the unused units if a claim is reversed	X		
POS.245	Ability to generate denial notices to Members.	X		
POS.246	**17. Prior Authorization - Automated Prior Authorization**			
POS.247	Ability to provide automated approval of authorizations based upon any Federal, State, and BMS policy and guidelines.	X		
POS.248	Ability to integrate an automated PA system while maintaining system performance metrics.	X		
POS.249	The ability to search up to 24 months of recipient administrative data including medical claims, pharmacy claims and encounter data.	X		
POS.250	The ability to retain once-in-a lifetime medical codes (such as hysterectomy, etc.) for search in prior authorization requests as defined by BMS.	X		
POS.251	Table-driven criteria that is customized and can be quickly adapted to meet changes in Bureau's pharmacy policy and criteria updates.	X		
POS.252	Data analysis tools, and Vendor analysis on an ongoing basis, to identify clinical and utilization issues that may warrant new screening criteria.	X		
POS.253	**18. Pricing**			
POS.254	Ability to price all claims in accordance with BMS policies and guidelines.	X		
POS.255	Ability to accommodate and calculate payments applying various co-pay/cost sharing arrangements as defined or approved by the BMS.	X		
POS.256	Ability to pay different dispensing fees based on criteria established by the BMS.	X		
POS.257	Ability to support a Medicaid AWP (average Wholesale Price - Department of Justice) pricing methodology	X		
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.	X		
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.	X		
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.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
POS.261	**19. Pricing - Pricing Formulas**			
POS.262	Ability to utilize industry standard pricing including, at a minimum:	X		
POS.263	AWP (Average Wholesale Price)	X		
POS.264	Medicaid AWP (average Wholesale Price - Department of Justice)	X		
POS.265	SMAC (State Maximum Allowable Cost)	X		
POS.266	WAC (Wholesale Acquisition Cost)	X		
POS.267	ASP (Average Sales Price)		X	
POS.268	FUL (Federal Upper Limit)	X		
POS.269	Direct price pricing where appropriate	X		
POS.270	Other as defined by BMS during DDI		X[1]	
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.	X		
POS.272	Compound prescriptions are to be reimbursed with an additional $1.00 Dispensing Fee.	X		
POS.273	Ability to manage the 340-B pricing as defined by BMS.	X		
POS.274	Ability to support different dispensing fees to different types of pharmacies as defined by BMS.	X		
POS.275	Ability to support a DAW 1 code and reimburse at the brand rate.	X		
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).	X		
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.	X		
POS.279	Ability to support primary payer reject codes as defined by BMS.	X		
POS.280	Ability to support multiple co-pay requirements based upon the total price or status of the drug.	X		
POS.281	Ability to maintain co-pays based on BMS policy for various eligibility groups or product designation.	X		
POS.282	**21. Financial Processes**			
POS.283	Ability to include on-line access to the following:	X		
POS.284	Recoupments	X		
POS.285	Voids	X		
POS.286	Refunds made	X		
POS.287	Request for additional information sent	X		
POS.288	Number of outstanding requests pending	X		
POS.289	Other as defined by BMS during DDI		X[1]	
POS.290	Ability to reprocess pharmacy claims when needed.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
POS.291	Ability to perform mass claims reprocessing.	X		
POS.292	Ability to update the FFS claims payment to track all recoupment, refund and adjustment activity.	X		
POS.293	Ability to reimburse pharmacies as approved by the BMS in accordance with applicable Federal regulations.	X		
POS.294	Ability to provide a method to pay pharmacists an incentive (based upon rules approved by BMS).		X	
POS.295	**22. Reporting - General**			
POS.296	Ability to generate standard reports (as defined by BMS during DDI) and customized reports.	X		
POS.297	Ability to support an online/on-demand Member history report. The results should contain enough information to reflect the following:	X		
POS.298	A drug profile history, and should be in a format which can be either stored or displayed on an online screen.	X		
POS.299	A drug utilization history, and should be in a format which can be either stored or displayed on an online screen.	X		
POS.300	Ability to export reports for enhanced manipulation and analysis.	X		
POS.301	Ability to provide for the electronic delivery of reports to identified destinations.	X		
8	**8. General and Technical (GT)**			
GT.1	**1. Change Control**			
GT.2	Ability to provide an automated software modifications change request tracking system.	X		
GT.3	The system should enable BMS to control and monitor system change requests.	X		
GT.4	Change requests are expected to include all necessary documentation (as defined by the BMS-approved change management plan).	X		
GT.5	Ability for BMS to set and change priority levels on individual change requests.	X		
GT.6	Ability for BMS to track process metrics and other detail, including:	X		
GT.7	The estimated and actual hours allocated to each change request	X		
GT.8	Specific personnel assigned to each change request	X		
GT.9	Scheduled completion date for each change request	X		
GT.10	Total cost (if maximum allowable hours exceeded)	X		
GT.11	Total approved operations charge increase (if any)	X		
GT.12	A separate total for equipment requirements (if applicable) related to the modification	X		
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	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
GT.16	Ability for BMS to specify/modify auto archive rules.	X		
GT.17	Ability to provide archival and purge processes that do not degrade or interrupt the system.	X		
GT.18	Ability to easily retrieve archived data for online review, export and reporting.	X		
GT.19	Ability to restore archived data for reviewing, copying and printing.	X		
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:	X		
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)	X		
GT.23	Full and complete back-up copies of all data and software on tape and/or disk	X		
GT.24	Storage of all back-up copies in a secure off-site location	X		
GT.25	Routine testing to verify the completeness, integrity, and availability of back-up information	X		
GT.26	Support for immediate restoration and recovery of lost or corrupted data or software from a disaster event	X		
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).	X		
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.	X		
GT.29	Ability to provide point-in-time recovery of data to the last completed transaction.	X		
GT.30	Ability to allow for continued use of the system during back-up.	X		
GT.31	The Vendor is to perform back-ups during non-peak processing hours, minimizing the impact to operational activities.	X		
GT.32	**4. Problem Management**			
GT.33	Ability to write all errors to an error log.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.34	Ability to allow for a BMS administrator to view, filter, sort and search the error log.	X		
GT.35	Ability to allow for an administrator (Vendor personnel) to archive error log entries based upon user-defined criteria.	X		
GT.36	Ability to allow for a user to define an alert message to be executed upon the occurrence of an error.	X		
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).	X		
GT.38	**5. Release Management**			
GT.39	Major releases are to be evaluated and approved by BMS prior to application.	X		
GT.40	The Vendor is to send notification to BMS when releases are available to be evaluated.	X		
GT.41	The Vendor is to provide BMS with detailed documentation that lists all fixes and functionality for each release.	X		
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.	X		
GT.43	The Vendor is to maintain version control and provide BMS with current system and user documentation, and operating procedures manuals.	X		
GT.44	Ability to allow centralized deployment of system updates and system maintenance.	X		
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.	X		
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.	X		
GT.48	Ability to provide a role-based Single Sign On (SSO) solution.	X		
GT.49	Requests for access are to come from an authoritative source(s) as defined by BMS.	X		
GT.50	Ability to require that all users (including all vendor support staff members) have a unique user ID and password, where:	X		
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.	X		
GT.52	Passwords are to be strong passwords (e.g., contain caps/numbers, cannot use prior passwords, etc.).	X		
GT.53	Passwords are to be stored in encrypted form.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	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.	X		
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.	X		
GT.56	**Preventive Controls:** Controls designed to prevent errors and unauthorized events from occurring.	X		
GT.57	**Detective Controls:** Controls designed to identify errors and unauthorized transactions which have occurred in the system.	X		
GT.58	**Corrective Controls:** Controls to ensure that the problems identified by the detective controls are corrected.	X		
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.	X		
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.	X		
GT.61	The system's import and export capabilities are to provide user-level security options to control access to sensitive information.	X		
GT.62	Ability to support file, record, and field-level security.	X		
GT.63	Ability to provide document-based security.	X		
GT.64	Ability to update all security roles automatically when a change in the "master" role is made.	X		
GT.65	Ability to provide functional security to control what processes can be performed by certain users.	X		
GT.66	Ability to allow local/central System Security Administrators to add and change permissions for local/central system access.	X		
GT.67	Ability to prohibit display of passwords on the sign-on screen when entered by the user.	X		
GT.68	Ability to log and report all unauthorized access attempts by terminal ID, user ID, date, and time.	X		
GT.69	Ability to allow System Administrator to re-set user passwords.	X		
GT.70	Ability to allow users to change their passwords.	X		
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.	X		
GT.72	Ability to terminate access if there is no activity on a user	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	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.	X		
GT.74	Ability to immediately disable access to any user or user group after a predetermined number of attempts to log-on.	X		
GT.75	Ability to ensure that all applications comply and are compatible with existing State and Federal guidelines preventing unauthorized access.	X		
GT.76	Employ a security approach that integrates MMIS components to provide role-based access with a single log-on.	X		
GT.77	Ability to provide an audit trail of record changes, including user and date of change.	X		
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.	X		
GT.79	Ability to trace data from the final place of recording back to its source of entry.	X		
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).	X		
GT.81	Ability to transmit and receive HIPAA-compliant transactions using multiple methods (e.g., web-based, dial-up, batch file).	X		
GT.82	Ability to transmit and receive HIPAA-compliant transactions using a variety of devices including PCs and touch tone phones.	X		
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.	X		
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.	X		
GT.85	**7. Standards**			
GT.86	The system is expected to be flexible and readily adaptable to changing State and Federal requirements.	X		
GT.87	The Vendor is to provide BMS with an inventory of all hardware and software to be placed within the State government infrastructure.	X		
GT.88	The Vendor is expected to support current technologies for data interchange (e.g., XML).	X		
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).	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.90	The system is to use a relational database management system (RDBMS).	X		
GT.91	**8. Support**			
GT.92	The Vendor is expected to provide a technical help desk, accessible to users via phone.	X		
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.	X		
GT.94	The system is to have the "built-in" capability to provide BMS authorized support through remote access to the application.	X		
GT.95	Ability to allow for BMS-defined severity levels for support.	X		
GT.96	The following describe desired capabilities of the Vendor's support tool:	X		
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.	X		
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).	X		
GT.99	Ability to add electronic attachments to a ticket.	X		
GT.100	Ability to allow configuration of call routing and delegation criteria, and severity, prioritization and escalation criteria.	X		
GT.101	Include knowledge base, Frequently-Asked-Questions (FAQ) components, and phone scripts that can be updated manually or via automatic imports.	X		
GT.102	Ability to facilitate mass e-mail and fax notifications to enrolled providers.	X		
GT.103	Ability to allow the recording of inbound and outbound communications with the ability to retain recordings as specified by BMS.	X		
GT.104	The Call Center should have a central database for call tracking records that can be queried by both Vendor and BMS users.	X		
GT.105	Ability to use MMIS data repositories to automatically display information regarding the caller.	X		
GT.106	Ability to capture date-specific and user-specific free form text for each call center ticket.	X		
GT.107	Provide role-based system training for BMS personnel, their vendors and their business partners upon request of BMS.	X		
GT.108	Provide training to BMS or its subsequent vendor regarding:	X		
GT.109	Computer operations, including production control monitoring procedures	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.110	Controls and balancing procedures	X		
GT.111	Extension routines (pre/post SQL)	X		
GT.112	Other manual operations as necessary	X		
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.	X		
GT.115	MMIS modules and applications are to integrate successfully and effectively with minimal or no customization.	X		
GT.116	Utilize open architecture standards and scalability to promote integration throughout all MMIS business processes and sub-processes.	X		
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.	X		
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.	X		
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.	X		
GT.120	Ability to "lock" a claim to prevent concurrent updates to the same claim.	X		
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).	X		
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.	X		
GT.123	Ability to maintain an integrated repository of Provider information, including a single unique identifier (NPI), for all Providers.	X		
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.	X		
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).	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
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.	X		
GT.128	The system is to interface with and provide data to a Decision Support System/Data Warehouse.	X		
GT.129	Ability to produce required Federal and State data sharing, including (but not limited to) the following:	X		
GT.130	Program management reports (formerly known as Management and Administrative Reporting Subsystem (MARS))	X		
GT.131	Program Integrity reports (formerly known as Surveillance and Utilization Review Subsystem (SURS))	X		
GT.132	Medicare Modernization Act (MMA)	X		
GT.133	Medicaid Statistical Information System (MSIS)	X		
GT.134	The system is to accept the same Provider electronic billing data set required by the Medicare program for crossover claims from COBA.	X		
GT.135	Ability to employ online real-time or batch updates of data between the MMIS and other systems, depending on the interface requirements.	X		
GT.136	Ability to produce a listing on an as-requested basis of all submitters with their submitter ID.	X		
GT.137	Ability to maintain the submitter ID on the claim record.	X		
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:	X		
GT.139	**Health Care Claims**	X		
GT.140	ASC X12N 837 Health Care Claim: Professional	X		
GT.141	ASC X12N 837 Health Care Claim: Institutional	X		
GT.142	ASC X12N 837 Health Care Claim: Dental	X		
GT.143	National Council for Prescription Drug Programs (NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1, Release 0	X		
GT.144	**Eligibility for a Health Plan:**	X		
GT.145	ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response	X		
GT.146	**Health Care Claim Status:**	X		
GT.147	ASC X12N 276/277 Health Care Claim Status Request and Response	X		
GT.148	**Referral Certification and Authorization:**	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.149	ASC X12N 278 Health Care Services Review - Request for Review and Response	X		
GT.150	**Health Plan Premium Payments:**	X		
GT.151	ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products	X		
GT.152	**Enrollment and Dis-enrollment in a Health Plan:**	X		
GT.153	ASC X12N 834 Benefit Enrollment and Maintenance	X		
GT.154	**Health Care Payment and Remittance Advice:**	X		
GT.155	ASC X12N 835 Health Care Claim Payment/Advice	X		
GT.156	**Coordination of Benefits:**	X		
GT.157	ASC X12N 837 Health Care Claim: Professional	X		
GT.158	ASC X12N 837 Health Care Claim: Institutional	X		
GT.159	ASC X12N 837 Health Care Claim: Dental	X		
GT.160	**National Council for Prescription Drug Programs:**	X		
GT.161	(NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1	X		
GT.162	**Acknowledgements:**	X		
GT.163	ASC X12 824: Application Reporting Version 4010/5010	X		
GT.164	ASC X12 277: Health Care Payer Unsolicited Claim Status (Claims in Process Report)	X		
GT.165	**New transaction content to include:**	X		
GT.166	ASC X12N 269: Health Care Coordination of Benefits Request and Response	X		
GT.167	ASC X12N 270/271: Health Care Eligibility/Benefit Inquiry and Response (with commercial insurance carriers)	X		
GT.168	ASC X12N 274: Health Care Provider Inquiry and Information Response Guide	X		
GT.169	ASC X12N Health Care Provider Credentialing Implementation Guide	X		
GT.170	ASC X12N Health Care Provider Directory Implementation Guide	X		
GT.171	ASC X12N Health Care Provider Information Implementation Guide	X		
GT.172	ASC X12N Additional Information to Support a Health Care Services Review	X		
GT.173	ASC X12N 275: Additional Information to Support a Health Care Claim or Encounter	X		
GT.174	ASC X12N 841: Specifications/Technical Information	X		
GT.175	The system is to accommodate future versions of the HIPAA electronic PA transactions.	X		
GT.176	The system is to comply with all HIPAA EDI standards adopted by the BMS.	X		
GT.177	The Vendor is to provide for both an online DDE (direct data entry) process and receipt of electronic prior authorizations.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	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).	X		
GT.179	Ability to use high speed data transfer functionality to send and receive information (where available).	X		
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.	X		
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.	X		
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.	X		
GT.183	Ability to schedule and support file transfer as requested and agreed upon by the Bureau.	X		
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.	X		
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.	X		
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.	X		
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.	X		
GT.188	The Vendor is to implement edits, processes and reporting to eliminate undesired duplication of records and transactions, including:	X		
GT.189	Automatically edit fields for reasonableness, validity, format and consistency with other data present in update transaction.	X		
GT.190	Transaction reconciliation reporting for file/data reconciliation with external data sources (e.g., totals and detail information, difference reports, change reports).	X		
GT.191	Ability to generate error reports at the summary and detail levels that include all data necessary to resolve errors.	X		
GT.192	Ability to reload or resend records if they have not been applied correctly to the appropriate data repository.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.193	Ability to detect duplicate files or records and isolate them for manual review and further processing.	X		
GT.194	Ability to incorporate a method to view and edit interface files for investigation and further processing.	X		
GT.195	Ability to provide a method to "roll back" data to a pre-interface status.	X		
GT.196	Ability to create messages that accurately describe errors received as a result of a data transfer.	X		
GT.197	Ability to provide ad-hoc query capability against interface source files.	X		
GT.198	Ability to export records identified by BMS, when required by the BMS.	X		
GT.199	The system is to create and retain an audit trail of all interface activity in accordance with BMS Data Retention Policy.	X		
GT.200	**11. Workflow Management**			
GT.201	Ability to include comprehensive workflow management functionality that supports:	X		
GT.202	Definition, and possibly modeling, of workflow processes and their constituent activities.	X		
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.	X		
GT.204	Run-time interactions with users and Information Technology (IT) application tools for processing the various activity steps.	X		
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:	X		
GT.206	Start and completion conditions	X		
GT.207	Activities and rules for navigation between them	X		
GT.208	Tasks to be undertaken by BMS staff involved in the process	X		
GT.209	Authorized approvers	X		
GT.210	References to applications which may need to be invoked	X		
GT.211	Definition of other workflow-relevant data	X		
GT.212	Ability to support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.	X		
GT.213	Ability to incorporate simple low-level workflow processes into more complex higher-level workflow processes.	X		
GT.214	Ability to support supervisory operations for the management of workflow including:	X		
GT.215	Assignments/re-assignments and priorities	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.216	Status querying and monitoring of individual documents and other work steps or products	X		
GT.217	Work allocation and load balancing	X		
GT.218	Approval for work assignments and work deliverables via a tiered approach	X		
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	X		
GT.220	Monitoring of key information regarding a process in execution, including:	X		
GT.221	Estimated time to completion	X		
GT.222	Staff assigned to various process activities	X		
GT.223	Any error conditions	X		
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.	X		
GT.225	Ability to use workflow management functionality to route and assign cases to the appropriate State and county staff and offices.	X		
GT.226	**12. Test Environments**			
GT.227	Ability to maintain four regions/environments: (1) a test region/environment, (2) a staging 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 test, staging, and training regions be housed on the same hardware as the production region. The training region is to contain a copy of the information that is defined in the production system. Vendors are not to invoke additional license fees for the test, staging, and training environments.	X		
GT.228	Vendor should use a user acceptance test environment that would mirror all programs in production through the life cycle of the claim, to include reports and the financial records.	X		
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).	X		
GT.230	Ability to create MMIS data (Provider, health plan, Member or claim) in a test environment, as needed for testing.	X		
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.	X		
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.	X		
GT.233	**13. Automated Voice Response System (AVRS)**			
GT.234	The AVRS is to support the following Provider inquiries:	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.235	Prior Authorization status	X		
GT.236	Check Medicaid Member eligibility, third party insurance and managed care coverage for a specific date.	X		
GT.237	Query coverage limitations for the Member.	X		
GT.238	Query the co-pay requirement for a service.	X		
GT.239	Query Member restrictions.	X		
GT.240	Query for status of any claim or PA request they submit whether electronically or manually submitted.	X		
GT.241	Query warrant status and amounts.	X		
GT.242	Query Remittance Advice information.	X		
GT.243	The AVRS is to support the following Member inquiries:	X		
GT.244	Check Medicaid Member eligibility for a specific date.	X		
GT.245	Query and update managed care enrollment.	X		
GT.246	AVRS system is to be compatible with the State's phone systems and with industry telephony standards.	X		
GT.247	Ability to provide separate toll-free AVRS telephone numbers for Providers, Members, and other entities as identified by the BMS.	X		
GT.248	Ability to validate the AVRS caller/user (according to BMS defined criteria).	X		
GT.249	The AVRS should accept payment inquiries based on either NPI or Provider ID.	X		
GT.250	Ability for callers using the contact/call center management system to transfer to the AVRS system.	X		
GT.251	The system should use automated menus, including an easily accessible option for reaching a live operator.	X		
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.	X		
GT.254	The Vendor is expected to require Provider to give NPI or atypical provider identifier, at a minimum, before responding to inquiries.	X		
GT.255	Ability to authenticate the caller/user (per BMS specified criteria).	X		
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.	X		
GT.257	Ability to use automated repeat call options.	X		
GT.258	Ability to integrate with an automated phone messaging system.	X		
GT.259	Ability to use automated message purge function with activity reporting.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
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.	X		
GT.261	Ability to configure navigation paths and prompts based on the caller's anticipated information needs.	X		
GT.262	Ability to record customized messages directed to selected Provider or Member groups.	X		
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).	X		
GT.264	Ability to configure navigation paths and prompts based on information from the MMIS (e. g., transfer call based on Provider specialty).	X		
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.	X		
GT.267	Ability to manage all MMIS related contacts (telephone, email, web portal, AVRS, mail, fax, etc.).	X		
GT.268	Ability to maintain a record (including an audit trail) of all contacts.	X		
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.	X		
GT.270	Ability to query on the history of each contact.	X		
GT.271	Ability to view related contact records from a single contact record.	X		
GT.272	Ability to assign a unique tracking or control number to each contact.	X		
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.	X		
GT.274	Ability to use caller phone number and/or ID number to access related MMIS data and previous contacts.	X		
GT.275	The system is expected to receive and track summary level mailing data from the enrollment broker for reporting purposes.	X		
GT.276	Ability to upload attachments to contact records.	X		
GT.277	Ability to link scanned images to contact records to provide one view of all related materials (e.g., images, letters, and interactions).	X		
GT.278	Ability to provide correspondence functions to include the	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	following:			
GT.279	Template development and the ability for users to select desired correspondence from a list of available templates	X		
GT.280	Display, print, and save correspondence via the EDMS component of the MMIS	X		
GT.281	Regenerate correspondence	X		
GT.282	Allow users to suppress or allow auto generation of correspondence based on user configurable event-driven criteria	X		
GT.283	Allow users to insert and override address information on correspondence	X		
GT.284	Allow users to add free form text to individual or groups of correspondence	X		
GT.285	Other as defined by BMS during DDI		X[1]	
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.).	X		
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:	X		
GT.289	Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant)	X		
GT.290	Interactive Claims Inquiry (276/277 – DDE compliant)	X		
GT.291	Interactive Claim Submission (DDE compliant) to allow a Provider to submit a claim, including HIPAA/EDI compliant responses	X		
GT.292	Remittance Advice (RA) (835)	X		
GT.293	Interactive claim submission (837 transactions)	X		
GT.294	Ability to support an EDI Translator and Validator.	X		
GT.295	**17. Electronic Document Management System (EDMS)**			
GT.296	Integrate EDMS functionality into the MMIS that supports, at a minimum, the following capabilities:	X		
GT.297	Document management	X		
GT.298	Content management	X		
GT.299	Records management	X		
GT.300	Document capture and imaging	X		
GT.301	Document-centric collaboration	X		
GT.302	Workflow management including document workflow	X		
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.	X		
GT.304	Provide multiple search options (e.g., Structured Query Language (SQL), various index search options, content-	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	based searches, etc.) to view contents.			
GT.305	Ability to track all versions of each document.	X		
GT.306	Ability to present users with the latest revision of a document with the option to view previous versions.	X		
GT.307	Ability to support the management of documents created in BMS standard office applications.	X		
GT.308	Ability to allow drag-and-drop functionality to be used when creating or editing a document.	X		
GT.309	Ability to include, at a minimum, the following document management capabilities:	X		
GT.310	Accessible letter templates and forms	X		
GT.311	On-line, updateable templates that allow users to customize on an as-needed basis	X		
GT.312	Store documents and files	X		
GT.313	Generate materials in both hard copy and electronic format, including forms and letters	X		
GT.314	Ability to create letter templates and forms for the following areas:	X		
GT.315	Provider enrollment materials	X		
GT.316	General correspondence/notices for Providers and Members	X		
GT.317	Letters (financial, denial, EOMB, etc.)	X		
GT.318	Coordination Of Benefits (COB) letters	X		
GT.319	Managed Care Plan/Care Management Plan (MCP) letters	X		
GT.320	Prior Authorization (PA) letters	X		
GT.321	Ability to generate pre-populated forms.	X		
GT.322	Ability to easily match up related documents such as claims and supporting attachments in a many to one relationship.	X		
GT.323	Ability to support cataloging/indexing of all imaged documents.	X		
GT.324	Ability to utilize bar code technology that minimizes manual indexing and automates the retrieval of scanned documents.	X		
GT.325	Provide backup capability for manually indexed scanned documents.	X		
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:	X		
GT.327	Provider enrollment materials and licensure	X		
GT.328	Claim forms and attachments	X		
GT.329	PA forms and attachments	X		
GT.330	COB/TPL (including Medicare)	X		
GT.331	Provider correspondence including but not limited to RTP	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.332	Member correspondence	X		
GT.333	Contractor correspondence	X		
GT.334	Business partner correspondence	X		
GT.335	Web portal correspondence	X		
GT.336	Member enrollment materials	X		
GT.337	Notices	X		
GT.338	Letters	X		
GT.339	Audit materials	X		
GT.340	Others as defined by BMS		X[1]	
GT.341	**18. Reports**			
GT.342	Ability to download reports in various formats, such as PDF, Excel, Word, etc.	X		
GT.343	Ability to export reports for enhanced manipulation and analysis.	X		
GT.344	Provide integrated print capability for any interface page within the MMIS.	X		
GT.345	The Vendor is to provide a searchable data dictionary.	X		
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.	X		
GT.347	Provide for the electronic delivery of reports to identified destinations.	X		
GT.348	Provide role-based access to BMS staff to view reports and current manuals online.	X		
GT.349	Ability to produce multi-dimensional, flexible, ad hoc reports across business functions which meet the following reporting needs:	X		
GT.350	Financial reporting		X	
GT.351	Budget forecasting		X	
GT.352	Fiscal planning and control		X	
GT.353	Claims payment accuracy		X	
GT.354	Cash flow		X	
GT.355	Timely reimbursement analysis		X	
GT.356	Recipient cost and user of services		X	
GT.357	Cost/benefit analysis		X	
GT.358	Third party recovery		X	
GT.359	Prescription drug policy		X	
GT.360	Cost and user of prescription drugs		X	
GT.361	Recipient participation		X	
GT.362	Eligibility and benefit design		X	
GT.363	Geographical analysis		X	
GT.364	Program planning		X	
GT.365	Policy analysis		X	

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.366	Federal waiver program evaluation		X	
GT.367	Program performance monitoring		X	
GT.368	Provider reimbursement policy		X	
GT.369	Institutional rate-setting		X	
GT.370	Medical assistance policy development		X	
GT.371	Provider participation		X	
GT.372	Service delivery patterns		X	
GT.373	Adequacy of and access to care		X	
GT.374	Quality of care		X	
GT.375	Outcomes assessment		X	
GT.376	Disease management		X	
GT.377	External reporting		X	
GT.378	Public information		X	
GT.379	Managed Care Plan (MCP) planning and analysis		X	
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.	X		
GT.381	Provide a process by which reports may be delivered by email in accordance with HIPAA rules.	X		
GT.382	Provide archival storage of reports that complies with BMS records retention standards.	X		
GT.383	Ability to store reports for rapid retrieval.	X		
GT.384	Provide ability for users to extract data, manipulate the extracted data, and specify the desired format and media of the output.	X		
GT.385	Ability to display consistent BMS-approved headers and footers.	X		
GT.386	Ability to identify and use consistent report fields.	X		
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.	X		
GT.388	Ability to track and store detailed information regarding all reporting requests including, but not limited to:	X		
GT.389	Who requested the information	X		
GT.390	Date	X		
GT.391	Time	X		
GT.392	What the report included	X		
GT.393	Report storage upon completion	X		
GT.394	Route the entire history on-line.	X		
GT.395	Ability to categorize and organize reports by source system, data content, purpose, frequency and other staff selected options.	X		
GT.396	Ability to search the reports repository by date, time, report title, report ID, run date and key words.	X		
GT.397	Ability to highlight, cut, paste, and print any selection of	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	the report.			
GT.398	Ability to sort the reports list by date, time report title, run date, and other criteria.	X		
GT.399	Ability to establish and apply archival and purge parameters to reports.	X		
GT.400	Ability to easily and flexibly create new reports through an automated and user-friendly report writer tool.	X		
GT.401	Ability to use identifier mathematical functions format and manipulate data within reports.	X		
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.	X		
GT.404	The system user interface is to be compatible with user defined display settings.	X		
GT.405	Provide integrated print capability for any interface page within the MMIS.		X	
GT.406	Include at minimum the following features and capabilities:	X		
GT.407	Drill down and look up functionality to minimize re-entry of information across multiple screens.	X		
GT.408	Multi-tasking and multiple window capability, including split screens.	X		
GT.409	Search capabilities to allow retrieval by Provider, Member, ad pay, procedure code, NDC or others as defined by BMS.	X		
GT.410	Ability to tab and mouse through data fields and screens.	X		
GT.411	The system should provide menus that are understandable by non-technical users and provide secure access to all functional areas.	X		
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.	X		
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.	X		
GT.414	Ability to generate drop-down lists to identify options available, valid values, and code descriptions, by screen field.	X		
GT.415	Ability to utilize the following standards for all screens, windows, and reports:	X		
GT.416	All headings and footers standardized	X		
GT.417	Current date and local time displayed	X		
GT.418	All references to dates displayed consistently throughout the system	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.419	All data labels and definitions consistent throughout the system and clearly defined in user manuals and data element dictionaries	X		
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	X		
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).	X		
GT.423	Ability to generate alerts when changes are made to policies and procedures and system tables or functionality.		X	
GT.424	Ability to generate alerts when the anticipated return time on a query or report job exceeds a defined time limit.		X	
GT.425	Ability to generate alerts that assist in monitoring time-sensitive activities.	X		
GT.426	Ability to generate alerts to a user-defined group or individual.	X		
GT.427	Ability to generate alerts to notify staff when they need to take action in connection with workflow events.	X		
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.	X		
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.	X		
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.	X		
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.	X		
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.	X		
GT.434	Include secure and non-secure tabs.	X		
GT.435	Provide public information without requiring authentication.	X		
GT.436	Provide Internet security functionality to include firewalls,	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
	intrusion detection, and encrypted network/secure socket layer.			
GT.437	Handle PHI through authentication, along with encryption methods to secure PHI.	X		
GT.438	Ability to display and require the user to accept web site terms of agreement when entering the web portal.	X		
GT.439	Utilize an authentication process to handle multiple layers of security levels as defined by BMS.	X		
GT.440	Establish user access to predefined BMS levels such as page level, field and data element level.	X		
GT.441	The system is to provide a protected web site with secure passwords and log-ons to include:	X		
GT.442	Instructions on how to use the secure site	X		
GT.443	Site map	X		
GT.444	Contact information	X		
GT.445	Send users their initial password via email and require that they change their password at next sign-on.	X		
GT.446	Provide the ability to expire a password in a given number of days according to BMS standards.	X		
GT.447	Provide self-service password resets.	X		
GT.448	Prohibit the display of passwords at the sign-on screen when entered by the user.	X		
GT.449	Notify MMIS users at regular intervals defined by BMS that security access tables are to be cleared unless otherwise directed.	X		
GT.450	Delete account profiles after a period of inactivity as defined by BMS.	X		
GT.451	Inactive users should not be deleted from history.	X		
GT.452	Allow Providers to be authorized to access only their own claim information.	X		
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.	X		
GT.454	Include static and easily updated Web pages.	X		
GT.455	Include a desktop environment with browser capability for easy navigation.	X		
GT.456	Provide a user interface that allows all users to move easily throughout the system.	X		
GT.457	Support a menu and control system with highly flexible navigation.	X		
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.	X		
GT.459	Provide user interface features and capabilities including:	X		
GT.460	Pull down menus and window tabs	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.461	Scalable true type screen and printing fonts	X		
GT.462	Upper and lower case alphabetic characters	X		
GT.463	Ability to tab and mouse-click through data fields and screens	X		
GT.464	Use the following standards for all screens, windows, and reports:	X		
GT.465	Maintain a consistent theme throughout the site and standardize all headings and footers with index tabs as identified by BMS.	X		
GT.466	Display current date and time in a system-wide consistent format.	X		
GT.467	Utilize data labels and definitions in a system-wide consistent manner and as defined in user manuals and data element dictionaries.	X		
GT.468	Generated messages are to be available in both mixed font and mixed case formats.	X		
GT.469	Screens should distinguish between production and test environments.	X		
GT.470	Comply with the American Disabilities Act (ADA) development standards for user screens.	X		
GT.471	Comply with the Older Americans Act development standards for user screens.	X		
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.	X		
GT.473	Conform to any State, Department or Bureau specified standards regarding the look and feel of the web.	X		
GT.474	Support multiple communication lines and provide fail-over capability.	X		
GT.475	Provide growth capacity for high volumes of activity.	X		
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.	X		
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.	X		
GT.478	Allow for (HIPAA-compliant) email submission by user initiated from a link on the website.		X	
GT.479	Provide flexible web-based reporting that meets external reporting needs and requirements defined by BMS.	X		
GT.480	Ability to ensure that web portal field definitions comply with system field definitions.	X		
GT.481	Provide inquiry capabilities for categories including:	X		
GT.482	Prior Authorization (PA)	X		
GT.483	Remittance Advice (RA)	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	NO Unable to Provide
GT.484	Provider 1099 information	X		
GT.485	Other as defined by BMS during DDI		X[1]	
GT.486	Ability to generate tracking numbers for web portal-submitted Provider enrollment applications and updates.	X		
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.	X		
GT.488	Ability to allow users to download or print a copy of completed submitted forms.	X		
GT.489	Ability to accept electronic attachments via the web portal and match them to the corresponding system record (including enrollment applications).	X		
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).	X		
GT.491	The web portal should allow authorized users to perform Electronic Data Interchange (EDI) transactions, such as, but not limited:	X		
GT.492	Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant)	X		
GT.493	Interactive Claims Inquiry (276/277 – DDE compliant)	X		
GT.494	Interactive Claim Submission (DDE compliant) to allow a Provider to submit a claim, including HIPAA/EDI compliant responses	X		
GT.495	Remittance Advice (RA) (835)	X		
GT.496	Interactive claim submission (837 transactions)	X		
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)		X[1]	
GT.498	Provide the capability to display confirmation messages for requestor transactions.	X		
GT.499	Provide help screens and tutorials (e.g., guides to the Provider enrollment and Prior Authorization processes).	X		
GT.500	Provide on-line option for end-users to report any technical problems with the web application and web pages.	X		
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.	X		

Require-ment Number	Description of Requirement	YES without Customi-zation	YES with Customi-zation	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:	X		
GT.504	Cost reports		X	
GT.505	Provider acceptance of the verification report		X	
GT.506	Rate reconsideration requests		X	
GT.507	Provider correspondence		X	
GT.508	Ability to accept and transfer specified files to and from Providers to the MMIS via the web portal.	X		
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.		X	
GT.510	Ability to provide a private document page that displays a list of the available documents for each logged-in Provider.	X		
GT.511	Ability to upload rate information in batch or in bulk.	X		
GT.512	Ability to provide Provider-specific inquiry access to secured information, such as:	X		
GT.513	Automated Cost Report (ACR) (data and reports)	X		
GT.514	Error reports as part of the cost verification process	X		
GT.515	Rate setting package report	X		
GT.516	Cost verification report	X		
GT.517	Provider acceptance of the Verification report	X		
GT.518	MDS error/authorization reports	X		
GT.519	Individual Assessment Form (IAF) scores	X		
GT.520	IAF error reports	X		

Molina provides responses to RFP Appendix E.

[1] Any changes, additions, deletions or unspecified 'other' requirements to the specified requirements shall be subject to the formalized change control procedure.

Sample Reports, Forms, and Deliverable Formats

Molina Medicaid Solutions

Some of the information furnished in this proposal in response to RFP MED11014 is submitted in confidence and contain trade secrets and/or privileged or confidential information and such information shall only be disclosed for evaluation purposes. Provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of West Virginia shall have the right to use or disclose the information therein to the extent provided in the Contract. This restriction does not limit the State of West Virginia's right to use or disclose information obtained from any source, including the Proposer, without restrictions.

This information is proprietary or confidential and contains trade secret information that is privileged and is therefore exempt from disclosure under the provisions of West Virginia Code 29B-1-4.

Pages containing such proprietary or confidential trade secret information are appropriately marked.

INTRODUCTION

RFP Requirement 3.2.2 The Vendor should also propose a comprehensive initial Project Management Plan that describes how they intend to complete each phase of the project. The Plan should include (but not be limited to) the following: - Tab D

1. *Work Breakdown Structure and Deliverable 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 at a minimum:*
   a. *Scope Management Plan*
   b. *Schedule Management Plan*
   c. *Cost Management Plan*
   d. *Quality Management Plan*

   Human Resources Management Plan
   e. *Communications Management Plan*
   f. *Risk Management Plan*
   g. *Issue Management Plan*
   h. *Change Management Plan*
   i. *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. *Transition Plan*
11. *Weekly Status Report Template*
12. *Monthly Status Report Template*

Molina Medicaid Solutions (Molina) has extensive, recent experience creating and delivering quality project deliverables. Each sample provided includes a table of contents as well as a sufficient number of pages to demonstrate Molina's ability to produce the required deliverable. Each representative sample consists of:

- A cover page indicating the sample's title
- An introduction which describes how the sample is assembled, including hypertext links to the various sections, if applicable
- Table of contents followed by deliverable excerpts.

Figure D-1 contains a list of samples provided:

Figure D-1: Sample Reports, Forms, and Deliverable Formats

APPENDIX	REPRESENTATIVE SAMPLE DELIVERABLE TITLE
D01	Proposed Project Management Plan
D02	WBS and Deliverable Dictionary
D03	Project Schedule
D04	Staffing Plan
D05	Facility Plan
D06	Documentation Management Plan
D07	Training Plan
D08	Testing Plan
D09	Scope Management Plan
D10	Scheduled Management Plan
D11	Cost Management Plan
D12	Quality Management Plan
D13	Human Resource Management Plan
D14	Communication Management Plan
D15	Risk Management Plan
D16	Issue Management Plan
D17	Change Management Plan
D18	Integration Management Plan
D19	Workflow Management Plan
D20	Transition Plan
D21	Weekly Status Report Template
D22	Monthly Status Report Template
D23	Certification Readiness Plan
D24	Implementation Plan
D25	Problem Management Plan
D26	Technical Architecture Description

Molina provides examples of all requested DDI deliverables specified in the RFP.

All sample deliverables contain confidential and proprietary information and have been redacted.

Please refer to Section E for the initial deliverables required by the RFP.

Initial Start–Up Phase Plans Approach and Methodology

Initial Deliverables

Molina Medicaid Solutions

INTRODUCTION

RFP Requirement 3.2.6.1.1: The Vendor should also include in their proposal the following plans and their components:

1. *Comprehensive, initial 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.*
2. *Comprehensive, initial Configuration Management Plan*
3. *Comprehensive, initial Data Conversion Plan*
4. *Comprehensive, initial Disaster Recovery and Business Continuity Plan,*
5. *Comprehensive, initial Data and Records Retention Plan*

Molina Medicaid Solutions (Molina) has extensive, recent experience creating and delivering quality project deliverables. Each initial deliverable provided includes a table of contents as well as a sufficient number of pages to demonstrate Molina's ability to produce the required deliverable. Each representative sample consists of:

- A cover page indicating the initial deliverable's title
- An introduction which describes how the initial deliverable is assembled
- Table of contents followed by initial deliverable excerpts.

Figure E-1 contains a list of initial deliverables provided:

Figure E-1: Initial Deliverables

NUMBER	INITIAL DELIVERABLE TITLE
E01	Security, Privacy and Confidentiality Plan
E02	Configurations Management Plan
E03	Data Conversion Plan
E04	Disaster Recovery and Business Continuity Plan
E05	Data Retention and Records Plan

Molina provides all RFP-requested DDI initial deliverables.

All initial deliverables contain confidential and proprietary information and have been redacted.

Please refer to Section D for sample deliverables and reports specified to be delivered with the proposal.

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