Iowa Medicaid Enterprise System Services Request for Proposal

RFP MED-12-001

Incorporating Amendments 1, 2, 3, 4,5 and 6

Release Date: June 6, 2011
Proposal Due Date: September 16, 2011

Fields of Opportunities

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

June 6, 2011

Dear Bidders:

Thank you for your interest in the Iowa Medicaid Enterprise System Services Procurement. You are invited to submit bid proposals in accordance with the attached Request for Proposals (RFP) MED-12-001. The Department of Human Services (referred to as the Department) will select contractors to provide the services described in this RFP.

Bidders may offer bid proposals for the Core MMIS scope of work (systems and operations), the Pharmacy Point- of- Sale (POS) scope of work (systems and operations) or both. Each individual component proposal must be self-sufficient. Bidders must submit each component proposal separately according to the submittal requirements described by this RFP.

The Department will hold a bidders' conference on the date listed in RFP Section 2.1 Procurement Timetable at a location and time to be determined. Although attendance at the bidders' conference is not a mandatory requirement for submission of a proposal, the Department strongly encourages bidders to attend. Bidders that have submitted **a Letter of Intent to Bid** may submit written questions beginning Wednesday, June 07, 2011 through Wednesday, June 29, 2011, via e-mail to: medicaidrfp@dhs.state.ia.us for the purpose of clarifying the RFP's contents. **All bid proposals must be submitted by September 2, 2011, at or before 3:00 p.m. Central Time to**:

Mary Tavegia
Issuing Officer
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

Regardless of the reason, late responses will not be considered and will be disqualified.

Responses must be signed by an official authorized to bind the bidder to the scope of work for the RFP component bid under consideration. Also, please include your federal identification number on the transmittal letter of your response. Evaluation of bid proposals and selection of bidders will be completed as quickly as possible after receipt of responses.

The Department looks forward to receiving your bid proposals.

Regards,

Mary Tavegia
Issuing Officer, RFP MED-12-001
Iowa Department of Human Services

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1 PROCUREMENT OVERVIEW

In alignment with the Centers for Medicare & Medicaid Services (CMS) Medicaid Information Technology Architecture (MITA), the State of Iowa currently operates a modular Medicaid business model using multiple contractors and operating a certified Medicaid Management Information System (MMIS). This unique business model is a complex, modular MMIS structure that requires an interdependence of the various modules as well as their supporting contracts.

In anticipation of an orderly transition of the current system services contracts that are expiring, the state must competitively procure these services. The following sections highlight the content of this procurement:

1.1: Procurement Background

1.2: Request for Proposal (RFP) Purpose

1.3: Authority

1.4: RFP Summary

1.5: RFP Organization

1.1 Procurement Background

The Iowa Department of Human Services (DHS) is represented as the Department throughout this RFP) is the single state agency responsible for administering the Medicaid program in Iowa. The Iowa Medicaid Program reimburses providers for delivery of services to eligible Medicaid members under Title XIX of the Social Security Act through enrolled providers and health plans.

The Department directs the Iowa Medicaid Enterprise (IME), which comprises state management of the Iowa Medicaid Program and the third-party professional services and systems services contractors that jointly administer the Iowa Medicaid Program. The Department has determined that the continuation of the current business model provides the best operational support to the Iowa Medicaid Program.

The Department chooses to continue with the IME in contracting for best-practice approaches from a variety of vendors for the professional services and system services that support the Iowa Medicaid Program operation. Procurement of the system services is required, as contracts for system services will expire on June 30, 2013. The Department is procuring system services at this time for the following:

- MMIS and Core MMIS operations
- Pharmacy Point-of-Sale (POS) System and POS operations

Bidders may offer bid proposals on one or both systems and related operations, but each individual proposal must be self-contained and self-sufficient.

The Iowa MMIS has been in continuous operation since October 1979. It has evolved continually as a result of phased-in developments and enhancements. The Iowa MMIS is currently certified and eligible for 75 percent federal financial participation (FFP) under 42 Code of Federal Regulations (CFR), Part 433, Subpart 3 and Section 1903(a)(4) of the Social Security Act.

1.2 RFP Purpose

The Department's purpose for this procurement is to promote fair, impartial and open competition among all prospective bidders for system services business and technical processes for the Iowa Medicaid Program. As an outcome of the required procurement, the Department intends to meet the following objectives:

To secure contractors to support the unique and highly complex nature of Iowa's modular Medicaid program administration structure.

To replace the Iowa MMIS and POS systems to meet all federal and state requirements as stated in the CFR and the needs of Iowa as listed in the RFP. These systems must meet all requirements for CMS certification.

The MMIS and POS systems meet the system requirements, standards and conditions in Part 11 of the State Medicaid Manual, as periodically amended.

The new vision of IME is modular, with a flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming, available in both electronic and hard copy readable formats. The new vision for the IME is comprised of the following modules:

- Member Management
- Provider Management
- Claims Receipt
- Claims Adjudication
- Prior Authorization
- Reference Data Management
- Third-Party liability Management
- Health Insurance Premium Payment
- Program Management Reporting
- Federal Reporting
- Financial Management
- Program Integrity Management
- Managed Care
- Waiver, Facility and Enhanced State Plan Services Management
- Immunization Registry Interface
- Pharmacy Point-of-Sale
- Rules Engine System
- Web Portal
- Workflow Imaging and Document Management
- Electronic Data Management and Automatic Letter Generation

- Call Center Management System*
- Program Integrity*
- Right Fax*
- Data Warehouse/Decision Support (DW/DS)*

** These modules are not being replaced during this procurement.*

The systems architecture and framework developed by the CORE MMIS contractor must be interoperable with other state enterprise-wide applications, including the state-wide health information exchange and the eligibility systems. The contractor must participate in activities that align data sources where it is determined to be in the best interest of the state, including but not limited to the creation of an enterprise-wide provider directory and member identity management. Respondents to this RFP must comply with the Enhanced Funding Requirements: Seven Conditions and Standards, Medicaid IT Supplement (MITS-11-01-v1.0). Additionally, the MMIS must remain compliant with Section 1104 of Patient Protection and Affordable Care Act (PPACA).

The resultant winners of the contract awards will perform all contractor responsibilities of the respective system services components, as defined by this RFP and its supporting documentation, throughout the duration of the contract as specified in the sample contract in RFP Attachment O Sample Contract.

1.3 Authority

This RFP is issued under the authority of Title XIX of the Social Security Act (as amended), the regulations issued under the authority thereof, and the provisions of the Code of Iowa and rules of the Iowa Department of Administrative Services (DAS). All bidders are charged with presumptive knowledge of all requirements of the cited authorities, as well as any system services performance review standards. The submission of a valid bid proposal by any bidder will constitute admission of such knowledge on the part of the bidder.

1.4 RFP Summary

The Department's objective for this procurement is to maintain the current business model of the cohesive IME with "best-of-breed" contractors located with state staff at a common facility. The IME is not unlike the conceptual view of the operation of a managed care organization (MCO) or health maintenance organization (HMO). This strategy allows the state to retain greater responsibility for the operation and direction of healthcare delivery to Medicaid members in Iowa.

RFP Section 4 Operating Environment describes the tools that are in place for the IME system services component contractors. As part of their operation, all contractors operating within the IME will use the following existing, common managerial tools where necessary to perform their functions:

- **OnBase is the current workflow process management system. The new Core MMIS contractor has the option to replace the workflow process management system or operate and maintain the current workflow system**.
- The Data Warehouse/Decision Support (DW/DS) system that the state operates and maintains.

- The Cisco Unified Contact Center Express contact management (call center) system.

Of particular importance is the Department's intent to award individually the system services and related operations in this RFP to obtain the most effective services available today. The Department intends to purchase the managerial skills and knowledge specific to each system services component from vendors with specializations and staff expertise in the designated administrative management areas.

Bidders may choose to bid one of the two scopes of work; MMIS and Core MMIS operations or POS system and POS operations. A primary vendor may partner with a subcontractor to achieve a full set of services for either scope of work.

A bidder may choose to bid both scopes of work; however each bid must be a separate and distinct proposal so it may be evaluated independently.

The system services contractors will continue to support a federally certified MMIS and comply with relevant mandates under the Health Insurance Portability and Accountability Act (HIPAA) legislation. The co-location with state staff and staff from other functional IME contractors will continue to yield significant efficiencies for the IME, allowing the state to continue to provide a highly effective level of service for both members and providers alike.

Bidders will describe a complete solution for each component that they bid on, including a work plan to prepare for operations. Work plans should contain tasks and subtasks, duration, resources, milestones and deliverables, and target dates for the milestones and deliverables. All dates are subject to change, as they will be reviewed and integrated into the overall IME design, development and implementation (DDI) work plan.

Since this procurement has the potential of resulting in two contracts, the identification and explanation of all interfaces and inputs that the bidder's solution requires from other IME contractors is an important evaluation criterion. As such, the work plan for each proposal submitted must also identify the required interfaces to other key data sources. During DDI, it is essential that each contractor specify any contractor interface-related decision support requirements or capabilities that the DW/DS team can develop to streamline business processes for the IME.

Bidders who are awarded contracts will be required to work with the professional services contractors and state technical staff to support integration of the respective work plans into the overall project plan for the IME. RFP Section 2.1 Procurement Timetable identifies the timeframe that bidders who have been awarded contracts will have after contract award in which to complete all transition-related tasks.

The Core MMIS contractor must implement all hardware and software required to support the MMIS in the Iowa Data Center located in Des Moines, Iowa and is responsible for operation and maintenance of the hardware and software for a period ending one month after the MMIS is certified by CMS unless IME elects to exercise the option to extend the contractor operation and maintenance for one or more years. Once the Core MMIS contractor ends the operation and maintenance phase, responsibility of all hardware and software licenses will be transferred to the Department.

The POS is to be implemented and operated on contractor hardware and software.

1.5 RFP Organization

This RFP contains the following primary sections:

Section 1: Procurement Overview

Section 2: Procurement Process

Section 3: Program Description

Section 4: Operating Environment

Section 5: General Requirements

Section 6: Start-Up and Implementation Phases

Section 7: MMIS and POS System Requirements

Section 8: MMIS and POS Operational Requirements, Certification and Turnover Phases

Section 9: Proposal Format and Content

Section 10: Evaluation Process

Section 11: Attachments

2 PROCUREMENT PROCESS

This section includes the following topics:

2.1: Procurement Timetable

2.2: Issuing Officer

2.3: Communication Restrictions

2.4: RFP Amendments

2.5: RFP Intent

2.6: Resource Library

2.7: Bidders' Conference

2.8: Letter of Intent to Bid

2.9: Questions and Clarification Requests

2.10: Proposal Amendments and Withdrawals

2.11: Proposal Submission

2.12: Proposal Opening

2.13: Proposal Preparation Costs

2.14: Proposal Rejection

2.15: Disqualification

2.16: Nonmaterial Variances

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2.19: Proposal Content Verification

2.20: Proposal Clarification

2.21: Proposal Disposition

2.22: Public Records and Requests for Confidential Treatment

2.23: Copyrights

2.24: Release of Claims

2.25: Oral Presentations

2.26: Proposal Evaluation

2.27: Financial Viability Review

2.28: Notice of Intent to Award

2.29: Acceptance Period

2.30: Review of Award Decision

2.31: Definition of Contract

2.32: Choice of Law and Forum

2.33: Restrictions on Gifts and Activities

2.34: No Minimum Guaranteed

2.1 Procurement Timetable

The following dates are informational. The Department reserves the right to change the dates.

Table 1: IME System Services Procurement Timetable

Key Procurement Task	Date
Issue System Services Request For Information (RFI)	February 21, 2011
Vendor Demonstration Day(s)	March 15-16, 2011
System Services RFI comments due	March 22, 2011
Review and Finalize System Services RFP for CMS approval	March 22, 2011
System Services RFP to CMS for approval	March 29, 2011 – May 27, 2011
Notice of intent to issue System Services RFP	April 08, 2011
Issue System Services RFP	June 06, 2011
Letter of intent to bid requested	June 07, 2011 – July 13, 2011
Bidders' questions due	June 07, 2011 – July 13, 2011
Bidders' Conference	June 21, 2011
Written responses to bidders' questions	July 27, 2011
Bidder's clarifications to Department responses	August 3, 2011 (3:00 pm CT)
Department clarification responses	August 12, 2011
Closing date for receipt of bid proposals and amendments	September 16, 2011 (3:00 pm CT)
Systems Services RFP Evaluation	September 19, 2011 – November 21, 2011
Oral presentations	October 31, 2011 – November 04, 2011
Best and final offers requested	November 10, 2011
Best and final offers due	November 15, 2011
Recommendations to Medicaid Director	November 22, 2011
CMS evaluations and intent to award approvals	November 23, 2011 – December 16, 2011
Notice of intent to award to successful bidders	December 21, 2011
Completion of contract negotiations and execution of the contract	January 03, 2012 – January 10, 2012
CMS contract approval	January 11, 2012
Design, Development and Implementation (DDI)	February 01, 2012 – September 30, 2014 (32 months)
Begin Operations	October 01, 2014

2.2 Issuing Officer

The issuing officer is the sole point of contact regarding the RFP from the date of issue until the Department selects the successful bidders.

Mary Tavegia, Issuing Officer
RFP MED-12-001
Contract Administrator
Iowa Department of Human Services
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

2.3 Communication Restrictions

From the issue date of this RFP until announcement of the successful bidder, bidders may contact only the issuing officer or designee. The Department may disqualify bidders if they contact any state employee other than the issuing officer or designee regarding this RFP.

The issuing officer will respond only to questions regarding the procurement process. The Department requests that bidders submit their point of contact for any required bidder follow-up by the Department's issuing officer. Bidders must submit questions related to the procurement process in writing by mail to the issuing officer or by e-mail to *medicaidrfp@dhs.state.ia.us* by 3:00 p.m., Central Time on the due date for questions listed in RFP Section 2.1 Procurement Timetable or in writing at the bidders' conference on the date listed in the timetable. Questions related to the interpretation of the RFP follow the protocol set forth by Section 2.9. The Department will not accept verbal questions related to the procurement process.

2.4 RFP Amendments

The Department will post all amendments at *http://www.ime.state.ia.us/* in the Iowa Medicaid Enterprise Systems Procurement link. The Department advises bidders to check the Department's homepage periodically for any amendments to this RFP, particularly if the bidder originally downloaded the RFP from the Internet. The Department will require bidders to acknowledge receipt of subsequent amendments within their proposals. If the bidder requested this RFP in writing from the Department, the bidder will automatically receive all amendments.

2.5 RFP Intent

The Department intends that this RFP provide bidders with the information necessary to prepare a competitive bid proposal. This RFP process is for the Department's benefit and the Department intends that it provide the Department with competitive information to assist in the selection of bidders to provide the desired services. Each bidder is responsible for determining all factors necessary for submission of a comprehensive bid proposal.

2.6 Resource Library

A resource library is available electronically for potential bidders to review material relevant to the RFP. Information on how to obtain access to the electronic resource library will be available

at *http://www.ime.state.ia.us/IMEResourceLibrary.html.* RFP Attachment K lists materials that will be available in the resource library.

2.7 Bidders' Conference

A bidders' conference will be held on the date listed in RFP Section 2.1 Procurement Timetable at a location to be determined by the Department. Although attendance at the bidders' conference is not a mandatory requirement for submission of a proposal, the Department strongly encourages bidders to attend.

The purpose of the bidders' conference is to discuss with prospective bidders the work to be performed and to allow prospective bidders an opportunity to ask questions regarding the RFP. The Department will not consider verbal discussions at the bidders' conference to be part of the RFP unless confirmed in writing by the Department and incorporated as an amendment to this RFP. The Department will record the conference. The Department may defer questions that bidders ask at the conference that the Department cannot answer completely during the conference. The Department will post a copy of the questions and answers on the Department's web site at *http://www.ime.state.ia.us/* in the Iowa Medicaid Enterprise Systems Procurement link.

2.8 Letter of Intent to Bid

Submitting a letter of intent to bid is optional. If bidders choose to submit one, they may mail, send via delivery service or hand deliver (by the bidder or the bidder's representative) a letter of intent to bid to the issuing officer by 3:00 p.m., Central Time on the due date listed in RFP Section 2.1 Procurement Timetable. The letter of intent to bid shall include:

- The bidder's name and mailing address
- Name and e-mail address for designated contact person
- Telephone and facsimile (fax) numbers for designated contact person
- A statement of intent to bid for the specified contract

The Department will not accept electronic mail or faxed letters of intent to bid. The Department asks bidders who plan to submit bid proposals for multiple RFP functions to submit separate letters of intent to bid for each function on which they intend to bid. The Department's receipt of a letter of intent ensures the sender's receipt of written responses to bidders' questions in the formal question-and-answer process, comments and any amendments to the RFP.

2.9 Questions and Clarification Requests

The Department invites bidders to submit written questions and requests for clarifications regarding the RFP. **The Department must receive a letter of intent to bid from the bidder in order for the Department to respond to the bidder's questions**. Any ambiguity concerning the RFP, as well as the contract language in Attachment O must be addressed through the question and answer process, as bidders are prohibited from including assumptions in their bid proposals. The issuing officer must receive the written questions or requests for clarifications before 3:00 p.m., Central Time by the due date in RFP Section 2.1 Procurement Timetable. The Department will not respond to verbal questions. If the question or request for

clarification pertains to a specific section of the RFP, then the question or request for clarification must reference the RFP page and section numbers.

Bidders must submit questions and comments to the issuing officer by mail or electronic mail and not via fax. For questions via e-mail, bidders should use the following e-mail address: *medicaidrfp@dhs.state.ia.us.*

The Department will respond to bidders' questions and responses to requests for clarifications on or before the date listed in RFP Section 2.1 Procurement Timetable to bidders who have submitted a letter of intent to bid. Responses to questions will be available on the Department's web site at *http://www.ime.state.ia.us/* in the Iowa Medicaid Enterprise Systems Procurement link.

The Department will not consider the written responses to be part of the RFP. If the Department decides to modify the RFP based on the written responses, the Department will issue an appropriate amendment to the RFP. The Department assumes no responsibility for verbal representations made by its officers or employees unless the Department confirms such representations in writing and incorporates them into the RFP.

2.10 Proposal Amendments and Withdrawals

The Department reserves the right to amend this RFP at any time. If the amendment occurs after the closing date for receipt of bid proposals, the Department may, in its sole discretion, allow bidders to amend their bid proposals in response to the Department's amendment if necessary.

The bidder may also amend its bid proposal prior to the proposal due date specified in RFP Section 2.1 Procurement Timetable. The bidder must submit the amendment in writing, sign it and mail it to the issuing officer before the deadline for the final receipt of proposals (unless the Department extends this date). The Department will not accept e-mail or faxed bid proposal amendments.

Bidders, who submit bid proposals in advance of the deadline, may withdraw, modify or resubmit proposals at any time prior to the deadline for submitting proposals. Bidders that modify a bid proposal that has already been submitted must submit modified sections along with specific instructions identifying the pages or sections being replaced. The Department will accept modifications only if bidders submit them prior to the deadline for final receipt of proposals. Bidders must notify the issuing officer in writing if they wish to withdraw their bid proposals. The Department will not accept e-mail or faxed requests to withdraw.

2.11 Proposal Submission

The Department must receive the bid proposal, addressed as identified below, before 3:00 p.m., Central Time on the due date in RFP Section 2.1 Procurement Timetable.

Mary Tavegia, Issuing Officer
RFP MED-12-001
Contract Administrator
Iowa Department of Human Services
Iowa Medicaid Enterprise

200 Army Post Road, Suite 2
Des Moines, Iowa 50315

The Department will not waive this mandatory requirement. The Department will reject any bid proposal received after this deadline and return it unopened to the bidder. Bidders must allow ample delivery time to ensure timely receipt of their bid proposals. It is the bidder's responsibility to ensure that the Department receives the bid proposal prior to the deadline. Postmarking by the due date will not substitute for actual receipt of the bid proposal by the Department. The Department will not accept e-mail or faxed bid proposals.

Bidders must furnish all information necessary for the Department to evaluate the bid proposal. The Department may disqualify bid proposals that fail to meet the requirements of the RFP which are located in Attachment L. The Department will not consider verbal information from the bidder to be part of the bidder's proposal.

2.12 Proposal Opening

The bid proposal opening by the issuing officer is an informal process, the bid proposals will remain confidential until the Evaluation Committee has reviewed all of the bid proposals submitted in response to this RFP and the Department has announced a Notice of Intent to Award a contract. Upon request, the Department may disclose the identity of bidders who have submitted letters of intent to bid or bid proposals.

2.13 Proposal Preparation Costs

The costs of preparation and delivery of the bid proposals are solely the responsibility of the bidders.

2.14 Proposal Rejection

The Department reserves the right to reject any or all bid proposals in response to this RFP, in whole or in part, and to cancel this RFP at any time prior to the execution of a written contract. Issuance of this RFP in no way constitutes a commitment by the Department to award a contract.

2.15 Disqualification

The Department reserves the right to eliminate from the evaluation process any bidder not fulfilling all requirements of this RFP. Failure to meet a requirement shall be established by any of the following, as well the specifics outlined by RFP Attachment L Bid Proposal Requirements Checklist:

a. The bidder fails to deliver the bid proposal by the due date and time as defined in the RFP section 2.1 Procurement Timetable.

b. The bidder fails to deliver the Cost Proposal in a separate, sealed envelope in the same box(es) with Technical Proposals.

c. The bidder states that a service requirement cannot be met.

d. The bidder's response materially changes a service requirement.

e. The bidder's response limits the rights of the Department.

f. The bidder fails to include information necessary to substantiate that the bidder will be able to meet a service requirement. A response of “will comply” or merely repeating the requirement is insufficient.

g. The bidder fails to respond to the Department’s request for information, documents or references.

h. The bidder fails to include a bid proposal security in its Cost Proposal.

i. The bidder fails to include any signature, certification, authorization, stipulation, disclosure or guarantee requested in this RFP.

j. The bidder fails to comply with other mandatory requirements of this RFP.

k. The bidder presents the information requested by this RFP in a format inconsistent with the instructions of the RFP.

l. The bidder initiates unauthorized contact regarding the RFP with state employees.

m. The bidder provides misleading or inaccurate responses.

n. The bidder includes assumptions in its bid proposal. Any ambiguity concerning the Department’s needs must be addressed through the question and answer process.

Bidders are to follow the requirements set forth in this RFP. However, it is not the Department’s intent to disqualify bid proposals that suffer from correctible flaws. At the same time, it is important to maintain fairness to all bidders in the procurement process. Therefore, the Department reserves the discretion to permit cure of variances, waive variances or disqualify bid proposals.

2.16 Nonmaterial Variances

The Department reserves the right to waive or permit cure of material and nonmaterial variances in the bid proposal if the Department determines it to be in the best interest of the Department to do so. Nonmaterial variances include minor informalities that do not affect responsiveness, that are merely a matter of form or format, that do not change the relative standing or otherwise prejudice other bidders, that do not change the meaning or scope of the RFP or that do not reflect a material change in the services.

The determination of whether or not to disqualify a proposal and not consider it for award of a contract for any of these reasons or to waive or permit cure of variances in bid proposals, is at the sole discretion of the Department. No bidder shall obtain any right by virtue of the Department’s election to not exercise that discretion. In the event the Department waives or permits cure of nonmaterial variances, such waiver or cure will not modify RFP requirements or excuse the bidder from full compliance with RFP specifications or other contract requirements if the bidder is awarded the contract. The determination of materiality is in the sole discretion of the Department.

2.17 Reference Checks

The Department reserves the right to contact any reference provided in the bidder’s response as a means to assist in the evaluation of the bid proposal, to verify information contained in the bid proposal and to discuss the bidder’s qualifications and the qualifications of any key personnel or subcontractors identified in the bid proposal.

2.18 Information from Other Sources

The Department reserves the right to obtain and consider information from other sources about a bidder, such as the bidder's capability and performance under other contracts.

2.19 Proposal Content Verification

The content of a bid proposal submitted by a bidder is subject to verification. Misleading or inaccurate responses shall result in disqualification.

2.20 Proposal Clarification

The Department reserves the right to contact a bidder after the submission of bid proposals for the purpose of clarifying a bid proposal to ensure mutual understanding. This contact may include written questions, interviews, site visits, and a review of past performance if the bidder has provided goods or services to the Department or any other political subdivision wherever located or requests for corrective pages in the bidder's proposal.

The Department will not consider information received if the information materially alters the content of the bid proposal or alters the services the bidder is offering to the Department. An individual authorized to legally bind the bidder shall sign responses to any request for clarification. Responses shall be submitted to the Department within the time specified in the Department's request.

2.21 Proposal Disposition

All bid proposals become the property of the Department. The Department will not return them to the bidder. At the conclusion of the selection process, the contents of all bid proposals will be in the public domain and be open to inspection by interested parties subject to exceptions provided in Iowa Code Chapter 22 or other applicable law.

2.22 Public Records and Requests for Confidential Treatment

The Department may treat all information submitted by a bidder as public information following the conclusion of the selection process unless the bidder properly requests that information be treated as confidential at the time of submitting the bid proposal. Iowa Code Chapter 22 governs the Department's release of information. Bidders are encouraged to familiarize themselves with Chapter 22 before submitting a proposal. The Department will copy public records as required to comply with the public records laws.

Bidders must include any request for confidential treatment of information in the transmittal letter with the bidder's proposal. In addition, the bidder must enumerate the specific grounds in Iowa Code Chapter 22 that support treatment of the material as confidential and explain why disclosure is not in the best interest of the public. The request for confidential treatment of information must also include the name, address and telephone number of the person authorized by the bidder to respond to any inquiries by the Department concerning the confidential status of the materials. RFP Section 9 Proposal Format and Content provides information about this request and other transmittal letter requirements.

The bidder must mark conspicuously on the transmittal letter any bid proposal that contains confidential information, itemize all pages with confidential material under the above-referenced "request for confidential treatment of information" section of the transmittal letter, and conspicuously mark (in the footer) as containing confidential information each page upon which confidential information appears. The Department will deem identification of the entire bid proposal as confidential to be nonresponsive and disqualify the bidder.

If the bidder designates any portion of the bidder's proposal as confidential, the bidder will submit a "sanitized" copy of the bid proposal from which the bidder has excised the confidential information. The excised copy is in addition to the number of copies requested in RFP Section 9 Proposal Format and Content. The bidder must excise the confidential material in such a way as to allow the public to determine the general nature of the removed material and to retain as much of the bid proposal as possible. RFP Section 9 Proposal Format and Content provides Instructions for the "sanitized copy."

The Department will treat the information marked confidential as confidential information to the extent that such information is determined confidential under Iowa Code Chapter 22 or other applicable law by a court of competent jurisdiction. In the event that the Department receives a request for information marked confidential, written notice shall be given to the bidder at least seven days prior to the release of the information to allow the bidder to seek injunctive relief pursuant to Section 22.8 of the Iowa Code.

The Department will deem the bidder's failure to request confidential treatment of material as a waiver by the bidder of their right to confidentiality.

2.23 Copyrights

By submitting a bid proposal, the bidder agrees that the Department may copy the bid proposal for purposes of facilitating the evaluation of the bid proposal or to respond to requests for public records. The bidder consents to such copying by submitting a bid proposal and represents/warrants that such copying will not violate the rights of any third party. The Department shall have the right to use ideas or adaptations of ideas that bid proposals present.

2.24 Release of Claims

By submitting a bid proposal, the bidder agrees that it will not bring any claim or cause of action against the Department based on any misunderstanding concerning the information provided herein or concerning the Department's failure, negligent or otherwise, to provide the bidder with pertinent information as intended by this RFP.

2.25 Oral Presentations

The Department will request bidder finalists to make an oral presentation of the bid proposal. The Department will ask bidders that are finalists for more than one RFP component to present all component presentations together. RFP Section 10 Evaluation Process provides additional information on the oral presentations process and the subsequent best and final offer process.

The presentation will occur at a facility located in Des Moines, Iowa. The determination of participants, location order and schedule for the presentations (that the Department will provide during the evaluation process) is at the sole discretion of the Department. The presentation may include slides, graphics or other media that the bidder selects to illustrate the bidder's

proposal. The presentation shall not materially change the information contained in the bid proposal.

2.26 Proposal Evaluation

The Department will review in accordance with RFP Section 10 Evaluation Process all bid proposals that bidders submit in a timely manner and that meet the mandatory submittal requirements of this RFP. The Department will not necessarily award any contract resulting from this RFP to the bidder offering the lowest cost to the Department. Instead, the Department will award each individual contract to the compliant bidder whose bid proposal receives the most points in accordance with the evaluation criteria set forth in RFP Section 10 Evaluation Process. Moreover, the Department may choose not to award a contract for a particular component. The recommendations for award of contracts presented by the evaluation committees are subject to final approval and sign-off by the State Medicaid Director.

2.27 Financial Viability Review

For each of the components, the compliant bidder whose bid proposal receives the most points in accordance with the evaluation criteria is subject to a review for financial viability. The Department may designate a third party to conduct a review of financial statements, financial references and any other financial information that the compliant bidder provides in the Company Financial Information section of the bid proposal.

2.28 Notice of Intent to Award

The Department will send by e-mail a notice of intent to award for each contract to all bidders who have submitted a timely bid proposal. The notices of intent to award are subject to execution of a written contract and, as a result; do not constitute the formation of contracts between the Department and the apparent successful bidders.

2.29 Acceptance Period

The Department and the apparent successful bidders will complete negotiation and execution of the contracts by the due date that RFP Section 2.1 Procurement Timetable specifies. If an apparent successful bidder fails to negotiate and execute a contract, the Department (in its sole discretion) may revoke the award and award the contract to the next highest ranked bidder or withdraw the RFP. The Department further reserves the right to cancel the award at any time prior to the execution of a written contract.

2.30 Review of Award Decision

Bidders may request review of the award decision by filing a judicial review action pursuant to Iowa Code Chapter 17A.19.

2.31 Definition of Contract

The full execution of a written contract shall constitute the making of a contract for services. No bidder shall acquire any legal or equitable rights relative to the contract services until the Department and the apparent successful bidders have fully executed the contract.

2.32 Choice of Law and Forum

The laws of the State of Iowa govern this RFP and resultant contract, excluding the conflicts of law provisions of Iowa law. Changes in applicable laws and rules may affect the award process or the resulting contract. Bidders are responsible for ascertaining pertinent legal requirements and restrictions. Any and all litigation or actions commenced in connection with this RFP shall be brought in the appropriate Iowa forum.

2.33 Restrictions on Gifts and Activities

Iowa Code Chapter 68B restricts gifts which may be given or received by state employees and requires certain individuals to disclose information concerning their activities with state government. Bidders are responsible to determine the applicability of this chapter to their activities and to comply with the requirements. In addition, pursuant to Iowa Code Section 722.1, it is a felony offense to bribe or attempt to bribe a public official.

2.34 No Minimum Guaranteed

The Department anticipates that the selected bidder(s) will provide services as the Department requests. The Department will not guarantee any minimum compensation to be paid to the bidder(s) or any minimum usage of the bidder(s) services.

3 PROGRAM DESCRIPTION

The following sections provide an overview of the Iowa Medicaid Program:

3.1: Medicaid Program Administration

3.2: Overview of Present Operation

3.3: Summary of Program Responsibilities

3.1 Medicaid Program Administration

Multiple state and federal agencies administer the Iowa Medicaid Program. The following sections describe their roles.

3.1.1: Iowa Department of Human Services

3.1.2: United States (U.S.) Department of Health and Human Services

3.1.3: Iowa Medicaid Enterprise Professional Services

3.1.1 Iowa Department of Human Services

The Iowa Department of Human Services (the Department) is the single state agency responsible for the administration of the Iowa Medicaid Program. The Department has six divisions, five field services area offices, and nine state facilities that serve developmentally disabled, mentally ill or juvenile clients. The six divisions of the Department include:

a. The Division of Fiscal Management.

b. The Division of Data Management.

c. The Division of Field Operations.

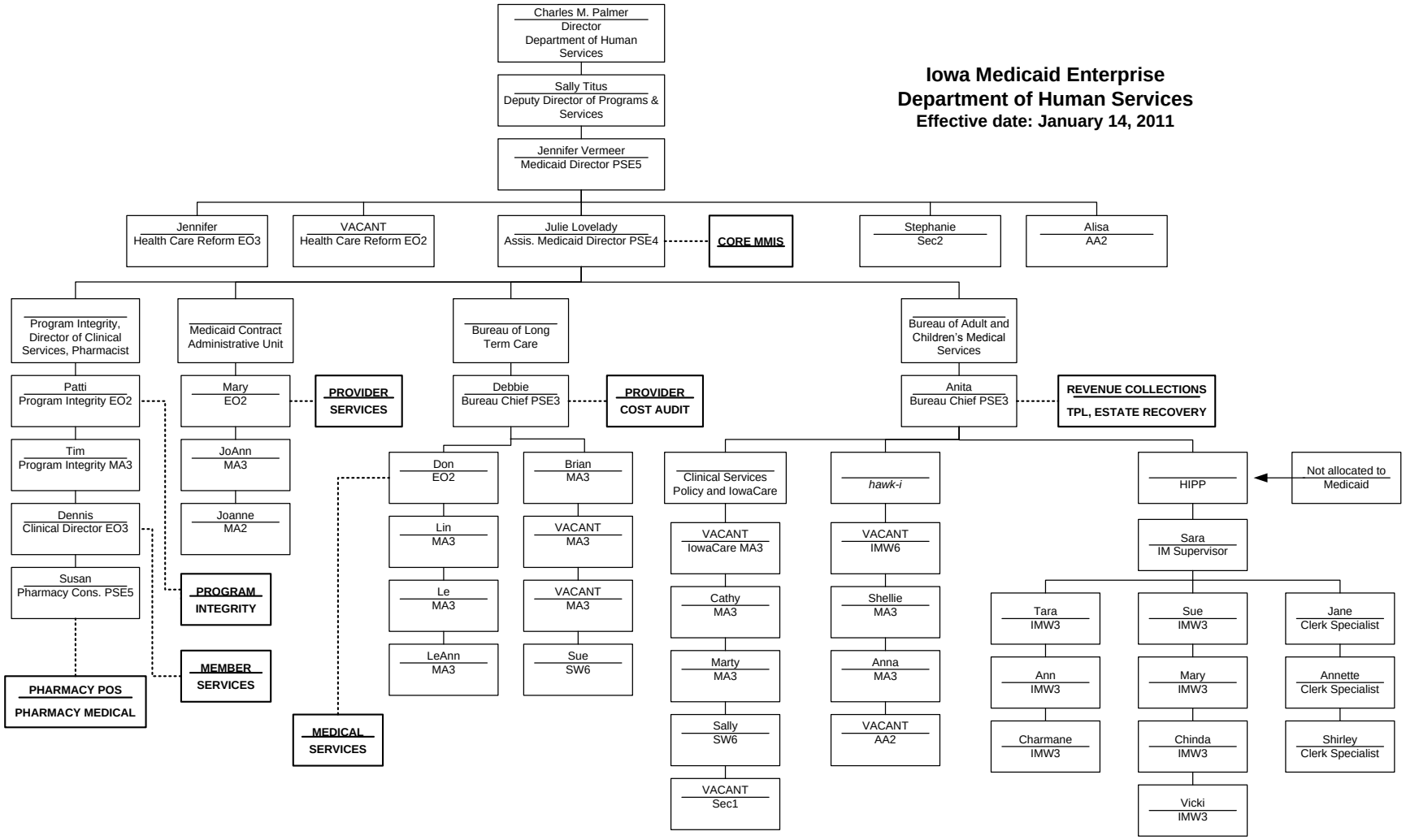
d. The Division of Adult, Children, and Family Services.

e. The Division of Mental Health and Disability Services.

f. Iowa Medicaid Enterprise.

The responsibilities for the Medicaid program have been dispersed within the Division of Adult, Children, and Family Services, the Division of Data Management, the Division of Fiscal Management , Division of Mental Health and Disability Services and the Iowa Medicaid Enterprise (led by the State Medicaid Director), all reporting to the Director for the Department. The Iowa Medicaid Enterprise governs the Bureau of Long Term Care, the Bureau of Medical Management and Health Plan Contracting, the Bureau of Health Insurance Premium Payment (HIPP) and *hawk-i*. The work of these bureaus has significant impact on the Medicaid policy. Primary responsibility for the MMIS rests with the Core MMIS contractor supported by the Department of Administrative Services Information Technology Division. The Core MMIS contract, as are all contracts, is under the management of the IME through a contract manager. Ancillary systems (many of these systems have become part of system services procurement) are supported by the Department's Division of Data Management (DDM). An illustration of the Department's organization is available at *http://www.dhs.state.ia.us/docs/DHS_TableOrganization.pdf*. The following figure illustrates the current organizational structure for the Iowa Medicaid Enterprise (IME).

Figure 1: IME Organizational Structure



3.1.2 U.S. Department of Health and Human Services

Within the U.S. Department of Health and Human Services, three agencies administer the Medicaid program. The following paragraphs describe their roles.

The Centers for Medicare and Medicaid Services (CMS) is responsible for promulgating Title XIX (Medicaid) regulations and determining state compliance with regulations. CMS also is responsible for certifying and recertifying all state MMIS operations.

The Office of Inspector General (OIG) is responsible for identifying and investigating instances of fraud and abuse in all state Medicaid programs. The Inspector General's office also performs audits of all state Medicaid programs.

The Social Security Administration is responsible for supplemental security income (SSI) eligibility determination. The Social Security Administration transmits this information via a state data exchange (SDX) tape to the state for updating the eligibility system. Information is also provided on Medicare eligibility through beneficiary data exchange and Medicare Parts A and B buy-in files. The Department then provides SSI and Medicare eligibility information to the Core MMIS contractor as part of the eligibility file update process.

3.1.3 Iowa Medicaid Enterprise Professional Services

The professional services contractors of the IME include responsibilities directly in support of the claims processing and data retrieval. In addition their activities promote the State's responsibilities for service assessment and quality indicators. The professional services contractors and activities are described below.

3.1.3.1 Medical Services

The Medical Services contractor activities include an array of professional and medical activities to support claims adjudication, program evaluation and quality assessment including the following functions: general medical and professional support; prevention and promotion, which includes early and periodic screening, diagnosis and treatment (EPSDT) support; prior authorization for medical and professional services (excluding pharmacy prior authorizations), quality of care evaluation for managed care and long-term care (LTC) participants, and LTC reviews. The following are functions associated with the Medical Services contractor:

- Medical Support
- Children's Health Care Prevention and Well-Child-Care Promotion
- Medical Prior Authorization
- Long-Term Care (LTC) Reviews
- Quality of Care
- Health Information Technology

3.1.3.2 Pharmacy Medical Services

The Pharmacy Medical Services contractor activities include retrospective drug utilization review (RetroDUR), review and approval of prior authorization (PA) requests for prescription drugs, maintenance of the preferred drug list (PDL), and the supplemental rebate program. The following are functions associated with the Pharmacy Medical Services contractor:

- RetroDUR
- Pharmacy Prior Authorization
- Preferred Drug List (PDL) and Supplemental Rebate Program

3.1.3.3 Provider Services

The Provider Services contractor encompasses the functions necessary to encourage and support provider participation in the Iowa medical assistance programs, enroll providers and maintain provider data and provide training and assistance to providers who participate. In addition, this encompasses the activities required to educate providers and respond to provider inquiries. These functions are primarily the responsibility of the Provider Services contractor and follow Department policies.

The Provider Services function includes those processes required to maintain a repository of provider information. The provider master file, which resides in the Medicaid Management Information System (MMIS), includes all active and inactive providers for use in claims processing, management reporting, surveillance and utilization review, managed care and other program systems and operations. The provider subsystem supports the Provider Services contractor's business. The following are functions associated with the Provider Services contractor:

- Provider Enrollment
- Provider Inquiry and Provider Relations
- Stale-Dated Checks
- Provider Outreach and Education
- Provider Training
- IME Support Services
- Individualized Services Information System (ISIS) Help Desk and Quality Assurance

3.1.3.4 Member Services

The Member Services contractor includes activities related to interacting with people who receive services through the Iowa Medicaid or IowaCare Programs. The Department's income maintenance workers (IMWs) determine the individuals' eligibility for benefits, and the Department develops policy for all Medicaid and IowaCare programs. The Member Services contractor will serve as the managed health care (MHC) enrollment broker. Members shall be able to obtain answers to their inquiries regarding their MHC enrollment and their services received and payable under their Medicaid or IowaCare program without having their call transferred to other areas. The Member Services contractor will also provide departmental publications that assist members in their understanding of Iowa's Medicaid and IowaCare policies and benefits provided.

The Member Services contractor also includes the activities related to monitoring member care: locking in members to particular providers when necessary and managing treatment for particular conditions. In addition, the Member Services contractor will conduct activities related to improving the outcomes of delivery of services to members, including but not limited to analysis of and intervention with high-cost populations. The following are functions associated with the Member Services contractor:

- Managed Health Care Enrollment Broker
- Member Inquiry and Member Relations
- Member Outreach and Education
- Member Quality Assurance
- Medicare Part A and Part B Buy-In
- Lock-In
- Disease Management
- Enhanced Primary Care Management

3.1.3.5 Revenue Collections

The Revenue Collections contractor is generally responsible for all third-party liability (TPL) activities for the Iowa Medicaid Program. Revenue Collections encompasses an array of collection functions for the Medicaid program, including identification and recovery of funds owed to the Department as a result of third-party insurance payments, liens, tax offsets and provider overpayments. The third-party insurance function is the major activity which includes identifying third-party insurance resources, updating the TPL files, identifying funds to be recovered, requesting funds from the liable party, tracking and follow-up on the requests, and tracking payments received. The following are functions associated with the Revenue Collections contractor:

- TPL Recovery
- Lien Recovery
- Provider Overpayment
- Provider Withholds
- IowaCare Premium Payments
- Credit Balance Recovery

3.1.3.6 Estate Recovery Services

Estate recovery refers to the federal requirement that Medicaid expenditures made on behalf of certain Medicaid members be recovered from their estate upon the death of the member. The Estate Recovery Services contractor identifies deceased members and the medical expenditures made on their behalf, identify assets that exist for recovery and take the necessary steps to collect from the identified assets. The following are data sources associated with the Estate Recovery Services contractor:

- Medicaid Management Information System (MMIS)

- Department of Public Health files of deceased members
- Buy-in files

The Estate Recovery Services functions include the following:

- Recoverable Assets
- Criteria for Exemptions and Delays
- Estate Recovery
- Medical Assistance Income Trusts and Special Needs Trust Recovery

3.1.3.7 Provider Cost Audits and Rate Setting

The Provider Cost Audits and Rate Setting contractor is generally responsible for all activities related to fiscal analyses and recommendations for rate setting for the Iowa Medicaid Program. This encompasses the tasks to determine reimbursement rates for the Department-specified provider types and for auditing the accuracy of provider cost records. The following are functions associated with the Provider Cost Audits and Rate Setting contractor:

- Rate Setting, Cost Settlements, and Cost Audits
- State Maximum Allowable Cost Program Rate Setting
- Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration
- Reimbursement Technical Assistance and Support
- IowaCare

3.1.3.8 Program Integrity

The Program Integrity contractor is responsible for developing and updating parameters for use in the production of Program Integrity reports in the MMIS, conducting desk reviews of providers (using the Program Integrity reports) in order to identify potentially fraudulent and abusive patterns, and conducing provider field audits to verify the findings of desk reviews. The Program Integrity contractor conducts field audits on a sample of providers for whom the Program Integrity reports do not indicate potentially fraudulent or abusive practices. When the reviews or audits indicate aberrant billing practices, the Program Integrity contractor will identify overpayments and send a request to the provider for refunds of the overpayments. When audits indicate fraudulent practices, the Program Integrity Audit contractor will refer the case to the Medicaid Provider Fraud Control Unit (MPFCU). The following are the functions associated with the Program Integrity contractor:

- Provider Analysis
- Provider Audits
- Desk Reviews
- Program Integrity Reporting format
- Utilization Reviews

3.2 Overview of Present Operation

This section includes the following topics:

3.2.1: Systems Responsibilities

3.2.2: Current MMIS Interfaces

3.2.3: Eligibility

3.2.4: Providers

3.2.5: Covered Services

3.2.6: Provider Reimbursement

The IME has established funding, project management and quality assurance teams for Health Insurance Portability and Accountability Act (HIPAA) 5010, National Council for Prescription Drug Program (NCPDP) D.0, and International Classification of Diseases (ICD-10). In 2010 the project teams completed the gap analysis and strategic options analysis for all three projects. The HIPAA 5010 and NCPDP D.0 projects are testing and/or preparing to test with external partners and are on schedule to be fully implemented by January 1, 2012.

IME has selected an implementation strategy for ICD-10 that allows for full compliance by October 1, 2013. The project team members have been identified and will begin working on scope definition and business requirements in April 2011. Upon execution of a contract with the vendor awarded this RFP, the vendor will be asked to participate in a full project review and alignment. Project implementation and testing will be aligned to coordinate with the implementation of the new MMIS system.

IME has currently implemented the Electronic Health Record (EHR) incentive program using the Iowa Medicaid Portal Application (IMPA) for provider interfaces, CMS national level repository interfaces and OnBase for document and workflow management. Payments are made as gross adjustments through the MMIS system. As the program transitions from Adopt/Implement/Upgrade to meaningful use, the attestation will be modified to closely align with the CMS EHR registration application. Additional information on the current program can be found in the State Medicaid Healthcare Information Technology (HIT) Plan at the following web site: *http://www.ime.state.ia.us/Providers/EHRIncentives.html*

3.2.1 Systems Responsibilities

The Iowa MMIS is a mainframe application with primarily batch processing for claims and file updates. Noridian Administrative Services (NAS) is the Core MMIS contractor that manages the system, as well as the workflow management process system known as OnBase. The Division of Data Management (DDM) manages the separate DW/DS system, buy-in, TXIX, IMPA, Individualized Services Information System (ISIS) and the premium systems. Goold Health Systems, which is the POS contractor, manages the prescription drug POS system that provides real-time processing for pharmacy claims. More information about these applications and the current infrastructure is in RFP Section 4 Operating Environment.

The Iowa MMIS, as is the case with virtually all of the systems in operation today, is built around subsystems that organize and control the data files used to process claims and provide reports. The MMIS contains the eight standard subsystems recipient, provider, claims, reference, Management and Administrative Reporting (MAR), Surveillance and Utilization Review (SUR),

Managed Care and Third-Party Liability (TPL), as well as the supporting Medically Needy and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) subsystems.

3.2.2 Current MMIS Interfaces

A number of file interfaces exist between the MMIS and other computerized systems. The following is a sample of the systems that interface with the Iowa MMIS:

a. Title XIX system – The Department provides recipient eligibility updates daily to the Core MMIS contractor with full file replacement provided monthly. Title XIX also provides managed health care notices of eligibility with these update files.

b. Individualized Services Information System (ISIS) – The Department provides facility, Home and Community-Based Services (HCBS) waiver, Targeted Case Management (TCM), Remedial Services (Remedial Services will end effective July 1, 2011), Habilitation Services, Money Follows the Person (MFP) and Program for All-Inclusive Care for the Elderly (PACE) eligibility and services data daily to the Core MMIS contractor.

c. The Core MMIS contractor provides a complete provider file to the Department daily.

d. The Core MMIS contractor provides a paid claims file weekly to the Department's Division of Data Management (DDM).

e. Providers can opt to submit electronic claims through a clearinghouse to the Core MMIS contractor.

f. The Iowa Plan contractor provides encounter data to the Core MMIS contractor monthly.

g. Medicare Crossover Claims – Medicare intermediaries and carriers submit Medicare Parts A and B crossover claims to the Core MMIS contractor.

h. Medically Needy Spenddown – The Core MMIS contractor accumulates claim information on potential medically needy participants and notifies the Department's Iowa Automated Benefit Calculation (IABC) system when the person has met their spenddown requirement.

i. Monthly paid claims file – The Core MMIS contractor provides a monthly paid claims file to other contractors including but not limited to the current Revenue Collections contractor.

j. Iowa Department of Public Health – EPSDT eligibility data, except pharmacy data.

k. Automated license verification files from Iowa Board of Nursing, the Iowa Board of Medicine and the Iowa Dental Board.

l. For a completed list of all MMIS interfaces refer to the IME resource library at the following link: *http://www.ime.state.ia.us/IMEResourceLibrary.html.*

3.2.3 Eligibility

Through its field offices, the Department determines eligibility for people in all eligibility categories except SSI, for which the Social Security Administration determines eligibility. The Department produces and distributes all annual Medicaid eligibility cards.

The average number of Medicaid eligible members by fiscal year appears in the information contained in the resource library. The Iowa Medicaid Program recognizes both mandatory and optional eligibility groups, as described below.

This section includes the following topics:

3.2.3.1: Mandatory Title XIX Eligible Groups

3.2.3.2: Optional Title XIX Eligible Groups

3.2.3.3: IowaCare

3.2.3.4: Children's Health Insurance Program (CHIP)

3.2.3.5: Iowa Automated Benefit Calculation (IABC)

3.2.3.1 Mandatory Title XIX Eligible Groups

The following groups are covered under the mandatory eligibility category:

a. Supplemental Security Income (SSI) recipients.

b. Mandatory state supplementary assistance (SSA) recipients.

c. Former SSI or SSA recipients who are ineligible for SSI or SSA due to widow/widower Social Security benefits and who do not have Medicare Part A benefits.

d. Disabled adult children ineligible for SSI or SSA due to the parent's Social Security benefits.

e. Persons ineligible for federal medical assistance percentages (FMAP) or SSI because of requirements that do not apply to Medicaid.

f. Qualified Medicare beneficiaries (QMB) for payment of Medicare premiums, deductible and coinsurance only.

g. Specified low-income Medicare beneficiaries (SLMBs) for payment of Medicare Part B premium.

h. Qualifying individual 1 known as expanded specified low-income Medicare beneficiaries (E-SLMBs) for payment of Medicare Part B premium only.

i. FMAP recipients.

j. Transitional Medicaid for 12 months for former FMAP recipients who lost eligibility due to earned income.

k. Extended Medicaid for four months for former FMAP recipients who became ineligible due to recipient of child or spousal support.

l. Newborn children of Medicaid-eligible mothers.

m. Postpartum eligibility for pregnant women; eligibility continues for 60 days following delivery.

n. Qualified FMAP-related children under seven years of age, eligible for the Children's Medical Assistance Program (CMAP).

o. Foster care Medicaid under Title IV-E.

p. Qualified Disabled Working Persons (QDWP) for payment of Medicaid Part A premiums.

q. Pregnant women and infants (under one year of age) whose family income does not exceed 300 percent of the federal poverty level.

r. Children ages 1 through 18 whose family income does not exceed 133 percent of the federal poverty level.

s. Continuous eligibility for pregnant women that continues throughout the pregnancy once eligibility is established.

3.2.3.2 Optional Title XIX Eligible Groups

Iowa Medicaid elects to extend its services to individuals in the following categories:

a. 300 percent group – Individuals in medical institutions who meet all eligibility criteria for SSI except for income, which cannot exceed 300 percent of the SSI standard.

b. Those eligible for SSI, SSA or FMAP except for residents in a medical institution.

c. HCBS waivers for people living at home that would otherwise be eligible for Title XIX in a medical institution. This criterion includes waiver groups for: Acquired Immune Deficiency Syndrome (AIDS), ill and handicapped, elderly, intellectually disabled, physically disabled, brain injury and children's mental health.

d. Needy people in a psychiatric facility under age 21 or age 65 or over.

e. SSA optional recipients, who reside in a residential care facility, reside in a family life home, receive in-home health-related care, have dependent people or are blind.

f. Persons who are income-and resource-eligible for cash assistance but are not receiving cash assistance (SSI, FMAP or SSA).

g. Qualified FMAP related children over age 7 but under age 21 are eligible for the Children's Medical Assistance Program (CMAP).

h. Pregnant women with presumptive Medicaid eligibility, for whom authorized providers determine limited eligibility based on countable income not exceeding 300 percent of federal poverty level.

i. Women with presumptive Medicaid eligibility who have been diagnosed with breast or cervical cancer as a result of a screen under Department of Public Health Breast and Cervical screening program, for whom authorized providers determine eligibility for the full range of Medicaid-covered services. Eligibility is time-limited, usually not longer than three months. Women can be presumed eligible only once in a 12-month period.

j. Medically Needy Program – FMAP/SSI related groups who meet all eligibility requirements of the cash assistance programs except for resources and income and those who spenddown their income to not more than 133 percent of the FMAP payment.

k. Medicaid for Employed People with Disabilities (MEPD).

l. Non IV-E foster care Medicaid.

m. Non IV-E subsidized adoption Medicaid.

n. Medicaid for independent young adults, which provides Medicaid eligibility for youth who age out of foster care whose income is below 200 percent of federal poverty level.

o. Supplement for Medicare and Medicaid eligibility SSA coverage group, which provides cash to these individuals and requires mandatory Medicaid buy-in for their Medicare premiums.

p. Reciprocity that covers non-IV-E subsidized adoption Medicaid for children from other states.

q. Iowa Family Planning Network for Medicaid coverage of specific family planning related services (women who had a Medicaid-covered birth are eligible for 12 consecutive months following the 60-day postpartum period. Women who are at least 13 and under 45 years of age at or below 200 percent of the federal poverty level are also eligible).

r. Continuous eligibility for children who are under age 19 and have been determined to be eligible for ongoing Medicaid.

s. Medicaid for children with special needs that provides Medicaid to disabled children under the age of 19 whose family income is no more than 300 percent of the federal poverty level.

t. Presumptive eligibility for children effective January 1, 2010, for which authorized qualified entities determine eligibility based on countable income not exceeding 300 percent of the federal poverty level and citizenship.

3.2.3.3 IowaCare

IowaCare is an 1115 waiver that provides payment for limited benefits for individuals aged 19 through 64 using a limited provider network. To be eligible, individuals other than pregnant women must have countable income at or below 200 percent of the federal poverty level, not have access to other group health insurance, and pay premiums if income is above 150 percent of the federal poverty level unless a hardship is declared. Pregnant women and their newborn children are eligible for IowaCare if their gross countable income is below 300 percent of the federal poverty level and allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below. Services are available to IowaCare individuals at the University of Iowa Hospitals and Clinics in Iowa City, Iowa. Additionally, if a member is a resident of Polk County, services are available at Broadlawns Medical Center in Des Moines, Iowa and the Federally Qualified Health Centers (FQHC).

3.2.3.4 Children's Health Insurance Program (CHIP)

Iowa's CHIP is a combination of a Medicaid expansion and a separate stand-alone program called *hawk-i***,** which stands for Healthy and Well Kids in Iowa. The *hawk-i* program is administered independently from Medicaid, with eligibility determination, health and dental plan enrollment and premium payment collection performed by a separate contractor. Currently, no interfaces exist between the *hawk-i* program and the MMIS. Medicaid data and *hawk-i* data are available through the DW/DS system that the state maintains.

3.2.3.5 Iowa Automated Benefit Calculation (IABC)

The current eligibility system (Iowa Automated Benefit Calculation system) will be replaced via a separate RFP. The new system is expected to be implemented in 2013. The MMIS contractor will participate in activities regarding integration between the new eligibility system and the MMIS system. The new eligibility system will be required to follow the Enhanced Funding Requirements: Seven Conditions and Standards, Medicaid IT Supplement (MITS-11-01-v1.0).

3.2.4 Providers

The Iowa Medicaid Program provides direct reimbursement to enrolled providers who have rendered services to eligible members. Providers may be reimbursed for covered services following application, enrollment and completion of a provider agreement. The Iowa Medicaid Program currently recognizes a multitude of provider types with their corresponding MMIS code values, which can be found at *http://www.ime.state.ia.us/IMEResourceLibrary.html* in the resource library.

3.2.5 Covered Services

The Iowa Medicaid Program covers all federally mandated services as well as a number of optional services. The services currently covered under the program are listed in the Medicaid Guide at *http://www.ime.state.ia.us/IMEResourceLibrary.html* in the resource library.

3.2.6 Provider Reimbursement

This section includes the following topics:

3.2.6.1: Institutional Provider Reimbursement

3.2.6.2: Non-institutional Provider Reimbursement

3.2.6.3: Specific Provider Categories and Basis of Reimbursement

3.2.6.4: Restrictions on Reimbursement

3.2.6.1 Institutional Provider Reimbursement

Providers are reimbursed on the basis of prospective and retrospective reimbursement based on reasonable and recognized costs of operation. Some providers receive retroactive adjustments based on submission of fiscal and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to medical assistance members.

3.2.6.2 Non-institutional Provider Reimbursement

Providers are reimbursed on the basis of a fixed fee for a given service. If product cost is involved in addition to service, reimbursement is based on the actual acquisition cost of the product to the provider or the product cost is included as part of the fee. Increases in fixed fees may be made periodically, if funding is made available to do so.

3.2.6.3 Specific Provider Categories and Basis of Reimbursement

The Iowa Medicaid Program pays deductibles and coinsurance for services covered by Title XVIII (Medicare) of the Social Security Act. The program also pays the monthly premium for supplemental medical insurance (Medicare Part B) for most members age 65 or older and for certain blind or disabled people receiving medical assistance. Additionally, the Medicare Part A premium will be covered for members who qualify under the Qualified Medicare Beneficiary (QMB) Program. The Provider Reimbursement Categories table represents reimbursement methodologies for participating providers.

Table 2: Provider Reimbursement Categories

Institutional	Basis of Reimbursement
Inpatient	
Inpatient Hospital (General Hospital)	Prospective reimbursement system for inpatient hospital

Institutional	Basis of Reimbursement
	services based on diagnosis-related groups (DRGs)
Critical Access Hospital	Cost-based w/ cost settlement (in-state and out-of-state)
Psychiatric Medical Institution for Children (PMIC)	Cost-based per diem rate to a maximum established by the Iowa Legislature
State Mental Health Institution	Cost-based w/ cost settlement
Mental Hospital	Cost-based w/ cost settlement
Rehabilitation Hospital	Per diem rate
Psychiatric Hospital	Cost-based w/ cost settlement (in-state); Percentage of charges interim rate (out-of-state)
Outpatient	
Outpatient Hospital (general hospital; both in-state and out-of-state)	Ambulatory Payment Classifications (APC)-based
Critical Access Hospital	Cost-based w/cost settlement (in-state and out-of-state)
Laboratory Only	Fee schedule
Non-inpatient Programs (NIPS)	Fee schedule
Nursing Facilities	
Special Population Nursing Facility	Cost-based per diem without case-mix factor; Without cap for state-owned
Nursing Facility (NF)	Modified price-based case-mix adjusted per diem
Nursing Facility for the Mentally Ill (NF-MI)	Modified price-based case-mix adjusted per diem; With cap for non-state owned, without cap for state-owned
State-Owned Nursing Facility	Cost-based per diem without case-mix factor, without a cap
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Per diem rate, capped at 80th percentile, except for state Resource Centers (Woodward and Glenwood)
Other Institutional Reimbursements	
Home Health Agency	Cost-based with cost settlement
Family Planning Clinic	Fee schedule
Rural Health Clinic (RHC)	Cost-based w/cost settlement
Federally Qualified Health Center (FQHC)	Cost-based w/cost settlement
Partial Hospitalization	APC or fee schedule
Rehabilitation Agency	Medicare fee schedule
Acute Rehab Hospital	Per diem developed by submitted cost reports
Non-Institutional	**Basis of Reimbursement**
Practitioners	

Institutional	Basis of Reimbursement
Physician (Doctor of Medicine or Osteopathy)	Fee schedule – Resource-Based Relative Value Scale (RBRVS)
Dentist	Fee schedule
Chiropractor	Fee schedule (RBRVS)
Physical Therapist	Fee schedule (RBRVS)
Audiologist	Fee schedule (RBRVS) for professional services, plus product acquisition cost and dispensing fee
Psychiatrist	Fee schedule (RBRVS, to the extent rendered/billed by psychiatrist or psychologist and then only for Current Procedural Terminology CPT coded services)
Podiatrist	Fee schedule (RBRVS)
Psychologist	Fee schedule (RBRVS)
Certified Registered Nurse Anesthesiologist (CRNA)	Fee schedule (RBRVS)
Nurse Practitioner	Fee schedule (RBRVS)
Certified Nurse-midwife	Fee schedule (RBRVS)
Patient Manager (Primary Care Physician)	Capitated administrative fee
Optician	Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost.
Optometrist	Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost
Clinical Social Worker	Medicare deductibles/coinsurance
Services/Supplies	
Hospice	Medicare-based prospective rates, based on level of care provided
Clinics	Fee schedule
Ambulance Service	Fee schedule (Cost-based for critical access hospital-based ambulance)
Independent Laboratory	Fee schedule
X-Ray	Fee schedule (paid under either a Physician or Clinic billing)
Pharmacy/Drugs	Lower of: Average Wholesale Price (AWP) minus 12 percent non-specialty, Average Wholesale Price (AWP) minus 17 percent specialty, usual and customary, or the Maximum Allowable Cost (MAC) price (state or federal), plus dispensing fee
Lead Investigations	Fee schedule
Hearing Aid Dealer	Fee schedule for professional services, plus product acquisition cost and dispensing fee
Orthopedic Shoe Dealer	Fee schedule

Institutional	Basis of Reimbursement
Medical Equipment and Prosthetic Devices Provider	Fee schedule
Supplies	Fee schedule
Other Agency/Organization Reimbursements	
Ambulatory Surgical Center	Fee schedule
Birthing Center	Fee schedule
Community Mental Health Center	Fee schedule
EPSDT Screening Center	Fee schedule
Maternal Health Center	Fee schedule
Area Education Agency	Cost based
Local Education Agency	Cost based
Targeted Case Management	Cost-based w/cost settlement
Health Maintenance Organization	Predetermined capitation rate
Managed Mental Health and Substance Abuse	Predetermined capitation rate
HCBS Waiver Service Provider	Negotiated rates or fee schedule
Adult Rehabilitation Option	Cost-based with cost settlement
Remedial Services	Cost based with cost settlement
Habilitation Services	Cost based with cost settlement

3.2.6.4 Restrictions on Reimbursement

In an effort to control the escalating costs of the Iowa Medicaid Program, the following restrictions or limitations on reimbursement have been implemented as described in the following sections:

3.2.6.4.1: Copayments

3.2.6.4.2: Preadmission Review

3.2.6.4.3: Transplant and Pre-procedure Review

3.2.6.4.4: Preauthorization (PA) Requirements

3.2.6.4.1 Copayments

Copayments are applicable to certain optional services provided to all members, with the exception of the following:

a. Services provided to members under age 21.

b. Family planning services or supplies.

c. Services provided to members in a hospital, nursing facility, state mental health institution or other medical institution if the person is required, as a condition of receiving services in the

institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

d. Services provided to pregnant women.

e. Services provided by a health maintenance organization (HMO).

f. Emergency services as determined by the Department.

3.2.6.4.2 Preadmission Review

Some inpatient hospitalization admissions are subject to preadmission review by the Medical Services contractor. Payment is contingent upon the Medical Services contractor's approval of the stay.

3.2.6.4.3 Transplant and Pre-procedure Review

The Medical Services contractor conducts a pre-procedure review of certain frequently performed surgical procedures to determine medical necessity. They also review all requests for transplant services. Payment is contingent upon approval of the procedure by the Medical Services contractor.

3.2.6.4.4 Prior Authorization (PA) Requirements

The Iowa Medicaid Program requires PA for certain dental services, some durable medical equipment, eyeglass replacement if less than two years, hearing aids if over a certain price, home and community based services (HCBS Waivers), various prescription drugs and certain transplants. The Medical Services contractor performs prior authorizations, except for the drug prior authorizations which are performed by the Pharmacy Medical Services contractor.

4 OPERATING ENVIRONMENT

This section highlights the tools that are in use in the Iowa Medicaid Enterprise (IME) operating environment. All contractors operating within the IME will use existing common managerial tools where necessary to perform their operational functions. Detailed information about all of the tools is available in the resource library at *http://www.ime.state.ia.us/IMEResourceLibrary.html*. The following topics highlight these tools:

4.1: Iowa Medicaid Management Information System (MMIS)

4.1.1: Claims Processing Function

4.1.2: Recipient Function

4.1.3: Provider Function

4.1.4: Reference Function

4.1.5: Medically Needy Function

4.1.6: Management and Administrative Reporting (MAR) Function

4.1.7: Surveillance and Utilization Review Subsystem (SURS) Function

4.1.8: Third-Party Liability (TPL) Function

4.1.9: Prior Authorization Function

4.1.10: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Function

4.2: Eligibility Verification Information System (ELVS)

4.3: Data Warehouse and Decision Support (DW/DS) System

4.4: Workflow Process Management System (OnBase)

4.5: Right Fax

4.6: Call Center Management System

4.7: Iowa Automated Benefit Calculation (IABC) System

4.8: Individualized Services Information System (ISIS)

4.9: Title XIX

4.9.1: Medicare Prescription Drug Part D

4.9.2: Medicaid Medicare Information System (MMCR)

4.9.3: Medicaid IowaCare Premium System (MIPS) and Medicaid for Employed People with Disabilities (MEPD)

4.10: Social Security Buy-In (SSBI)

4.11: Medicaid Quality Utilization and Improvement Data System (MQUIDS)

4.12: Iowa Medicaid Electronic Records System (I-MERS)

4.13: Iowa Medicaid Portal Application (IMPA)

4.14: Pharmacy Point-of-Sale (POS) System

4.15: CareConnection® System

4.16: Impact Fraud and Abuse Detection System (IFADS)

4.17: ImpactPro

4.18: iQRMS Recovery Management System

4.19: Provider Self Review

4.1 Iowa Medicaid Management Information System (MMIS)

This overview of the Iowa MMIS includes the following topics below includes a description of all current MMIS subsystems.

4.1.1 Claims Processing Function

The claims processing subsystem is one of the most critical modules of the Medicaid Management Information System (MMIS). It captures, controls and processes claims data from the time of initial receipt (on hardcopy or electronic media) through the final disposition, payment and archiving of claims history files. The claims processing subsystem edits, audits and processes claims to final disposition consistent with the policies, procedures and benefit limitations of the Iowa Medicaid Program. To accomplish this, the subsystem uses the data contained in the most current recipient eligibility file, provider master file, reference files, TPL resource file and prior authorization (PA) file.

The claims processing subsystem maintains claims history including both paid and denied claims. The MAR and SUR subsystems use claims history in producing management and utilization reports, as does the claims processing subsystem in applying history-related edits and audits. Online inquiry is available for 36 months of adjudicated claims history, lifetime procedures and any claims still in process. Service limitations for vision, dental and hearing aid are displayed in the recipient eligibility subsystem key panel.

The claims processing subsystem processes, pays or disallows and reports Medicaid claims accurately, efficiently and in a timely manner. It accepts entry of claims through online examination and entry as well as from providers' submissions via magnetic tape, personnel computer (PC) diskettes and electronic transmission. The claims processing subsystem includes the ability to process Medicare crossover claims.

The claims processing subsystem provides up-to-date claims status information through online inquiry and provides data to the MAR, SUR and EPSDT subsystems and other accounting interfaces used to generate administrative reports. It ensures accurate and complete processing of all input to final disposition. The claims processing subsystem offers many online features such as online, real-time claim credits and adjustments.

Outputs of the claims processing subsystem include detailed remittance advices for providers and member explanations of medical benefits (EOMBs). This subsystem also produces updates to the claims history files, prior authorization file, recipient eligibility file and provider file.

The MMIS processes all Iowa claim forms and a variety of electronic media claims (EMC) including transfers from claims clearinghouses and direct computer data transfer. All claims entered into the subsystem are processed similarly according to claim type, regardless of the initial format of the claim document. Pre-processing is performed to reformat the various inputs into the MMIS claim layout because of the number of various EMC formats required to support Iowa Medicaid billing.

The system determines to either pay or deny a service according to criteria on the exception control file. This parameter table which is maintained online enables the Department to control the disposition of edits and audits without any programming effort involved. Separate exception codes are posted for each edit and audit exception for each line item. Each exception code can be set to several dispositions depending on such factors as input media (paper or magnetic tape) and claim type. Claim type is assigned by a combination of claim invoice and other indicators within the claim.

If all exceptions on a claim have a disposition of pay, deny or pay and report, the claim is adjudicated and the payment amount is computed according to the rules and regulations of the State of Iowa. If any exception for the claim is set to suspend, then the claim is either printed on a detailed suspense correction report or listed for an online suspense correction as dictated by parameters on the exception control file. A super-suspend disposition is used for edits so severe that no resolution short of correcting the error is possible (such as invalid provider data). The pay-and-report disposition allows the Department to test the impact of a new exception and decide how to treat the condition in the future such as pay, deny or educate providers. Claims with special exception codes are routed according to Department instructions. The specific unit responsible for correction of an exception is designated by the location code on the exception control file.

The MMIS allows the detail and summary resolution text to be entered on the text file of the reference subsystem. This information is then available to the resolution staff during exam entry, suspense correction and inquiry processes, thus providing an online resolution manual.

A remittance advice is produced for every claim in the system and shows the amount paid and the reasons for claim denial or suspense. The message related to each exception code is controlled by parameters on the exception control file. A different message can be printed according to claim submission media, claim type and whether the claim is denied or suspended. The actual text of the message is maintained online on the text file.

The MMIS maintains 36 months of adjudicated claims history online. The claims, as well as all claims in process, are available for online inquiry in a variety of ways. Claims can be viewed by member identification (ID), provider number, National Provider Identifier (NPI), claim transaction control number (TCN) or a combination of the above. The search criteria can be further limited by a range of service dates, payment dates, payment amounts, billed amounts, claim status, category of service, procedure codes or diagnosis codes within a claim type. Claims can be displayed either in detail, one claim per screen, in summary format and several claims per screen. Additional inquiry capability allows the operator to browse the member, provider or reference files from the claim screen to obtain additional information related to the claim. A summary screen is also available for each provider containing month-to-date, year-to-date and most recent payment information. The claims processing subsystem has the capability to suspend or deny claims based on TPL information carried in the MMIS files.

The MMIS supports cost containment and utilization review by editing claims against the prior authorization record to ensure that payment is made only for treatments or services which are medically necessary, appropriate and cost-effective. The Utilization Review (UR) criteria file provides a means of placing program limitations on service frequency and quantity as well as medical and contraindicated service limits. It provides a means for establishing prepayment criteria, including cross-referencing of procedure and diagnosis combinations.

The claims processing subsystem contains a claims processing assessment system (CPAS) module designed to provide claim sampling and reporting capability required to support the Department in conducting CPAS reviews.

Each step in document receipt processing and disposition includes status reporting and quality control. The Iowa MMIS generates several reports useful in managing claim flow and resolution. Reports are used to track the progress of claims at each resolution location, identify potential backlogs, pin-point specific claims that have suspended, monitor workload inventories and ensure timely processing of all pended claims. Meanwhile, quality control staff monitors all operations for adherence to standards and processing accuracy in accordance with contractual time commitments and error rates.

4.1.2 Recipient Function

The recipient subsystem is the source of all eligibility determination data for the MMIS, whether generated by the Department or by the MMIS. The information contained in the MMIS eligibility file is used to support claims processing, management and administrative reporting, surveillance and utilization review reporting, managed care functionality of assignment to Medicaid Patient Access to Service System (MediPASS), IowaCare, medical home and TPL. The recipient subsystem currently meets or exceeds all federal and state requirements for a Medicaid recipient subsystem.

The MMIS recipient subsystem is designed to provide the flexibility required to accommodate the Department's changing approach to the management of its public assistance programs. To minimize the impact of future changes, the MMIS' recipient subsystem uses a single recipient database that includes eligibility; lock-in, health maintenance organization (HMO), MediPASS, nursing home, waiver, client participation and Medicare data. The recipient subsystem manages the enrollment into managed care, including PCCM and IowaCare Medical Home.

The recipient subsystem accepts data only from the Title XIX system for eligibility and facility data. The recipient subsystem receives daily transmissions of eligibility updates from the Title XIX system, which are used for batch updates of the recipient eligibility file.

The MMIS batch file update methodology is supplemented with online, real-time updates to the recipient record. The guardian effective date and ID are added or updated through the online feature of the recipient subsystem. All online updates to the recipient eligibility file are thoroughly controlled to ensure the accuracy of the updates before they are applied to the file. Press the "Enter" key once data has been added or changed on a screen. Each field is edited and the full screen with any errors is highlighted. When all errors have been corrected, the screen is redisplayed to allow for final verification of update activity. Pressing the "Enter" key a second time applies the updates to the recipient file.

Hard-copy audit trails are supported through the use of the online transaction log file. The transaction log files records a before and after image of each MMIS master file record updated online. The transaction log file is then used to support daily online update activity reporting and is retained for historical purposes.

The Department and the Core MMIS contractor share the responsibility for the operation of the recipient subsystem. The Department determines which individuals are eligible to receive benefits under the Iowa Medical Assistance program and sets limitations and eligibility periods for those individuals. The Department is responsible for transmitting, either electronically or by other approved media, eligibility data elements required to maintain the MMIS recipient eligibility file on both a daily and monthly basis.

The Core MMIS contractor is responsible for operating the MMIS recipient subsystem. The recipient subsystem will process the Department's daily and monthly update transmissions and submit all balancing and maintenance reports to the Department. Any discrepancies discovered during the update process are promptly reported to the Department.

The Core MMIS contractor provides reports from the recipient subsystem files in the format specified by the Department. These reports include the detailed recipient eligibility updates, recipient update control and update error reports. Several reports are created from monthly recipient processing, such as the recipient list reports, the possible duplicate reports and the recipient purge report.

4.1.3 Provider Function

The provider subsystem maintains comprehensive provider related information on all providers enrolled in the Iowa Medicaid Program to support claims processing, management reporting, surveillance and utilization review. The provider subsystem processes provider applications and information changes interactively using online screens. This capability for immediate entry, verification and updating of provider information, ensures that only qualified providers complying with program rules and regulations are reimbursed for services rendered to eligible Medicaid members. The provider subsystem currently meets or exceeds all federal and state requirements for a Medicaid provider subsystem.

The provider subsystem retains provider related data on six files: provider master file, the provider group file, provider intermediary file, Medicare-to-Medicaid cross-reference file, provider HMO plan file and the National Association of Boards of Pharmacy (NABP)-to-Medicaid cross-reference file. These files are used to interface with the claims processing, recipient, MAR, SUR, TPL and EPSDT subsystems to supply provider data for claims processing and provider enrollment and participation reporting. Major subsystem features include the following:

a. Online maintenance: Because additions and changes to the provider master file are processed online and in real-time, they can be verified immediately upon entry. They are also immediately available for use in processing claims and other system functions once all data is added or changed on a screen and the “Enter” key is pressed. The provider subsystem edits each field and redisplays the full screen with any errors highlighted. When all errors are corrected, the screen is redisplayed a final time to allow for visual verification of update activity. Pressing the “Enter” key a second time results in the updates being applied to provider subsystem files.

b. Online inquiry: A powerful access capability allows inquiry to providers by various search paths including provider number, Social Security or federal employer identification number, provider name, unique physician identification number (UPIN), provider type, provider county, provider type within county and Drug Enforcement Administration (DEA) number. The inquiry can also be limited to only actively enrolled providers or can include all providers.

c. Enrollment: The online software is used to enroll providers of service, which formalizes the procedure for application, verification of state licensure and authorization for claim submission and payment.

d. Identification: The provider subsystem provides a method of identifying each provider's type and specialty, as well as the claim types the provider is allowed to submit.

e. Cross-referencing: The system provides the following methods of cross-referencing provider numbers:

    1. Relate provider to as many as ten provider groups.

    2. Identify an infinite number of member providers for a provider group.

    3. Relate provider to as many as ten billing agents.

4. Identify member providers for a billing agent.
5. Maintain previous provider number.
6. Maintain new provider number.
7. Relate to alternative practice locations or billing entities.
8. Identify lien-holder provider number.
9. Identify provider as managed care along with maximum enrolled number of members.
10. Identify all Medicaid provider IDs related to an NPI.

f. Institutional rates: The provider subsystem maintains institutional rates by charge mode, level of care and effective dates.

g. Hold and review: The provider subsystem maintains six occurrences of provider review indicators for the review and suspension of claims for specific dates of service, procedures, diagnoses or type of service codes.

h. Language indicator: On screen one, this indicator identifies the different languages spoken in the provider's office, including Spanish, Bosnian, Serb and Croatian, Vietnamese and Lao.

i. Special units and programs: The provider subsystem maintains the certified units used in hospital pricing.

j. Diagnosis related group (DRG) ambulatory patient classification (APC) pricing information: The provider subsystem maintains ten occurrences of DRG and APC base rates and add-ons by effective date.

k. Reports: The provider subsystem produces various provider listings, mailing labels and processing reports daily, monthly and on-request. Provider address labels may be requested by a number of different selection criteria.

l. Audit trails: This system module logs both a "before" and "after" image of each master file record updated online. The transaction log file is then used to support daily update activity reporting and is retained for historical needs.

4.1.4 Reference Function

The reference subsystem's function is to provide critical information to the claims processing and MAR subsystems. The data to support claims pricing and to enforce state limits on services resides in the reference subsystem. The basic design of the MMIS reference subsystem offers the Department flexibility in meeting changing program requirements.

Real-time file updating allows for the immediate editing and correcting of update transactions to all of the reference subsystem files. Once a transaction has been applied, it is effective immediately for claims adjudication. The subsystem provides many user-maintained parameters that allow the IME to fine-tune the edits and audits of the Iowa MMIS.

While the basic design of the system stresses online file updates and inquiries, the reference subsystem also incorporates batch updating of key files. The reference subsystem accepts batch procedure, diagnosis, DRG and APC updating.

The system accommodates mass adjustments due to retroactive price changes. The adjusted claim is priced against the policy in effect on the date of service, even if the price is established after the date that the claim was originally processed.

The MMIS reference subsystem supports the following files:

a. Procedure file: This file contains records for all Healthcare Common Procedure Coding System (HCPCS) procedure codes, International Classification of Diseases, Ninth Revision, International Classification of Diseases Clinical Modification (ICD-9-CM) procedure codes, Iowa-unique codes, national drug codes (NDCs) and revenue codes. Each record carries the following data:

   1. Procedure name.
   2. Age, gender, provider type, provider specialty, place of service and procedure code modifier limitations.
   3. Twenty segments, with beginning and ending dates containing pricing, prior authorization indicator and coverage by Medicaid control indicator. **Note:** EPSDT only, if no control indicator, deny, suspend for review, suspend for the Department review.
   4. Clinical labs, multiple description coding (MDC) diagnosis compatibility indicators, cross-reference indicators.
   5. Covered by Medicare indicator.
   6. Tooth number required, tooth surface required and tooth quadrant required indicators.
   7. Family planning, sterilization, hysterectomy and abortion indicators.
   8. Pre- and post operation days, laboratory certification codes and maximum units.
   9. Elective surgery, visit and surgery, surgical tray and MediPASS-override indicators.
   10. Lifetime, trauma, EPSDT, referral, copayment, multiple surgery, ambulatory surgical center, nursing home and duplicate check indicators.
   11. Provider charge indicators for category of service attached, provider type attached and provider attached.
   12. Conversion and scratchpad indicators.
   13. Claim type and scratchpad.
   14. HCPCS update, cross-reference type of services and prescribing provider.

b. Drug file: This file contains records for all drug codes. Each record carries the following data:

   1. Eleven-digit NDC code.
   2. Previous eleven-digit NDC code.
   3. Obsolete date.
   4. Drug name and manufacturer name (brand name).
   5. Age and gender limitations.
   6. Drug generic grouping and generic name.
   7. Specific therapeutic class (three characters).
   8. 30-day policy, unit quantity, unit measure.
   9. Max unit day supply, route code.
   10. Strength description.

11. Package size pricing indicator.
12. Three segments of unit dose package size.
13. Drug package size, activity counter.
14. Prior authorization high dose, prior authorization maintenance dose.
15. High dose exempt period.
16. Six month approval date, new use approval indicator, new use approval date.
17. Drug pricing data, begin date, end date, over-the-counter (OTC) minimum units, minimum supply, maximum supply, maximum days, catalog price, drug average wholesale price (AWP), drug estimated acquisition cost (EAC) and drug maximum allowable cost (MAC).
18. DEA, dialysis, nursing home, family planning indicators.
19. Dispensing fee indicator, over the counter indicator.
20. Six segments with drug class, drug efficacy study implementation (DESI) indicator, drug control code, prior authorization indicator and begin and end dates.
21. Six segments of rebate effective dates and rebate indicators.

c. Diagnosis file: This file contains records for all diagnosis codes. Each record carries the following data:

1. Diagnosis code.
2. Diagnosis name.
3. Age and gender limitations.
4. Medicaid control code, denies, suspend for review, not specific, suspend for the Department review, EPSDT only, no control.
5. Family planning, sterilization, abortion, prior authorization, emergency and accident indicators.
6. Diagnosis compatibility indicator and codes, diagnosis cross-reference indicators and codes.

d. DRG file: This file contains DRG records with the following data:

1. DRG code.
2. Unit code.
3. Age code.
4. Major diagnosis category.
5. Medical and surgery indicator.
6. DRG description.
7. DRG pricing, begin date, end date, average length of stay, inlier end day, outlier begin day, weight, mean log length of stay, standard deviation log length of stay.
8. Control code.

e. APG file: This file contains APG records with the following data only for claims prior to 10/01/2008:

1. APG code.
2. APG description.
3. APG pricing data, begin date, end date, weight.
4. Batch bill flag, non-covered flag and condition flag.

f. APC file: This file contains APC records with the following data for claims effective 10/01/2008:
   1. APC code.
   2. APC description.
   3. APC pricing data, begin date, end date, weight.

g. Prepayment utilization review criteria file: This file contains parameters to define program limitations on service frequency and quantity as well as medical and contraindicated service limits.

h. Provider charge file: This file contains records for procedures that require individual prices by specific provider, provider type or provider category of service.

i. Text file: This file contains records for various narratives required in the claims processing subsystem:
   1. Provider text.
   2. Exception code text.
   3. Explanation of benefits (EOB) text.
   4. Location text.
   5. Carrier text.
   6. Remittance advice newsletter text.
   7. Prior authorization reason text.
   8. Procedure range text.

j. Exception control file: This file contains records used to control the disposition of each edit or audit exception code. In addition to exception status, by type of claim and input media, this file carries such data as exception code description, indicator of whether to print a worksheet or a list, location code for review, EOB codes for denied or suspended services and control data to allow or disallow force payment or denial of the exception code.

k. System parameter file: This file contains records that are used throughout the system to control different types of limits and values.

4.1.5 Medically Needy Function

The Iowa medically needy subsystem's function is to accumulate, track and apply Medicaid claims to the spenddown for individuals who meet the categorical but not the financial criteria for Medicaid eligibility and who are described as medically needy. The purpose of the medically needy subsystem is to:

a. Receive case and member eligibility-related data from the Iowa Automated Benefit Calculation System (IABC) system, which is the system used for eligibility determination.

b. Create certification periods with spenddown amounts according to files transferred from the IABC system.

c. Prioritize medical expenses that have been submitted according to the Iowa Administrative Code and Code of Federal Regulations.

d. Apply verified medical expenses against the unmet spenddown obligation and reject expenses that cannot be applied to the spenddown obligation.

e. Notify the IABC system when the spenddown obligation has been met.

f. Track expenses that have been used for meeting spenddown.

g. Generate notification documents.

h. Update certification when requested by the Department's income maintenance (IM) workers.

Medically needy eligible individuals may be responsible for a portion of their medical expenses through the spenddown process. The Department's IM workers determine initial eligibility and the spenddown obligation for these members. The Title XIX system sends a record to the MMIS unit identifying these potential medically needy eligible individuals, which allows the MMIS to accumulate claims toward their spenddown amount.

The medically needy subsystem serves as an accumulator of claims that apply toward the spenddown amount. The subsystem displays the medically needy spenddown amount, the amount of claims that have accumulated towards the spenddown amount, information for each certification period, the date that the spenddown obligation is met and information about claims used to meet the spenddown obligation. Department staff can access these medically needy screens online.

Once individuals become eligible by meeting their spenddown obligation, Medicaid pays the claims that were not applied to the spenddown for that certification period. The medically needy function of the MMIS consists of processing claims for members eligible for the medically needy program, tracking medical expenses to be applied to the spenddown and providing reports of the spenddown activity.

Cases that have a spenddown obligation in either the retroactive or the prospective certification period have information passed from the IABC system, to the MMIS medically needy subsystem. Medically needy cases that are approved and have zero spenddown in both the retroactive and prospective certification periods, are maintained by the IABC system and are not passed to the MMIS medically needy subsystem. Individuals with active fund codes are automatically eligible for Medicaid. The IABC system passes information to Title XIX which then passes a member record to the MMIS when the member is eligible for Medicaid.

The Medicaid card is issued by a vendor under contract to the Department. The MMIS generates and sends a file to the contractor daily for new members who have not previously been issued a card. Members enrolled in the medically needy program are not eligible to receive an ID card until they have met spenddown obligations and their fund codes in the MMIS system have changed to eligible fund codes. The card does not have an expiration date (e.g., there is no annual reissuance). If a member needs a new card, Department staff use a system called Online Card Replacement Application (OCRA). The system generates a record that is passed daily to the MMIS and included in the daily file feed to the Medicaid card vendor. The MMIS tracks the card issuance date used to determine if a new member has been issued a card or not.

4.1.6 Management and Administrative Reporting (MAR) Function

The MAR subsystem provides the Department management staff with a timely and meaningful reporting capability in the key areas of Medicaid program activity. MAR reports are designed to assist management and administrative personnel with the difficult task of effectively planning, directing and controlling the Iowa Medicaid Program by providing information necessary to support the decision-making process.

The MAR subsystem presents precise information that accurately measures program activity and ensures control of program administration. The MAR subsystem also provides historical, trend and forecasting data that assists management in administering the Iowa Medicaid Program. In addition, the MAR subsystem provides necessary information to all levels of management to predict potential problems and plan solutions.

The MAR subsystem extracts key information from other subsystems for analysis and summarization. The MAR subsystem maintains this data in many different variations for use in producing its reports. This information can also be used as an extensive base of data for special or on-request reporting.

The Department and the Core MMIS contractor share responsibility for the ongoing operation of the MAR subsystem. The Department's responsibilities are to determine the format, reporting categories, parameters, content, frequency and medium of all routinely produced reports and special reports. The Department is also responsible for submitting information to be incorporated with MMIS data files for reporting, including budget data, buy-in premium data and managed care encounter data. In addition, the Department determines policy, makes administrative decisions, transmits information and monitors contractor duties based on MAR reports.

The Core MMIS contractor is responsible for operating the MAR subsystem and supporting all of the functions, files and data elements necessary to meet the requirements of the RFP. All reports have uniform cutoff points so that consistent data is input to each MAR report covering the same time period. A complete audit trail is provided among the MAR reports and between reports generated by MAR and other subsystems for balancing within the cycle.

The Core MMIS contractor produces and makes available the MAR reports and other outputs in formats, media and time frames specified by the Department. The Core MMIS contractor produces reports at different summary levels according to the Department specifications and verifies the accuracy of all reports.

The Core MMIS contractor develops, provides and maintains both system and user documentation for the Department personnel and its own staff. The Core MMIS contractor provides knowledge transfer for the Department personnel and contractors on an ongoing, as needed basis.

The MMIS MAR subsystem has been designed and refined to run within a batch-processing environment. The system is able to handle large amounts of input data, to manage system input and output (I and O) resources efficiently, to minimize program execution and central processing unit (CPU) time requirements and to provide reliable and effective restart and recovery capabilities. Following are some of the specific design features of the MMIS MAR subsystem:

a. Program coding techniques, which emphasize economical CPU usage and reduce paging and file I and O overhead.

b. Modular program structure, which aids readability and minimizes maintenance learning time.

c. Tabled valid values for all MMIS coding structures such as provider types, categories of service and aid categories, which are maintained through an automated data dictionary that enables additions, changes or deletions of code values without programmatic modifications.

d. Extensive internal program documentation.

e. Simplified design that emphasizes smaller, easily-coded programs, lending flexibility for maintenance and enhancements.

f. Thorough backup and restart capability that minimizes hardware use.

4.1.7 Surveillance and Utilization Review Subsystem (SURS) Function

The SUR subsystem operating in Iowa is designed to provide statistical information on members and providers enrolled in the Iowa Medicaid Program. The subsystem features effective algorithms for isolating potential misuse and produces an integrated set of reports to support the investigation of that potential misuse.

SUR provides extensive capabilities for managing data summarization, exception processing and report content and format. Parameter controls allow the user to limit the volume of printed material required for analysis. Parameter-driven data selection, sampling and reporting features further enhance the capabilities of the subsystem.

SUR produces comprehensive profiles of the delivery of services and supplies by Medicaid providers and the use of these services by Medicaid members. Both summary and detail claim data are available to the reviewer, who is able to control the selection of claims and content of reports through parameters. Statistical indices are computed for selected items to establish norms of care so that improper or illegal utilization can be detected.

The SUR subsystem has had many enhancements since its initial development. These enhancements include the addition of a statistical claim-sampling module, which enables the user to review a random sample of claims from the total population and reduces the resources required for large-volume providers. A claim-ranking module provides the user with reports on the volume of usage of procedures, drugs and diagnoses.

A parameter-controlled report writer allows the user to define the format in which the selected claims are to be displayed. The capability to print certain information from the procedure, drug and diagnosis file is also available.

Nursing home summary profiles were enhanced with a member composite analysis feature. The profiles incorporate all services rendered on behalf of a member while a resident is in the facility, regardless of the provider of service. Referring, prescribing and attending provider profiles, as well as group provider profiles, are made available to further enhance review capabilities for the user.

4.1.8 Third-Party Liability (TPL) Function

The TPL subsystem is a fully integrated part of the MMIS. A significant amount of TPL processing occurs within the recipient subsystem, claims processing subsystem and MAR subsystems.

TPL coverage is maintained by member within the recipient subsystem. The TPL resource file within the recipient subsystem contains member identification data, policy numbers, carrier codes, coverage types and effective dates. An indicator on the recipient eligibility file is set for those members having verified policy information on the TPL resource file.

The claims processing subsystem identifies claims with potential TPL coverage by examining the TPL resource file and indicators from the claim form. Claims for services with third-party coverage may be paid, paid and reported, suspended or denied based on the individual circumstances. The MAR subsystem produces various reports that support TPL activity.

The TPL subsystem uses data from various sources to perform the following functions:

a. Identify third-party resources available to Medicaid members.

b. Identify third-party resources liable for payment of services rendered to Medicaid members.

c. Avoid state costs for these services.

d. Recover third-party funds.

e. Report and account for related information.

4.1.9 Prior Authorization Function

The Core MMIS contractor is responsible for maintaining the prior authorization file which contains procedures requiring prior authorization, information identifying approved authorization, certification periods and incremental use of the authorized service. The Core MMIS contractor receives file updates from the Medical Services contractor for selected ambulatory and inpatient service authorization codes. These authorizations are loaded on the prior authorization file that is used by the MMIS for processing claims. The Core MMIS contractor must ensure that all claims are denied for services requiring pre-procedure review by the Medical Services contractor if a validation number indicating approval is not present on the PA file. The Core MMIS contractor is responsible for ensuring that in cases requiring preadmission review by the Medical Services contractor, payment is made only if an approval certification is present on the claim and that payment is made only for the approved number of days and at the specified level of care.

The Core MMIS contractor will also receive file updates from the Medical Services contractor on authorized services. These files will cover the array of services under the Medical Services contractor’s responsibility.

The Core MMIS contractor uses Individualized Service Information System (ISIS) as a prior authorization file to verify authorized services, members and rates for payment of home and community-based (HCBS) waiver services. ISIS is also used for prior authorization of facility, remedial services, habilitation services and targeted case management services. Approved service authorizations are sent from ISIS to the prior authorization subsystem. Approved eligibility spans are sent from ISIS through the Title XIX system to the MMIS recipient eligibility file.

All ISIS Waiver Service Authorizations are passed daily to the TXIX System (approx. two million service authorizations) for additional processing by the Prior Authorization subsystem. Only approved service authorizations are used in a match process with all ISIS Prior Authorization Service records. This process creates add, change and delete files that are passed daily to MMIS for ISIS service payments.

4.1.10 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Function

The EPSDT subsystem supports the Department in the timely initiation and delivery of services. It also supports care management; federal reporting and follow-up treatment tracking by interfacing with MMIS paid claims history and recipient eligibility.

The MMIS EPSDT subsystem satisfies all the Department requirements for member notification, services tracking and reporting. The subsystem maintains EPSDT eligibility and screening information, as well as required demographic data, on the recipient eligibility file and the EPSDT master file. It generates notifications, referral notifications, and a state-defined periodicity schedule based on the information collected from the recipient eligibility file and the EPSDT master file. The EPSDT subsystem reports all screenings and referrals and tracks the treatments, which result from screening referrals. Extensive detail and summary reports are produced as well as required federal reporting and case documentation.

4.2 Eligibility Verification Information System (ELVS)

The Eligibility Verification Information System (ELVS) performs three primary request and response functions for providers and other authorized users:

a. Recipient eligibility request and response.

b. Claims status request and response.

c. Provider summary request and response.

The system contains a telephone voice and touch-tone response module and a web portal.

4.3 Data Warehouse and Decision Support (DW/DS) System

The state-supported Data Warehouse and Decision Support (DW/DS) system provides data analysis and decision-making capabilities and access to information, including online access to flexible, user-friendly reporting, analysis and modeling functions. IME staff from the Department and contractors use the DW/DS system. The Department's Division of Data Management (DDM) provides technical support and assistance in developing queries and reports to fulfill the analytical needs for the IME. The DW/DS system provides IME users with the flexibility to produce reporting without MMIS reprogramming in acceptable formats that do not require manual intervention or data manipulation.

The DW/DS system maintains the most recent 10 years of claims data from the MMIS. The DW/DS system's relational database includes the full claim record for adjudicated claims and other member, provider, reference and prior authorization data from the MMIS.

4.4 Workflow Process Management System (OnBase)

OnBase from Hyland Software is an enterprise content management (ECM) software suite that combines document imaging, electronic document management, records management and workflow. Emdeon is used for the imaging of all documentation, such as paper claims and correspondence that flow into the IME via the mailroom. Once those documents are scanned into the system they follow the further path of classify, Optical Character Recognition (OCR) and verification before transferred to OnBase and placed in a workflow queue based on document type.

The IME utilizes the workflow module as the primary call log application for the call centers as well as a support application for the OnBase and MMIS help desk. The OnBase system is the responsibility of the Core MMIS Contractor. Other OnBase products in use include scanning computer output to laser disk (COLD), Document Import Processor (DIP) and Report Services. The scan modules are used to bring all correspondence received into the OnBase system. COLD and DIP are modules that are used to import documents from the other systems in the IME, including reports from the MMIS and claims from the Emdeon imaging system. Report Services is a module used to give the users a customizable interface to standard and ad-hoc reports in the OnBase system.

4.5 RightFax

RightFax is a fax management software product that accepts and sends faxes which uses a connector tool that allows the IME to automatically flow faxes from RightFax to OnBase for imaging and workflows. The software also allows IME users to send faxes from their desk tops. RightFax is supported by the Department of Data Management (DDM). The Core MMIS contractor is responsible for the interface to the document repository and workflow systems.

4.6 Call Center Management System

The current call center system is with Cisco® Unified Contact Center Express 7.0. Cisco Unified Contact Center Express provides easy-to-deploy, easy-to-use, secure, virtual, highly available and sophisticated customer interaction management for up to 300 agents. Its fully integrated self-service applications improve customer response with sophisticated and distributed automatic call distributor (ACD), interactive voice response (IVR), computer telephony integration (CTI) and agent and desktop services in a single-server contact-center-in-a-box deployment, while offering the flexibility to scale to larger more demanding environments. It also supports business rules for inbound and outbound voice, email, web and chat. Customer interaction management helps ensure that each contact is delivered to the right agent the first time. The following links provide information highlighting the Cisco system:

http://www.ime.state.ia.us/Reports_Publications/RFPMED10001.html

http://www.cisco.com/en/US/docs/voice_ip_comm/cust_contact/contact_center/crs/express_7_0/configuration/guide/uccx70ag.pdf

4.7 Iowa Automated Benefit Calculation (IABC) System

The Iowa Automated Benefit Calculation (IABC) System is a computer-based system designed to gather, process and store information about Department clients. It calculates benefit levels and issues state warrants, Food Assistance benefits and client notices.

The IABC system can receive data from or send data to associated systems such as the Iowa Collection and Reporting (ICAR) system and the Family and Children's Services (FACS) system and the Title XIX member eligibility system to perform related functions. Workers provide source data by means of personal computers located in each local office in the state. Data input is processed daily. The Unit of Quality Assurance in the DDM keeps records of all entries on microfiche either electronically or in hard copy.

The IABC system stores information about individuals and cases separately. Each case is composed of eligibility units for various programs. Information for individuals is connected to the case using the state identification number. The individual information contains demographic and income data. It also contains data for programs for which the individual is considered and the cases associated with that individual.

Individuals are dropped from a case after one year of inactivity on that case. Cases that are closed are kept on the master file permanently. Individuals are retained on the state ID portion of the individual master file.

The IABC system will be reviewed for upgrade by 2013. This system is the responsibility of the DDM and is outside the scope of this procurement.

The Core MMIS contractor will be required to participate in integration related activities with the Department and the new Eligibility System contractor to determine the interfaces, business and system requirements applicable to the new MMIS.

4.8 Individualized Services Information System (ISIS)

The purpose of ISIS is to assist workers in the facility, HCBS waiver, remedial (remedial services will be eliminated effective July 1, 2011), habilitation and targeted case management programs in both processing and tracking applications and authorizations through approval or denial. The ISIS application is used by Income Maintenance Worker (IMWs), case managers, Medical Services contractor staff, child health specialty clinics, transition specialists, financial management service authorization staff, member and provider customer service representatives and Department policy staff. ISIS is supported by MMIS and is included for replacement as part of the procurement.

The information for the approved member is sent from ISIS to the Title XIX system for additional processing. The Title XIX system passes the prior authorization service record to the MMIS to allow claims to pay at the assigned rates and units.

The process starts in ISIS upon receipt of a file created by the Title XIX system that contains facility and waiver program eligibility. The original data file is produced by the IABC system. The ISIS system prompts each participant to perform key tasks and each participant must respond by entering the appropriate information for that task before the process can move to the

next task. The final approval milestone must be completed (closed) before an approved service plan can be sent to the MMIS prior authorization subsystem.

The Core MMIS contractor will be required to participate in integration related activities with the Department and the new Eligibility System contractor to determine the interfaces, business and system requirements applicable to the new MMIS.

4.9 Title XIX System

The Title XIX system is currently supported by DDM and will be replaced by the CORE MMIS contractor.

The Title XIX system accepts member medical eligibility from the current IABC system which is scheduled to be replaced in 2013. In addition, other types of eligibility are passed from the following systems:

a. ISIS system passes eligibility indicators for Targeted Case Management, PACE, and Money Follows the Person programs, and County of Legal Settlement.

b. Data warehouse passes the Iowa Department of Public Health (IDPH) date of death.

c. Medicare Part A, B, and D entitlement/enrollment information is received from CMS.

The Presumptive Eligibility system supports Presumptive Eligibility determination for infants, children, pregnant women, and breast and cervical cancer treatment programs.

The Title XIX system processes each member record, reviews eligibility and determines the type of coverage group that provides the most benefits coverage for the member using hierarchical business rules. Then, the primary active eligibility coverage is analyzed and multiple coverages could be applied to provide the member with the eligibility they are entitled or assigned to. Those coverages could include Medicare Part A, B, and D Prescription Drug Coverage, Iowa Plan, Lock-in, enrollment or disenrollment in Managed Health Care, IowaCare Medical Home Assignment, Targeted Case Management, PACE, and Money Follows the Person.

The Title XIX System is responsible for members in the two Premium Payment Coverage groups, MEPD and IowaCare (MIPS). The Title XIX member eligibility record updates the respective MEPD or MIPS database. Both databases (MEPD and MIPS) are used for member premiums, payment and billing activities. After all eligibility has been set for each member, the Title XIX system adds the Federal Funding and Reporting codes for MARS Federal reporting.

Medicaid Eligibility is stored in the Title XIX system on a full-month basis, with 24 months of historical data included on the file. The Title XIX system checks for premium payments before passing eligibility to MMIS. The Title XIX System passes daily and monthly files to the MMIS:

a. Title XIX member eligibility which includes Medicaid, Presumptive eligibility, and Facility and Waiver Eligibility.
b. Prior Authorized Services.

c. Managed Health Care Potential eligibles and ongoing updates.

The Core MMIS contractor will be required to participate in integration related activities with the Department and the new Eligibility System contractor to determine the interfaces, business and system requirements applicable to the new MMIS.

4.9.1 Medicare Prescription Drug Part D Database

The Medicare Part D database is an eligibility component of the Title XIX System. The Part D file from CMS provides prescription drug eligibility for Dual eligible members on Medicaid-Medicare. The Medicare Part D database processes daily and monthly, sending and receiving files to and from CMS. Using Title XIX member data, records are created to indicate current, prospective, retroactive, or changed eligibility information in relation to dual eligibility. In an attempt to increase the match rate with CMS, the Title XIX System uses data in the Medicaid Medicare Information (MMCR) database to overlay the demographic data passed from IABC to both the Social Security Buy-in (SSBI) database and the Medicare Part D database. The Part D response records contain the Part D claw-back information and data for each member.

NOTE: Medicare Part D database processing is not a part of the SSBI, Iowa's part A and B Buy-in system.

The Core MMIS contractor will be required to participate in integration related activities with the Department and the new Eligibility System contractor to determine the interfaces, business and system requirements applicable to the new MMIS.

4.9.2 Medicaid Medicare Information Database (MMCR)

The MMCR database was created by the Title XIX system and contains both Medicare and Medicaid data for each member. In 2006, Medicare Part D Drug Coverage was enacted, and all Iowa dual eligibles were auto-assigned to Medicare Part D drug coverage which replaced the Iowa Medicaid drug coverage for dual eligible members. This made Medicare Part D an eligibility component of the Title XIX System.

The MMCR database provides the State with historical data passed originally from IABC and also CMS Medicare Parts A, B & D.

This database was created to store history information for Iowa Medicaid members entitled to Part A and/or Part B Medicare. The MMCR database identifies the Medicare status of members that appear to be eligible for Medicare Part D. This database is not only valuable as a research tool; it is also used to pass Medicare data to the MMIS and GHS, the Pharmacy POS contractor, for coordination of coverage for dual eligible members. Also, Part D information is passed to the MMIS for the generation of the Part D informational letter.

Another purpose of the MMCR database is sending a file of dual eligible members to the Coordination of Benefits Contractor (COBC), GHI, who is a CMS contractor. This file is used to identify Iowa's dual eligible members for Medicare crossover claims processing. This file is sent to the COBC bi-weekly. It contains new eligibility and updates for eligibility for all dual eligible members.

The MMCR database provides the State with historical data passed originally from the IABC System and also CMS Medicare Parts A, B and D. The Title XIX (Medicaid) portion of the MMCR database is created by using the demographic data in the Title XIX eligibility record. Each time a TXIX record is updated by IABC, if there are demographic changes, this information is stored in the MMCR database.

The federal information (Medicare) portion of the MMCR database is created by using the data from the CMS Enrollment Database (EDB) and Part D eligibility files. This portion contains demographic data as well as Medicare A, B and D entitlement and enrollment data. When information is received from CMS, all data is checked within the MMCR database, and if changes have been made, this record is identified by source, and stored within the database.

The Core MMIS contractor will be required to participate in integration related activities with the Department and the new Eligibility System contractor to determine the interfaces, business and system requirements applicable to the new MMIS.

4.9.3 Medicaid IowaCare Premium Subsystem (MIPS) and Medicaid for Employed People with Disabilities (MEPD)

MIPS is used to record premiums, billing statements, payments and granting hardship claims made for each IowaCare member who is assessed a monthly premium payment.

The MIPS subsystem is integrated within the Title XIX system. The MIPS system applies business rules to apply premium payments, create billing statements and grant timely hardship claims made for each IowaCare member who is assessed a monthly premium payment. This subsystem is also able to provide data for recoupment purposes.

MEPD is a Medicaid coverage group implemented to allow persons with disabilities to work and continue to have access to medical assistance. The MEPD subsystem is integrated within the Title XIX system. The MEPD system applies business rules for member Medicaid eligibility which includes applying premium payments and creating billing statements. The process and rules for this premium program are significantly different from the IowaCare rules, as MEPD Medicaid eligibility is dependent upon timely premium payment.

The Core MMIS contractor will be required to participate in integration related activities with the Department and the new Eligibility System contractor to determine the interfaces, business and system requirements applicable to the new MMIS.

4.10 Social Security Buy-In (SSBI)

The SSBI system is comprised of a Custom Information Control System (CICS) and VSAM mainframe component that supports Medicare Parts A and B entitlement, enrollment and premium activity. The SSBI system creates the Iowa interface with CMS for Medicare Part A and B entitlement and enrollment for Medicaid eligible members.

The Title XIX system provides member eligibility to the SSBI system. The SSBI system processes member eligibility along with previous Medicare buy-in eligibility, if any, and this information is then transmitted by Iowa to CMS once a month. CMS responds to the Iowa data in the second week of the following month. The CMS response file is processed by the SSBI system and provides Iowa the necessary Iowa Medicare premium totals and a record for each Iowa member denoting the Medicare eligibility and premium status. The Iowa member records are stored in the SSBI system.

The Core MMIS contractor will be required to participate in integration related activities with the Department and the new Eligibility System contractor to determine the interfaces, business and system requirements applicable to the new MMIS.

4.11 Medicaid Quality Utilization and Improvement Data System (MQUIDS)

The Medicaid Quality Utilization and Improvement Data System (MQUIDS) is a data entry and retrieval application designed to facilitate the Medical Services contractor's job functions used by Medical Services. It provides common graphical user interfaces that mask the complexities of business rules associated with data entry and display of information for user analysis. The content is guided by the business and policy requirements of medical review. The medical services reviews frequently involve the documentation of health information on individual members that must be protected. Additional information is available in the IME resource library. MQUIDS was written by Medical Services and runs on state software. MQUIDS is not being replaced as part of this procurement.

4.12 Iowa Medicaid Electronic Records System (I-MERS)

I-MERS is a web-based tool designed to help inform medical decisions by giving providers access to information about services Iowa Medicaid has paid for specific members. I-MERS is available to the following types of providers and administrative staff enrolled in Iowa Medicaid: physician, advanced registered nurse practitioners (ARNP), hospital, federally qualified health center (FQHC), rural health clinic (RHC), community mental health center (CMHC), psychiatric medical institution for children (PMIC), home health agency and pharmacy.

4.13 Iowa Medicaid Portal Application (IMPA)

a. The Iowa Medicaid Portal Application was initially created to support provider critical incident reporting. It has been expanded to include the following features. Provider Incident Reporting – This is a real-time web application that enables IMPA users and or providers who are legally responsible to report incidents. The application has rules-based workflow that integrates the provider reporting with DHS/IME policy and program staff.

b. Informational Letters (IL's) – All IL's are issued and made available through either secure login or anonymous access to the IME's list server. Users sign up for IL's under a variety of different categories (e.g., by Provider Type, by Claim Type, etc.) or a user can sign-up for e-mail notification for all IL's issued. The IL's are maintained within the portal for easy access and searching.

c. Remittance Advice – All providers now use IMPA to access image of their remittance advice(s).

d. Uploading Documents – There are several reports required for various Medicaid services and programs. Within IMPA, a user can upload a document (e.g. services report) and it is then loaded within the IME's document management system.

e. Re-Enrollment/New Provider Enrollment – the IME is preparing for provider re-enrollment. The entire process is accomplished via a web-based application within IMPA. This includes validation of existing provider information (e.g. Business Entity Management), current NPI's enrolled within Medicaid (Rendering NPI Roster, Pay-To NPI Roster), and the ability to upload any and all documents required as part of the enrollment (e.g., copy of a required

license). Shortly after the initiation of the re-enrollment process, all new provider enrollments will be accomplished using these modules in a web-based process.

f. Providers can complete their application and attestation to receive incentive payments for the adoption, implementation or upgrade of a certified electronic health record system.

g. Providers who have completed training use this portal to submit applications for presumptive eligibility for children.

4.14 Pharmacy Point-of-Sale (POS) System

The Pharmacy Point-of-Sale (POS) system supports two primary functions: pharmacy claims processing and drug rebate. The Pharmacy POS contractor interfaces with the Pharmacy Medical Services contractor to receive the pharmacy prior authorizations.

The Pharmacy POS system operates on a state owned hardware platform which is housed with the current POS contractor. The pharmacy POS contractor is responsible for developing and maintaining interfaces and achieving technical integration with all other modules that use pharmacy data.

The Pharmacy POS system provides for on-line, real time adjudication of pharmacy claims with edits, including application of prior authorization requirements and audits that support the Department's policies and objectives. The system includes the following functions:

a. Claims processing for pharmacy claims.

b. Reference (formulary file).

c. Prospective drug utilization review (ProDUR).

d. Drug rebates.

e. Verification of provider and client eligibility.

f. Cost avoidance edits for third-party liability including private insurance and Medicare.

g. Price determination utilizing all pricing sources required.

h. Copayment calculation and tracking in accordance with state regulations.

i. Dispensing fees requirements.

j. Standard ProDUR and customized ProDUR interventions.

k. Customized messaging.

l. Acceptance of prior authorization data from multiple sources.

m. Preferred drug list (PDL) and recommend drug list enforcement through claims processing.

n. Support for additional programs such as Medicare Part B and Medicare Transitional Assistance when they are initiated.

o. Customized override functionality.

p. Ability to implement smart PA edits using patient profiles and therapeutic classes.

q. Administration of all aspects of federal and supplemental rebates excluding supplemental rebate negotiation and contracting.

r. Patient restrictions or lock-ins.

s. Physician exemptions from certain edits.

4.15 CareConnection® System

CareConnection System (referred to as C3) is a data entry and retrieval application used by the Member Services unit. The information enables providers to access the claims and information related to the members they treat as well as to review, modify and approve plans of care. The system can be used to calculate the Iowa Medication Possession Ratios (MPR), designed to improve the quality of care and reduce costs to the Department.

4.16 Impact Fraud and Abuse Detection System (IFADS)

The IFADS solution is a fully web-based component that helps identify potential Medicaid fraud and abuse and speed recovery of program dollars used by Program Integrity. IFADS uses two applications Impact™ Fraud Analytics application (IFADS) and the CMS-certified Impact Surveillance and Utilization Review (ISUR). One uses peer grouping methodology and the other uses healthcare analytics and advanced data mining algorithms.

Other key components of the IFADS solution include:

a. A case tracking component that is used to track, document and support investigation and recovery activities.
b. A Provider Activity Spike Detection component automatically detects providers who have had large increases (or decreases) in billing activity.
c. A Random Sampling component allows users to draw random samples of claims, provider or member information.

IFADS also includes browse and search (“ad hoc like”), online reference code lookups, “top N” reports (by procedure code, diagnosis code and NDC), “dollars by month and quarter and year” reports, provider and client demographic information, links to current fraud and abuse articles, online Help and support materials such as archives from past ‘Users’ Meetings.

4.17 ImpactPro

Impact Pro is an episode-based modeling and care management tool that helps analyze care management teams utilize clinical, risk and administrative member profile information to target health care services used by Program Integrity. This allows care management teams to provide members with new program opportunities and assess the efficacy and quality of the member’s current intervention programs.

4.18 iQRMS Recovery Management System

iQRMS is a recovery and case management tool that tracks, manages and measures all stages of overpayment collection used by Program integrity. The collection of overpayments from providers includes generating lists of overpaid claims, mailing letters to providers, establishing accounts receivable files, responding to provider inquiries, adjusting notice of intent to recover letters and managing the collection of funds. iQRMS allows for the capture of notes from provider discussions, contact names and phone numbers to be recorded with the case.

Real time access to a provider's billing history and the case status allows the Department to effectively close cases. Use of this tool by the Department staff will enable the Program Integrity (PI) unit to meet the financial goals of this project.

4.19 Provider Self Review

Provider self review is an interface between the Department and the providers offering Internet technology to engage providers as a team in reviewing and analyzing their own suspect claims used by Program Integrity. It provides support for standard self audit process including alternative self audits.

Table 3: Current IME Tools

Current Iowa Medicaid Enterprise Tools	Not Replace	Replace
4.1: Iowa Medicaid Management Information System (MMIS)		X
4.1.1: Claims Processing Function		X
4.1.2: Recipient Function		X
4.1.3: Provider Function		X
4.1.4: Reference Function		X
4.1.5: Medically Needy Function		X
4.1.6: Management and Administrative Reporting (MAR) Function		X
4.1.7: Surveillance and Utilization Review Subsystem (SURS) Function		X
4.1.8: Third-Party Liability (TPL) Function		X
4.1.9: Prior Authorization Function		X
4.1.10: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Function		X
4.2: Eligibility Verification Information System (ELVS)	X	
4.3: Data Warehouse and Decision Support (DW /DS) System	X	
4.4: Workflow Process Management System (OnBase)	Optional	
4.5: Right Fax	X	
4.6: Call Center Management System	X	
4.7: Iowa Automated Benefit Calculation (IABC) System	*Department to replace under a separate RFP	
4.8: Individualized Services Information System (ISIS)		X
4.9: Title XIX		X
4:9.1: Medicare Prescription Drug Part D		X
4.9.2: Medicaid Medicare Information System (MMCR)		X
4.9.3: Medicaid IowaCare Premium System (MIPS) and Medicaid for Employed People with Disabilities (MEPD)		X
4.10: Social Security Buy-In (SSBI)		X
4.11: Medicaid Quality Utilization and Improvement Data System (MQUIDS)	X	
4.12: Iowa Medicaid Electronic Records System (I-MERS)	X	
4.13: Iowa Medicaid Portal Application (IMPA)	Optional	
4.14: Pharmacy Point-of-Sale (POS) System		X
4.15: CareConnection® System	X	
4.16: Impact Fraud and Abuse Detection System (IFADS)	X	

Current Iowa Medicaid Enterprise Tools	Not Replace	Replace
4.17: ImpactPro	X	
4.18: iQRMS Recovery Management System	X	
4.19: Provider Self Review	X	

5 GENERAL REQUIREMENTS

The system services components in this Request for Proposal (RFP) include those responsibilities directly in support of the MMIS and POS. In addition, these activities promote the state's responsibilities for service assessment and quality indicators. The system services component requirements sections include:

5.1: General Requirements for MMIS and POS

5.2: Staffing

5.3: Contract Management

5.4: Annual Performance Reporting

5.5: General Documentation

5.6: Operational Procedures Documentation

5.7: Knowledge Transfer

5.8: Security and Confidentiality

5.9: Accounting

5.10: Banking Policies

5.11: Payment Error Rate Measurement (PERM) Project

5.12: Subcontractors

5.13: Regulatory Compliance

5.14: Audit Support

5.15: No Legislative Conflicts of Interest

5.16: No Provider Conflicts of Interest

5.1 General Requirements for MMIS and POS

Following are the high-level general requirements for all modules:

a. The Department's intent in this procurement is to maintain the state's seamless delivery of all MMIS and POS system services for the Medicaid program. All contractor(s) and the responsible Department administrators will continue to be located at a common state location as part of the Iowa Medicaid Enterprise (IME) administration after implementation of the MMIS and POS.

b. The Department continues to emphasize the importance of coordination of efforts among state staff and all contractor(s). No single contractor can perform their required responsibilities without coordination and cooperation with the other contractors) All contractors are to maintain communication with each other and with state staff as necessary to meet their responsibilities to the Department.

c. The Department, through its contract managers, retains the role of contract monitor for all Requests for Proposal (RFP) system service contractor(s). The Department will favor, in

this procurement, bidders who have demonstrated success in cooperative, collaborative environments.

d. System services contractor(s) will interface with the IME Professional Services units which include:

   1. Medical Services.
   2. Pharmacy Medical Services.
   3. Provider Services.
   4. Member Services.
   5. Revenue Collections.
   6. Provider Cost Audits and Rate Setting (PCA).
   7. Program Integrity.

   Access the links below to review the IME Professional Services and Program Integrity RFPs, contracts and proposals.

   http://www.ime.state.ia.us/docs/IME_Professional_Services_RFP_IncorpAmend6.pdf

   http://www.ime.state.ia.us/Reports_Publications/RFP/RFPMED_10_013.html

   The system services contractor(s) will also interact with the DW/DS, call center system and other state systems as necessary to meet their responsibilities. The system services contractor(s) are required to bring skilled staff with demonstrated experience in querying Medicaid-related data and preparing reports for contractor and state use. The system services contractor(s) will designate a primary contact for developing queries and requesting assistance from the DW/DS system manager.

e. System services contractor(s) will interface with the following state entities :

   1. The Division of Data Management.
   2. The Department of Administrative Services Information Technology Department.
   3. The Eligibility Support Team.
   4. The Iowa Health Information Network.

f. Interfaces include online updates to the IME data systems or file transfers among the respective system services contractors' data systems and the IME data systems. The system services contractor(s) can have online access and authority to update files on the IME data systems (except systems that other state agencies operate) as necessary to perform their required responsibilities. These updates require ongoing effective communication between the respective contractor(s) and the Department to assure timely maintenance that is transparent to the IME data systems.

g. System services contractor(s) will respond to the Department requests for information and other requests for assistance within the timeframe that the Department specifies.

h. System services contractor(s) will prepare and submit to the Department requests for system changes and notices of system problems related to the Contractor's operational responsibilities.

i. System services contractor(s) will prepare and submit for Department approval suggestions for changes in operational procedure and implement the changes upon approval by the Department.

j. System services contractor(s) will ensure that effective and efficient communication protocols and lines of communication are established and maintained throughout the IME. The contractor(s) will take no action that has the appearance or effect of reducing open communication and association between the Department and contractor(s) staff.

k. System services contractor(s) will attend regular meetings with Department management and all other IME contractors to provide an overview of their performance standards and issue resolutions. These meetings generally occur on a monthly basis.

l. System services contractor(s) will meet regularly with other IME contractors and Department management to review account performance and resolve issues.

m. System services contractor(s) will provide to the Department reports regarding contractor activities for which the contractor will negotiate the content, format and frequency of these reports with the Department. The intent of the reports is to afford the Department and the contractor better information for management of the contractor's activities and the Medicaid program.

n. System services contractor(s) will maintain operational procedure manuals and in a format specified by the Department and update the manuals when changes occur.

o. In situations where the Department permits contractors to use external data systems, the contractors must provide electronic interfaces from those external data systems to the IME data systems to support automated performance reporting.

5.2 Staffing

Bidders are to propose sufficient staff who have the requisite skills to meet all requirements in this RFP and who can attain a satisfactory rating on all performance standards. The Department encourages bidders to leverage current IME staff. Bidders are required to include the number of proposed staff by functional area that they will use to fulfill the contract requirements.

5.2.1 Named Key Personnel

The Department is requiring key positions to be named for each module, consistent with the belief that the bidder should be in the best position to define the project staffing for the contractor’s approach to the RFP requirements. Resumes, along with letters of commitment for the start-up and implementation staff, must be supplied with the proposal.

Key staff must be available for assignment for the MMIS and POS projects on a full-time basis and must be solely dedicated to this project. Each key staff member must have the required experience.

Key staff positions for the System Services RFP are named below:

a. Account Manager.

b. Systems Implementation Manager.

c. Project Manager for the Project Management Office.

d. Quality Assurance Manager.

e. Data Conversion Manager.

f. Interface Manager.

g. Testing Manager.

h. Certification Manager.

i. Turnover Manager.

j. Systems Manager.

k. Claims Operations Manager.

l. POS Operations Manager.

5.2.2 Key Personnel Requirements

General requirements for key personnel are as follows:

a. The bidder must employ the account manager and project manager for the Project Management Office (PMO) for the MMIS and POS when the bidder submits the proposal.

b. The bidder must employ all other key personnel or must have a commitment from them to join the bidder's organization by the beginning of the contract start date with the exception of Certification, Operations, and Turnover staff.

c. The bidder must commit key personnel named in the proposal to the project from the start date identified in the table below for the start-up and implementation phases. The bidder may not reassign key personnel during this period, except in cases of resignation or termination from the contractor's organization or in the case of the death of the named individual.

The following table illustrates the qualifications, start date and any special requirements for key personnel who must be named for the system services phases.

Table 4: Key Personnel for the Start-Up and Implementation Phases

CORE MMIS and POS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
Account Manager	A minimum of four years of account management or senior supervisory experience for a government or private sector health care payor, including a minimum of three years of experience in a state of equivalent scope to Iowa.	Contract signing date.	Must be 100 percent dedicated to the Iowa Medicaid project. Must be employed by bidder when proposal is submitted.
Systems Implementation Manager	Require a minimum of five years of Medicaid related system design and management experience including the management of one MMIS and or one POS systems design and development project similar in size and scope to this project. Experience must involve project management of an enterprise-wide	Contract signing date.	Must be 100 percent dedicated to the Iowa Medicaid project.

CORE MMIS and POS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
	architecture, networking, multiple systems integration, hardware and software and managing a technical team and its activities from inception through post implementation on a minimum of one project of similar size and complexity to this project. A Bachelor's Degree in Information System Engineering, Computer Science or a related field is also required.		
Project Manager for the Project Management Office (PMO)	Require a minimum of three years (36 months) of project management experience including the management of at least one MMIS and or one POS systems design and development project similar in size and scope to this project that encompassed the full system development life cycle from initiation through post implementation. A minimum of two years of experience using Microsoft Project or like software.	Contract signing date.	Must be 100 percent dedicated to the Iowa Medicaid project. Must be employed by bidder when proposal is submitted.
Quality Assurance Manager	A Bachelor's Degree with at least three courses in statistics and or quality assurance and a minimum of three years progressive experience in the quality assurance function of a large scale claims processing organization or have at least five years progressive experience in the quality assurance function of a large scale claims processing organization. This position must report directly to the Account Manager.	Contract signing date.	Must be 100 percent dedicated to the Iowa Medicaid project.
Data Conversion Manager	Requires a minimum of five years experience managing data conversion for a MMIS and or a POS implementation project(s) or health care information systems. A Bachelor's Degree in Information System Engineering or a related field.	Contract signing date.	Must be 100 percent dedicated to the Iowa Medicaid project.

CORE MMIS and POS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
Interface Manager	A minimum of four years experience in systems integration, messaging modules and interface development. A Bachelor's Degree in Information System Engineering or a related field.	Contract signing date.	Must be 100 percent dedicated to the Iowa Medicaid project.
Testing Manager	A minimum of four years experience conducting system and user acceptance tests for a MMIS and or a POS or major health payor system. A Bachelor's Degree in Business Management or a related field is also required.	Contract signing date.	Must be 100 percent dedicated to the Iowa Medicaid project.

Table 5: Key Personnel for the Certification Phase

CORE MMIS and POS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
Certification Manager	A minimum of five years of Medicaid related system design and strong management and communication skills, experience including the management of one MMIS systems design and development project similar in size and scope to this project	Six months prior to phase start date.	Must be 100 percent dedicated to the Iowa Medicaid project.

Table 6: Key Personnel for the MMIS Operations Phase

CORE MMIS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
Account Manager	A minimum of four years of account management or senior supervisory experience for a government or private sector health care payor, including a minimum of three years of experience in a state of equivalent scope to Iowa.	Three months prior to phase start date	Must be 100 percent dedicated to the Iowa Medicaid project.

CORE MMIS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
Claims Operations Manager	A Bachelor's Degree, or equivalent experience and a minimum of four years experience managing claims processing operations and personnel for a Medicaid fiscal agent or private sector health care payor, including a minimum of two years MMIS experience.	Three months prior to phase start date	Must be 100 percent dedicated to the Iowa Medicaid project.
Systems Manager	A minimum of four years of MMIS operation experience as manager in a state of equivalent scope to Iowa. A Bachelor's Degree in Information System Engineering or Computer Science or a related field is also required. Equivalent experience may be substituted for the degree providing this manager is an active participant during the Iowa design, development and implementation phase.	Three months prior to phase start date	Must be 100 percent dedicated to the Iowa Medicaid project.
Quality Assurance Manager	A Bachelor's Degree with at least three courses in Statistics and or Quality Assurance and a minimum of three years progressive experience in the quality assurance function of a large scale claims processing organization or at least five years progressive experience in the quality assurance function of a large scale claims processing organization. This position must report directly to the Account Manager.	Three months prior to phase start date	Must be 100 percent dedicated to the Iowa Medicaid project.

Table 7: Key Personnel for the POS Operations Phase

POS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
Account Manager	A minimum of four years of account management or senior supervisory experience for a government or private sector health care payor, including a minimum of three years of experience in a state of equivalent scope to Iowa.	Three months prior to phase start date	Must be 100 percent dedicated to the Iowa Medicaid project.
Operations Manager	A Bachelor's Degree, or equivalent experience, and a minimum of four years experience managing pharmacy POS operations and personnel for a government or private sector health care payor, including a minimum of two years Medicaid POS experience.	Three months prior to phase start date	Must be 100 percent dedicated to the Iowa Medicaid project.

Table 8: Key Personnel for the Turnover Phase

MMIS and POS KEY PERSONNEL			
Key Person	**Qualifications**	**Start Date**	**Special Requirements**
Turnover Manager	A Bachelor's Degree and at least three years MMIS and or POS experience turning over operations similar in size and scope to Iowa. Turnover Manager must have sufficient delegation of management authority to make decisions and obligate contractor(s) resources to fulfill obligations of the Turnover Phase.	Six months prior to phase start date	Must be 100 percent dedicated to the Iowa Medicaid project.

5.2.3 Key Personnel Resumes

Resumes must include the following information:

a. Employment history for all relevant and related experience.

b. Names of employers for the past five years, including specific dates.

c. All educational institutions attended and degrees obtained.

d. All professional certifications and affiliations.

5.2.4 Key Personnel References

References for key personnel must meet the following requirements:

a. Must include a minimum of three professional references outside the employee's organization that can provide information about the key person's work on that assignment.

b. Must include the reference's full name, mailing address, telephone number and e-mail address.

c. Must include the agency's or company's full name and street address with the current telephone number and e-mail address of the client's responsible project administrator or service official who is directly familiar with the key person's performance.

d. Must be available to the Department to contact during the proposal evaluation process.

e. Must reflect the key person's past five years of professional experience.

f. The Department reserves the right to check additional personnel references.

5.2.5 Letter of Commitment

The proposal must include letters of commitment and resumes of all key personnel named for the Start-up and Implementation Phases.

5.2.6 Department Approval of Key Personnel

a. The Department reserves the right of prior approval for all named key personnel in the bidder's proposal.

b. The Department also reserves the right of prior approval for any replacement of key personnel.

c. The Department will provide the selected contractor 45 days to find a satisfactory replacement for the position except in cases of flagrant violation of state or federal law or contractual terms. Extensions may be requested in writing and approved by the Department.

d. The Department reserves the right to interview any and all candidates for named key positions prior to approval.

5.2.7 Changes to Contractor's Key Personnel

a. The contractor(s) may not replace or alter the number and distribution of key personnel as bid in its proposal without prior written approval from the Department which shall not be unreasonably withheld.

    1. Replacement for key personnel will have comparable knowledge transfer, experience and ability to the person originally proposed for the position.

    2. Replacement personnel, whom the Project Director or Contract Administrator have previously approved, must be in place performing their new functions before the departure of the key personnel they are replacing and for whom the Project Director or Contract Administrator has provided written approval of their transfer or reassignment.

    3. The Project Director or Contract Administrator may waive this requirement upon presentation of good cause by the contractor(s).

b. The contractor(s) will provide the Project Director or Contract Administrator with 15 business days notice prior to any proposed transfer or replacement of any contractor's key personnel.
    1. At the time of providing such notice, the contractor(s) will also provide the Project Director or contract administration with the resumes and references of the proposed replacement key personnel.
    2. The Project Director or Contract Administrator will accept or reject the proposed replacement of key personnel within 10 business days of receipt of notice.
    3. Upon request, the Project Director or Contract Administrator will have an opportunity to meet the proposed replacement key personnel in Des Moines, Iowa, within the 10 day period.
    4. The Project Director or Contract Administrator will not reject proposed replacement key personnel without reasonable cause.
    5. The Project Director or Contract Administrator may waive the 15 business day notice requirement when replacement is due to termination, death or resignation of a key employee.

5.2.8 Job Rotation

The contractor(s) will be required to develop and maintain a plan for job rotation and conduct knowledge transfer to staff to ensure that all functions can be adequately performed during the absence of staff for vacation and other absences.

5.2.9 Coverage during Vacations for Sensitive Positions

The contractor(s) will be required to designate staff who are trained and able to perform the functions of sensitive positions when the primary staff member is absent on consecutive days of vacation.

5.2.10 User Access

The contractor(s) may schedule maintenance during the off hours, from 7:00 p.m. to 6:00 a.m. Central Time (CT).

An application is considered unavailable when a user does not get the complete, correct full-screen response to an input transaction after depressing the "enter" key or another specified function key. The Department will notify the contractor(s) when they have determined the system is unavailable.

The contractor(s) must establish a performance dashboard that will report to the selected service level indicators from the Department applications to indicate availability of the selected application, plus an exception log identifying those applications that were not available during the reporting period. The contractor(s) will also include the calculation of user access availability in the report. The frequency, content and methodology for the reports must be approved by the Department. The contractor(s) will be responsible for providing and maintaining all necessary telecommunications circuits between the Department offices and the contractor's facilities.

Network response time shall be measured for all Department business days between the hours of 7:00 a.m. to 6:00 p.m. Central Time. Contractor(s) must provide an automated means to measure and report network response time that meets the Department requirements. The network response time is measured from the time the transaction is entered until all data is displayed on the screen or print process begins. Network response times are outlined in the performance standards.

5.2.11 Employees and Subcontractors

The contractor(s) shall comply with all federal and state requirements concerning fair employment, employment of the disabled and concerning the treatment of all employees without regard to discrimination by reason of race, color, religion, gender, national origin or physical disability.

5.2.12 Residency and Work Status

The contractor(s) must follow all federal and state laws regarding Social Security registration and legal work status of all staff employed or contracted by the contractor(s).

5.2.13 Background Checks

All staff employed or contracted by the contractor(s) working on the MMIS and POS must have a criminal background check done prior to employment and periodically as required by the state, with results submitted to the state for review. The contractor(s) must provide the Department with their background check criteria or guidelines for Department review and approval.

5.2.14 Bonding

The MMIS and POS contractor(s) must be bonded against loss or theft for all staff who handle or have access to checks in the contractor's performance of its functions.

5.2.15 Subcontractors

The Department reserves the right to prior approve all subcontractor(s) and subcontractor(s) work locations.

5.3 Contract Management

The State of Iowa has mandated performance-based contracts. State oversight of contractors' performance and payments to the contractor(s) are tied to meeting the performance standards identified in the contracts awarded through this RFP.

5.3.1 Performance Reporting and Quality Assurance

a. The contracts awarded through this RFP will contain performance standards that reflect the performance requirements in this RFP.
    1. The standards will include timeliness, accuracy and completeness for performance of or reporting about operational functions.

2. These performance standards must be quantifiable and reported using as much automation as possible.
3. The Department will select a subset of the standards for the contractor(s) to include in a quarterly public report.

b. In addition, the system services contractor(s) are responsible for internal quality assurance activities. The scope of these activities include the following functions:
   1. Identify deficiencies and improvement opportunities within the system services contractor's area of responsibility.
   2. Provide the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.
   3. Agree upon timeframes for corrective actions.
   4. Meet all corrective action commitments within the agreed upon timeframes.

5.3.2 State Responsibilities

The Department's contract administration for the IME is the principal contact with the system services contractor(s) and coordinates interaction between the Department and the professional services contractors. Contract administration includes the Contract Administration Office (CAO) and the Department's designated unit manager (contract manager) for each IME unit. The Department's contract administration is responsible for the following activities:

a. Monitor the contract performance and compliance with contract terms and conditions.
b. Serve as a liaison between the contractor(s) and other state users.
c. Initiate or approve system change orders and operational procedures changes.
d. Assess and invoke damages for contractor(s) noncompliance.
e. Monitor the development and implementation of enhancements and modifications to the system.
f. Review and approve completion of the contractor's documentation as required by the Department.
g. Develop, with participation from the contractor(s), compliance with performance standards, negotiate reporting requirements and measure compliance.
h. Review and approve contractors' invoices and supporting documentation for payment of services.
i. Coordinate state and federal reviews and assessments.
j. Consult with the contractor(s) on quality improvement measures and determination of areas to be reviewed.
k. Monitor the contractor(s) performance of all contractor(s) responsibilities.
l. Review and approve proposed corrective actions taken by the contractor(s).
m. Monitor corrective actions taken by the contractor(s).
n. Communicate and monitor facility concerns.

5.3.3 Contractor Responsibilities

The system services contractor(s) is responsible for the following contract management activities:

a. Develop, maintain and provide access to records required by the Department, state and federal auditors.

b. Provide reports necessary to show compliance with all performance standards and other contract requirements.

c. Provide to the Department reports regarding components contractors' activities. Individual system services contractor(s) are to propose and negotiate the content of these reports with the Department. The intent of the reports is to provide the Department and the component contractors with better information for management of the contractors' activities and the Medicaid program.

d. Prepare and submit to the Department requests for system changes and notices of system problems related to the contractor's operational responsibilities.

e. Prepare and submit for Department approval suggestions for changes in operational procedures and implement the changes upon approval by the Department.

f. Maintain operational procedure manuals and update the manuals when changes are made.

g. Ensure that effective and efficient communication protocols and lines of communication are established and maintained both internally and with Department staff. No action shall be taken which has the appearance of or effect of reducing open communication and association between the Department and contractor staff.

h. Meet regularly with all elements of the IME to review account performance and resolve issues between contractor and the Department.

i. Provide to the Department progress reports on system services contractor's activity as requested by the Department.

j. Meet all federal and state privacy and security requirements within the contractor's operation.

k. Work with the Department to implement quality improvement procedures that are based on proactive improvements rather than retroactive responses. The contractor(s) must understand the nature of and participate in quality improvement procedures that may occur in response to critical situations and will assist in the planning and implementation of quality improvement procedures based on proactive improvement.

l. Monitor the quality and accuracy of the contractor's own work.

m. Submit quarterly reports electronically or in hard copy of the quality assurance activities, findings and corrective actions (if any) to the Department.

n. Perform continuous workflow analysis to improve performance of contractor functions and report the results of the analysis to the Department.

o. Provide the Department with a description of any changes to the workflow for approval prior to implementation.

p. For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.

1. Implement a state-approved corrective action plan within the time frame negotiated with the state.
2. Provide documentation to the Department demonstrating that the corrective action is complete and meets state requirements.
3. Meet the corrective action commitments within the agreed upon timeframe.

q. Provide a written response to the Department via e-mail within two business days of receipt of e-mail on routine issues or questions and include descriptions of resolution to the issues or answers to the questions.

r. Provide a written response to the Department via e-mail within one business day of receipt of e-mail on emergency requests as defined by the state.

s. Maintain Department-approved documentation of the methodology used to measure and report completion of all requirements and attainment of all performance standards.

5.3.4 Performance Standards

The performance standards for the contract management functions are provided below.

a. Provide the monthly contract management reports within three business days of the end of the reporting period.

b. Provide monthly performance monitoring report within ten business days of the end of the reporting period.

c. Provide knowledge transfer on operational procedure changes as a result of upgrades or other changes within two weeks of the upgrade.

d. Complete updates to all documentation related to modifications performed on the system as defined by the Department.

e. Update operational procedure manuals within 10 business days of the implementation of a change.

f. Provide a response and resolution to the Department unit manager team within two business days of receipt to requests made in any form (e.g., e-mail, phone) on routine issues or questions.

g. Provide a response within one business day to the Department unit manager team on emergency requests, as defined by the state.

5.4 Annual Performance Reporting

The contractor(s) will provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June. (Example: Provide data by October 15, 2011, for the state fiscal year that ended on June 30, 2011.) The contractor will present the required data in Department approved format and content for the following annually reported performance standards. The Department will publish the annual measurements by the following February 15.

5.4.1 Reporting Deadline

The required reports will be provided within 10 business days of the end of the reporting period.

5.5 General Documentation

a. Create and update operational procedure manuals in the state-prescribed format within 10 business days of the implementation of a change.

b. Identify deficiencies and provide the Department with a corrective action plan through the internal quality control reviews within ten business days of discovery of a problem found.

c. Maintain the Department-approved documentation of the methodology used to measure and report on all completed contract requirements and all performance standards. State the sources of the data and include enough detail to enable the Department staff or others to replicate the stated results.

d. System services contractor(s) will designate a trainer for its component who will train the professional services contractor's staff.

e. Maintain and update the system design documentation, user manuals, and data dictionaries for all systems.

5.6 Operational Procedures Documentation

a. The system services contractor(s) must maintain operational procedures in the Department-prescribed format documenting the processes and procedures used in the performance of their IME functions. RFP Section 6 Start-up and Implementation Phases project management section provides further detail on the deliverables.

b. The contractor(s) will document all changes within 10 business days of the change in the format as defined by the Department. The contractor(s) will provide to the Department updated documentation within 10 business days of the date changes are installed before the Department provides a signoff of the task.

c. The contractor(s) must use version control to identify current documentation.

d. All documentation must be provided in electronic form and made available online.

e. The contractor(s) will maintain standard naming conventions in the documentation. The contractor(s) will not reference the contractor's corporate name in any of the documentation.

5.7 Knowledge Transfer

a. All contractor(s) staff will receive appropriate knowledge transfer in the systems functions that they will use.

b. The Department will require that the Core MMIS contractor conduct MMIS and workflow process management knowledge transfer.

c. The Department will arrange contact management (call center) and tracking system of knowledge transfer for all system services contractor(s) staff members who interface with these systems. Likewise, the Department will provide DS/DW system knowledge transfer to system services contractor(s) staff members who will use the system.

d. System services contractor(s) will be responsible for knowledge transfer to its staff in the system and operational procedures required to perform the contractor's functions under the contract.

e. System services contractor(s) will designate a trainer for its component who will train the professional services contractor's staff.

f. System services contractor(s) will provide initial and ongoing knowledge transfer to its staff in its operational procedures. The knowledge transfer will occur when:

   1. New staff or replacement staff is hired.
   2. New policies or procedures are implemented.
   3. Changes to policies or procedures are implemented.

5.8 Security and Confidentiality

a. When not occupying state space, the contractor(s) must provide physical site and data security sufficient to safeguard the operation and integrity of the IME. The contractor(s) must comply with the Federal Information Processing Standards (FIPS) outlined in the following publications, as they apply to the specific contractor's work:

   1. Automatic Data Processing Physical Security and Risk Management (FIPS Publication (PUB).31).
   2. Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB.41).

b. In all locations, the contractor(s) must safeguard data and records from alteration, loss, theft, destruction or breach of confidentiality in accordance with both state and federal statutes and regulations, including but not limited to Health Insurance Portability and Accountability Act (HIPAA) requirements. All activity covered by this RFP must be fully secured and protected.

c. Safeguards designed to assure the integrity of system hardware, software, records and files include:

   1. Orienting new employees to security policies and procedures.
   2. Conducting periodic review sessions on security procedures.
   3. Developing lists of personnel to be contacted in the event of a security breach.
   4. Maintaining entry logs for limited access areas.
   5. Maintaining an inventory of Department-controlled IME assets, not including any financial assets.
   6. Limiting physical access to systems hardware, software and libraries.
   7. Maintaining confidential and critical materials in limited access, secured areas.

d. The Department will have the right to establish backup security for data and to keep backup data files in its possession. Should the Department choose to exercise this option, it will in no way relieve the contractor(s) of its responsibilities.

5.8.1 Security Staff

The contractor(s) must operate a systems security unit under direct management control. The contractor(s) must separate duties of staff responsible for network connections, routing, firewall

management, intrusion detection, email service, user authentication and verification, password management and physical access control to ensure appropriate administrative, physical and technical controls are in place. At a minimum, the contractor(s) must implement and maintain the security and privacy standards set forth in Section 5 General Requirements of this RFP.

5.9 Accounting

a. The contractor(s) will maintain accounting and financial records (such as books, records, documents, and other evidence documenting the cost and expenses of the contract) to such an extent and in such detail as will properly reflect all direct and indirect costs and expenses for labor, materials, equipment, supplies, services, etc., for which payment is made under the contract. These accounting records will be maintained in accordance with generally accepted accounting principles (GAAP). Furthermore, the records will be maintained separate and independent of other accounting records of the contractor(s).

b. Financial records pertaining to the contract will be maintained for seven years following the end of the federal fiscal year during which the contract is terminated or until final resolution of any pending state or federal audit, whichever is later. Records involving matters of litigation will be maintained for one year following the termination of such litigation if the litigation has not been terminated within the seven years.

5.10 Banking Policies

System services contractor(s) in the IME may receive checks or money orders related to the work that they perform. These checks and money orders may be for refunds, recoveries, cost settlements, premiums or drug rebates. System services contractor(s) are to meet the following requirements for checks or money orders.

a. Any unit that receives checks or money orders will log and prepare all payments for deposit on the day of receipt and deliver them to the Revenue Collections contractor's designated point of contact for daily deposits.

b. Any unit that receives checks or money orders will assist in the maintenance and updating of the existing check classification code schematic, as necessary.

c. Any unit that receives checks or money orders will provide assistance to the Department, Division of Fiscal Management, in the reconciliation of the monthly Title XIX Recovery bank account if requested to do so.

Only the Revenue Collections contractor will make the deposits.

5.11 Payment Error Rate Measurement (PERM) Project

a. Pursuant to the Improper Payments Information Act (IPIA) of 2002 and federal regulations at 42 CFR Parts 431 and 457, all states are required to participate in the measurement of improper payments in the Medicaid and CHIP programs. Iowa's participation began in federal fiscal year 2008 (October 1, 2007, through September 30, 2008) and is scheduled to continue every three years. The PERM Project measures the following aspects of the Medicaid and CHIP programs:

    1. Eligibility – the eligibility of the Member for the program and, if applicable, enrollment in a managed care plan.

2. Medical Review – the medical necessity and appropriate medical classification of the service that was provided.
3. Data Processing Review – the appropriate processing of the paid claim in the claims processing system, taking into account all necessary edits. This includes verifying the appropriate rate cell and payment for managed care (capitation) payments.

b. The Centers for Medicare and Medicaid Services (CMS) manage the PERM Project for all states, in which they contract certain aspects of the work. Required state involvement includes work that is performed by the IME and its contractors. During the course of the PERM Project, IME policy staff and contractors are responsible for the following:

1. Department Program Integrity Director and Manager (Department Policy) – Project coordination between all IME units and overall project management for IME-related work.
2. DW/DS – Submission of paid claims data, including details associated with the claims that are selected for review.
3. Provider Services – Issuance of general project notifications, assistance with ensuring that providers submit their documentation timely, and provision of copies of licenses or other enrollment documents upon request.
4. Provider Cost Audits and Rate Setting – Assistance with repricing claims in cases of potential findings of overpayments or underpayments and consultation related to reimbursement methodologies and pricing of claims.
5. Medical Services – Re-review of providers' documentation related to potential medical review errors and recommendation as to potential disputes.
6. Core MMIS – Claims processing and MMIS expertise and consultation related to pricing and payment of claims.
7. Program Integrity – All follow-up provider recovery or repayment actions associated with findings of overpayments or underpayments.
8. Pharmacy Point-of-Sale (POS) DW/DS – Submission of paid claims data, including details associated with the claims that are selected for review.

5.12 Subcontractors

Subcontractors must comply with all requirements of this RFP for all work related to the performance of the contract.

5.13 Regulatory Compliance

a. System services components acquired through this procurement are to be fully compliant with state and federal requirements (including HIPAA requirements) in effect as of the date of release for the RFP and with any changes that subsequently occur unless otherwise noted.

b. Bidders are responsible for describing how their proposed solution meets and will remain in compliance with state and federal requirements (including HIPAA requirements for transactions and code sets, national provider identifiers (NPI) and privacy and security).

5.14 Audit Support

Contractor(s) are to support and provide assistance with any state and federal audits and certifications as the Department requests. Examples include but are not limited to the annual audit that the state auditor's office conducts (e.g., the Medicaid Integrity Group (MIG) review and the Office of the Inspector General (OIG) audits specified in the contract).

5.15 No Legislative Conflicts of Interest

a. In the event that the bidder(s) (prior to contract award) or contractor(s) (after contract award) is directly involved with or otherwise supports legislation impacting the Medicaid program but outside the role as the IME contractor, notification to the Department is necessary.

b. If this situation exists prior to proposal delivery, the bidder should reflect this status in the response to the requirements in this section. If it exists prior to contract award, the bidder must notify the issuing officer in writing. If it exists after contract award, the contractor(s) must notify contract administration prior to the next legislative session.

c. At all times, the bidder(s) or contractor(s) must ensure that the legislation does not pose a conflict of interest to IME work in their proposal and contract. If a conflict exists, the bidder(s) or contractor(s) must do one of these things: withdraw their support of the legislation; or withdraw from consideration for contract award (while a bidder) or terminate contract according to termination requirements in the contract (while a contractor). This ongoing restriction applies throughout all phases of the contract.

d. At no time will the contractor(s) use its position as a contractor with the Department or any information obtained from performance of this contract to pursue directly or indirectly any legislation or rules that are intended to provide a competitive advantage to the contractor(s) by limiting fair and open competition in the award of this contract upon its expiration or to provide advantage to the contractor(s) during the term of the contract resulting from this RFP.

5.16 No Provider Conflicts of Interest

a. The contractor(s) warrants that it has no interest and agrees that it shall not acquire any interest in a provider that would conflict, or appear to conflict, in any manner or degree with the contractor's obligations and performance of services under this contract.

b. The contractor(s) will meet the following specifications to preclude participation in prohibited activities:

    1. The contractor(s) will subcontract with another firm to conduct any desk reviews or on-site audits of a provider if the provider is a client of the contractor(s) and the provider also provides services for the Department. However, the subcontractor will not conduct desk review or on-site audit of provider if provider is a client of either the contractor(s) or subcontractor when said entity also provides services for the Department.

    2. The contractor(s) will not use any information obtained by virtue of its performance of this contract and its relationship with the Department to provide what would be "inside information" to the contractor's clients who are providers of medical, social or rehabilitative treatment and supportive services on behalf of the Department or to the organizations that represent such providers.

3. The contractor(s) will disclose its membership on any and all boards. The contractor(s) will not use any information obtained by virtue of its contractual relationship with the Department to its advantage by voting, speaking to or attempting to influence board members in the performance of services by that board's organization.
4. The contractor(s) will not have ownership in any provider or provider organization that contracts with the Department or is approved by the Department to provide medical, social or rehabilitative treatment and supportive services on behalf of the Department.

6 START-UP AND IMPLEMENTATION PHASES

The Department is issuing this RFP to obtain the services of a contractor(s) to design, develop, implement and operate new state-of-the-art MMIS and POS systems that meet the business needs of the Iowa Medicaid Enterprise (IME). The current Core MMIS and POS contractors will continue to operate the current systems until the new MMIS and POS systems are implemented. The new MMIS and POS must meet all the contractual requirements described in this RFP and all applicable attachments.

The MMIS and POS systems must meet CMS certification requirements for enhanced federal funding. The proposed solutions must include the MMIS and POS modules, interfaces and infrastructure identified in RFP Section 7 MMIS and POS System Requirements upon review and certification by CMS.

The successful contractor for the implementation of the MMIS must implement all hardware and software required to support the MMIS in the state's data center located in Des Moines, Iowa, and is responsible for operation and maintenance of all hardware and software for a period ending one month after the MMIS is certified by CMS unless the Department elects to exercise the option to extend the contractor's operation and maintenance of the MMIS for one or more years. When the Core MMIS contractor's operation of the MMIS ends, ownership of all hardware and software licenses must transfer to the Department. The Core MMIS contractor will continue to maintain and support the MMIS software throughout the life of the contract.

The POS is to be implemented and operated on contractor hardware and the POS contractor will maintain and operate all hardware and software.

As part of the successful proposal, the Department requires a comprehensive management approach, system design and testing plan that results in a concurrent implementation of all modules of the MMIS and POS systems. This concurrent implementation must include the conversion of all data from the current MMIS and POS systems prior to implementation.

The Department is open to alternative approaches to the overall implementation of the new MMIS to solicit their ideas to maximize the opportunities for success.

The proposed solution for the new MMIS must be flexible enough to support a variety of health care delivery systems, including fee-for-service (FFS) and managed care, be built as a multi-payer solution. The system must provide the capability to process claims and data from multiple programs and multiple plans within programs. A "program" is defined as a group of members eligible to receive medical services paid by state and or federal funds by virtue of the members' demographic or other characteristics. A "plan" is defined as a specific subset of medical services in a program with a subset of eligible members.

The Department may select an Independent Verification and Validation (IV&V) and Quality Assurance (QA) Services vendor that will operate technically, managerially and financially independent of the MMIS and POS contractor(s) and that will perform the following functions:

a. Ensure the software provided by the contractor(s) meets the users' needs (Validation).

b. Check that the system is well engineered (Verification).

c. Ensure the quality of deliverables.

d. Participate in Joint Application Design (JAD) sessions.

e. Conduct audits as determined by the Department.

During the implementation phase, the IV&V and QA Services vendor will be acting with the full authority of the Department in performing its evaluation activities. The MMIS and POS contractor(s) must cooperate with the IV&V and QA Services vendor in all aspects of implementation phase and operations phase of the project as well as other phases of the project as directed by the Department.

6.1 Contract Phases

Within the parameters of the phases described below, the contractor(s) must develop detailed plans to design, develop, test and implement certifiable MMIS and POS systems and to take over all operations from the current contractors. There are specific requirements for each phase. Schedules within the phases may overlap.

The Department requires effective implementation of quality management practices to be used through all phases of the contract. The contractor's proposal must address quality management practices in each of the following phases.

The activities resulting from the system services contracts will occur in the phases described below:

6.2: Start-Up Phase

6.3: Implementation Phase

6.4: Transition to Operations

Operations Phase – refer to Section 8

Certification Phase – refer to Section 8

Turnover Phase – refer to Section 8

6.2 Start-Up Phase

The start-up phase for the Core MMIS and POS contractor(s) include those activities in preparation to begin work.

6.2.1 Activities

The contractor(s) must create all project management deliverables, conduct a kick-off meeting and prepare the Implementation facilities.

6.2.1.1 State Responsibilities

a. Name executive sponsor for project.

b. Participate in kick-off meetings.

c. Review all contractor deliverables and provide response within 15 business days.

d. Identify the members for the implementation team.

e. Identify the IV&V and QA Services vendor.

f. Identify named representatives from other contractors who support the IME and who will participate in implementation activities.

6.2.1.2 Contractor Responsibilities

a. Prepare an agenda for the Department approval for the kick-off meeting.

b. Conduct a kick-off meeting(s) for the Department within 10 business days of the contract start date.

6.2.2 Facilities

The following topics describe the facility requirements for the system services contractor(s) during the start-up phase.

6.2.2.1 Temporary Office

After successful negotiation of contract(s), the Core MMIS and POS contractor(s) will need to establish a temporary primary project site in Des Moines, Iowa, within a 10-mile radius of the Iowa Medicaid Enterprise facility, which is located at 100 Army Post Rd., Des Moines, IA 50315. The temporary primary project site must be established within 45 days of the contract award and approved by the Department. All costs associated with the temporary offices are the responsibility of the contractor(s). The Core MMIS and POS systems implementation key personnel will perform duties at these Des Moines facilities where the implementation functions will be performed.

The POS contractor may perform some implementation activities that the Department approves at an offsite location, but all work sessions involving Department staff must be conducted in Des Moines, Iowa, at the temporary primary project site. The POS contractor support staff for requirements validation, acceptance testing, and certification must also be conducted in Des Moines, Iowa.

All work related to this RFP must be performed in the United States.

6.2.2.2 Meeting Rooms and Workspace Requirements – Start-up and Implementation

The contractor(s) must supply adequate meeting rooms to accommodate required contractor(s) staff and up to 20 Department implementation team members attending regular status and strategy meetings. The contractor(s) is responsible for furnishing appropriate equipment that will accommodate, at minimum, 30 MMIS and 10 POS Department and other contractor testers as determined by the Department. The contractor(s) is responsible for the furnishing of the telecom equipment to accommodate 100 lines, network access, and supplies for the facility, as well as kitchen and break room access for department staff.

The meeting rooms must have at a minimum two computers with Internet and Intranet access, two projectors for displaying Internet-based and Windows PowerPoint presentations, telecom equipment with high-quality speakerphones for multiple remote staff to attend meetings by telephone and ability to access network printer(s) in the same building for use by meeting participants and for testers. Meeting rooms must also accommodate video conferencing and web-based application sharing for attendees.

The contractor(s) must provide a minimum of 10 dedicated workspaces for the Department.

The contractor(s) must provide 10 dedicated parking spaces and sufficient parking for staff attending meetings and performing testing.

6.2.2.2.1 State Responsibilities

a. Approve the Core MMIS and POS contractor(s) temporary offices located in Des Moines, Iowa.

b. Approve the meeting rooms, workspace and required equipment and parking spaces.

6.2.2.2.2 Contractor Responsibilities

a. The contractor(s) must secure temporary facilities in Des Moines, Iowa within 45 days of contract award.

b. Provide the meeting rooms, workspace and parking for the Department staff.

c. Provide a testing facility to accommodate at minimum, 30 MMIS and 10 POS testers.

d. The contractor(s) must ensure their facility has the necessary equipment as referenced in section 6.2.2.2 of the RFP.

6.2.2.3 Permanent Facilities

The Department requires that all staff directly associated with the provision of contract services to the IME during the Operations, Certification and Turnover Phases will be located at the IME permanent facility unless prior approval is requested and granted by the Department. Within the General Requirements section of the technical proposal, the bidder will provide the Department with the estimated total number of staff, specifying key personnel and other managers or supervisors. Approval for offsite work will be rarely granted by the Department.

In the event that the Iowa Medicaid Enterprise facility is not available for full occupancy, all affected IME contractor(s) will maintain their temporary local offsite office space at the contractor's expense. The Department will make every effort to identify any delays as early as possible.

The Pharmacy Point-of-Sale (POS) system may be operated at an offsite location approved by the Department, but the local contract staff associated with the POS functions (excluding systems staff) will be located at the IME facilities.

6.2.2.3.1 State Responsibilities

At the permanent facilities during the Operation, Certification and Turnover Phases, the Department will provide at no cost to the contractor(s), the following for operational staff:

a. Office space.

b. Desks, chairs, and cubicles.

c. Network infrastructure and network connections.

d. Personal computers.

e. Telephones and facsimile (fax) machines.

f. Photocopiers and copier paper and envelopes.

g. Network printers.

h. Software Licenses for commercially-available packages.

i. Conference rooms at the IME site for meetings among contractor(s) personnel, state staff, providers and other stakeholders.

6.2.2.3.2 Contractor Responsibilities

The Department requires contractor(s) to provide the following equipment at the permanent facility during the Operations, Certification and Turnover phases:

a. Proprietary or other software that is not commercially available (other than the standard commercial packages provided by the Department) and as approved by the Department. The contractor(s) must provide the sufficient number of software licenses to their respective staff as well as to Department staff and IME contract staff. There are approximately 400 staff that comprise of Department and contractor staff that reside at the IME facility. If the software requires use by other IME units, the contract(s) will provide the required number of software licenses as determined by the Department.

b. Personal workstation printers and associated cables and software, as approved by the Department, to connect them to and use them at the workstations for which the contractor(s) must sign over ownership to the Department.

c. Office supplies (except for copier paper and envelopes).

d. Any special needs equipment for ergonomic or other purposes.

6.2.3 Project Management

The contractor(s) must know and actively apply professional project management standards to every aspect of the work performed under this contract. The contractor(s) must adhere to the highest ethical standards, and exert financial and audit controls and separation of duties consistent with Generally Accepted Accounting Principles (GAAP), Generally Accepted Auditing Standards (GAAS) and Generally Accepted Government Auditing Standards (GAGAS).

During the project Start-Up Phase, the contractor(s) must establish the appropriate level and type of project management standards and procedures to successfully complete the requirements of each phase of the contract. This section identifies the mandatory requirements, tasks and deliverables for project governance, which the contractor(s) must perform. The following are minimum requirements:

6.2.3.1 State Responsibilities

The Department responsibilities regarding Project Management include:

a. Provide access to documentation of any state-mandated project management policies, processes and tools.

b. Identify resources for the Department’s project management office (PMO).

c. Provide direction to the Independent Verification and Validation (IV&V) and QA Services vendor.

d. Review and approve contractor’s project management approach and methodologies and deliverables.

e. Review and approve metrics and data sources that Department, contractor(s) and IV&V and QA Services vendor will use to measure project progress and effectiveness.

f. Participate in weekly project status meetings with the contractor(s) and IV&V and QA Services vendor.

g. Review and approve the contractor(s) project status reports.

h. Review and approve all deliverables.

i. Report ongoing project progress to IME executive management.

j. Obtain decisions from executive steering committee on any identified issues, as needed to keep the project on schedule.

k. Complete, review and approve any change management requests (CMRs) arising from maintenance and system enhancement requests that exceed the scope of the requirements for the implementation.

l. Review and approve the project management plans that must be implemented for each project during the Start-up Phase.

m. Review and approve the measurement, calculation, content and format of contract management reports.

n. Approve contractor's key personnel, including reviewing resumes of proposed key personnel and notifying the contractor(s) in writing of its approval or disapproval.

o. Monitor the contractor's performance and compliance with contract terms, standards, and conditions.

p. Provide access to appropriate Department staff.

q. Review and approve contractor(s) invoices and supporting documentation for payment of services.

r. Coordinate the Department, state and federal reviews, certifications and compliance audits.

s. Respond within 10 business days to any documents presented for review and requests for information.

6.2.3.2 Contractor Responsibilities

a. Implement the project management office (PMO).

b. Provide the Department with the project management approach and methodologies.

c. Identify the metrics and data sources that the Department, contractor(s) and IV&V and QA Services vendor will use to measure project progress and effectiveness.

d. Participate in weekly project status meetings with the Department and IV&V and QA Services vendor.

e. Provide the Department and IV&V and QA Services vendor project status reports.

f. Report ongoing project progress to the Department and IV&V and QA Services vendor.

g. Identify, monitor, control and report (with statistics and aging criteria) issues and resolutions, as needed, to keep the project on schedule to the Department and IV&V and QA Services vendor.

h. Provide justification to the Department for any CMRs arising from maintenance and system enhancement requests that exceed the scope of the requirements for the implementation.

i. Provide the Department with changes to key personnel, including resumes of proposed key personnel, in writing within 15 business days of contract signing.

j. Submit timely invoices and supporting documentation to the Department for payment of services.

k. Participate in any Department, state and federal reviews, certifications and compliance audits.

6.2.3.3 PMO Processes, Policies and Procedures

The contractor(s) must deliver to the Department a PMO overview document that describes all PMO processes, policies and procedures. The document must include the PMO methodologies and tools used to report, monitor and control the projects, scheduling and prioritization of project activities, PMO staff roles and responsibilities, project scope and change management, procedures to control costs, mitigating risks, managing issues, tracking action items and decisions, methods to track and approve accomplishments and document management.

The Department will provide a central repository for all project artifacts (deliverables, status reports). The contractor(s) must provide the Department and IME contractors with access to all project tools. The cost of such access shall be incurred by the contractor(s).

6.2.3.4 Industry Standards

The contractor(s) is required to implement and maintain all systems with strict adherence to published, industry recognized standards, including but not limited to, the Capability Maturity Model Integration® (CMMI) and Standards from the Institute of Electrical and Electronic Engineers (IEEE) or a comparable model approved by the Department for all application development and maintenance.

The contractor(s) is further required to use a proven project management, software development methodology, and system development life cycle methodology for managing design, development and implementation projects that conform with:

- IEEE/EIA 12207.0-1996, IEEE/EIA Standard-Industry Implementation of International Organization for Standardization (ISO)/International Electro Technical Commission (IEC) 12207:1995, Standard for Information Technology-Software Life Cycle Processes
- IEEE Standard 1058-1998, IEEE Standard for Software Project Management Plans (SPMP)
- IEEE Standard 1074-1997, IEEE Standard for Developing Life Cycle Processes

The contractor(s) is also required to adhere to the American National Standards Institute (ANSI) and Project Management Institute, Inc. (PMI) principles for project management, as stated in the Project Management Body of Knowledge® (PMBOK).

Failure to adhere to the above stated guidelines will result in the corrective action plans, in accordance with the performance standards of this RFP.

6.2.3.5 Establish a Project Management Office (PMO)

The contractor(s) must establish a PMO in the contractor's office in Des Moines, Iowa, within 45 calendar days of award of the contract. The PMO must be managed by a project manager as defined in section 5.2.2 Key Personnel Requirements of this RFP. The contractor's PMO will be required to work closely with the Department's PMO and the IV&V and QA Services vendor throughout the project and the Implementation Phase.

6.2.3.6 Project Management Portal

Within 45 days of the award of the contract, the contractor(s) will establish a secure Enterprise Project Portal to serve as the electronic repository for the official Project Work Plan (PWP), all deliverables and other project artifacts from project start-up through operations. The portal must allow authorized users to view the project work plan, all deliverables and other project artifacts from project start-up through operations in a real-time environment and generate reports on project status. The portal must provide the capability to email alerts advising individuals of task assignments, task status and notification that the due date for an assigned task has passed. All project deliverable drafts and working copies must be stored and shared in the portal to facilitate communication and collaborative work. Authorized Department and IV&V and QA Services vendor staff must have the capability of uploading documents onto the portal. The portal must operate in a secure environment where user access and privileges are dependent on authorizations that will be decided by the Department.

6.2.3.6.1 State Responsibilities

a. Review and approve the project management portal plan.

b. Populate folders as necessary when they become available.

c. Identify authorized users from the Department and IV&V and QA Services vendor and identify their privileges.

d. Test access and privileges for users from the Department and IV&V and QA Services vendor.

6.2.3.6.2 Contractor Responsibilities

a. Provide a project management portal plan for the Department review and approval.

b. Maintain security settings.

c. Establish portal folders.

d. Populate folders with appropriate documentation.

e. Identify authorized contractor portal users and their privileges.

f. Provide access privileges to the Department and IV&V and QA Services vendor authorized users.

g. Test access and privileges for users from the contractor organization(s).

h. Notify, provide knowledge transfer and troubleshoot authorized users in portal usage.

i. The contractor(s) will maintain and support the project management portal throughout all the phases of the contract or as directed by the Department.

6.2.3.6.3 Performance Standards

a. Establish the project management portal and receive approval from the Department within 45 days of the contract award.

b. The project management portal must be kept current within one week of approved deliverables.

6.2.3.7 Project Management Plans

Within 45 days of award of the contract, each contractor will submit, for approval by the Department, project management plans prepared in accordance with the PMBOK ® principles. The plans must describe the contractor's management approach, organizational structure, formal and informal communications procedures, meeting agendas and meeting notes, progress reporting, correspondence tracking, issues resolution procedures, risk management and mitigation, submission of invoices and procedures for reporting earned value performance management statistics.

No development will begin on the project until the Department has approved all project management plans. The contractor(s) must keep project management plans current and updated within three business days at all times throughout the life of the Implementation and Certification Phases of the project for Department review and approval. The project management plans are described in the following sections.

6.2.3.7.1 Communications Management Plan

The contractor(s) must deliver to the Department a communications management plan including a stakeholder analysis. The contractor(s) will determine all Department communications needs, including status reporting and project monitoring and create a process to meet those needs. During all phases of the project the contractor(s) will execute the plan with formal weekly status reports in formats approved by the Department. The contractor(s) must include a chart showing the flow of communication.

6.2.3.7.2 Project Work Plan for Implementation

The contractor(s) will revise the project work plan submitted in the technical proposal to reflect any change in dates or activities based on contract negotiations. The detailed project work plan will identify all tasks, activities, milestones and deliverables for the project and will be used by the Department to monitor the contractor's progress. Elements of this deliverable include:

a. A narrative overview of the work plan tasks and schedule including dependencies the contractor(s) used in the development of the PWP.

b. Description of each task, subtask and activity.

c. A Work Breakdown Structure (WBS) in Microsoft Project or an alternative acceptable to the Department identifying all tasks, subtasks, milestones and deliverables with key dates, predecessors and successors for each.

d. Proposed location(s) for activities to be performed.

e. Personnel resources applied by name and level of effort in hours.

f. The Department resource requirements including required skills, level of expertise, and level of effort.

g. Gantt chart.

h. Program Evaluation Review Techniques (PERT) or dependency chart.

i. Resource matrix by subtask, summarized by total hours per person, per month.

6.2.3.7.2.1 Project Work Plan Baselines

The project work plan will include tasks for the Department to set and approve the baseline. The original estimates will form the project baseline. Once established, the baseline will only be modified with approval from the Department. The approved baseline will be used for all project metrics reported weekly during the weekly status meeting. During execution of the project, the contractor(s) must measure performance according to the WBS and manage changes to the plan requested by the Department. When major tasks are completed, the contractor(s) must seek formal acceptance from the Department as well as formal acceptance of each deliverable.

6.2.3.7.3 Risk Management Plan

The contractor(s) must use a standard risk management plan that:

a. Addresses the process and timing for risk identification.

b. Describes the process for tracking and monitoring risks.

c. Identifies the contractor(s) staff that will be involved in the risk management process.

d. Identifies the tools and techniques that will be used in risk identification and analysis.

e. Describes how risks will be quantified and qualified and how the contractor(s) will perform risk response planning.

For each risk, the contractor(s) must evaluate and set the risk priority based on likelihood and impact, assign risk management responsibility and create a risk management strategy. For each significant accepted risk, the contractor(s) must develop risk mitigation strategies to limit the impact. The risk management plan must include aggressive monitoring for risks, identify the frequency of risk reports and describe the plan for timely notification to the Department of any changes in risk or trigger of risk events. In the event that a risk occurs, the associated information for the risk transfers from the risk management plan to the issues management plan.

6.2.3.7.4 Issues Management Plan

The contractor(s) shall deliver to the Department an issues management plan. The plan must describe the process, tools and techniques used in issue identification and analysis, tools for tracking and monitoring issues, rules for prioritizing issues, methods of reporting all issues and description of steps for issue resolution. In addition, the issues management plan must include procedural descriptions and automated reporting processes for action items resulting from issues.

6.2.3.7.5 Quality Management Plan

The contractor(s) must deliver to the Department and employ a formal quality management plan that includes checklists, measures and tools to measure the level of quality of each deliverable. The quality measurement process applies to plans and documents as well as programs and operational functions. The quality management plan must reflect a process for sampling and audits and for continuous quality improvement. An updated quality management plan must be submitted to the Department for approval annually. The plan must include a proposed process for the Department review and approval of contractor(s) deliverables.

The plan must address how the contractor(s) will organize an internal quality assurance unit with at least the minimum staffing indicated in this RFP. During DDI, this unit is responsible for ensuring the quality of all deliverables prior to submission to the IV&V and QA Services vendor

and the Department. After implementation, this unit is responsible for quality review of all output, including an appropriate sampling by the contractor(s) of all processed claims from the MMIS and POS, quality assurance of all performance standards and corrective action plans (CAPs).

6.2.3.7.6 Staffing Management Plan

The contractor(s) must deliver to the Department a staffing management plan based on the requirements in this RFP including organizational charts with defined responsibilities and contact information. Resources must be allocated by name or by type (including required skills and level of expertise) to the WBS, during the Implementation Phase and for projects during the Operations Phase. During project execution, the contractor(s) must provide appropriate knowledge transfer and management supervision to all staff. Alternates for key staff must be provided.

The contractor(s) must deliver, at the inception and annually, a staffing plan for each operations section. If the contractor(s) staff for any operations section is found to be deficient by the Department, the contractor(s) must revise the staffing plan within 15 days of notice and employ the additional staff at no additional cost to the Department.

6.2.3.7.7 Applications Implementation Plan

The contractor(s) must deliver to the Department a comprehensive applications development and maintenance plan, describing the contractor's approach to implementation of the MMIS and POS including all design and development activities required to meet RFP requirements. The plan must describe implementation methodologies, requirements gathering and tools for managing requirements, project planning, subcontractor management, software configuration management, process focus, process definition, quality assurance process and monitoring, knowledge transfer, integrated software management approach, software product engineering and peer reviews. The plan will include system integration testing, regression testing, stress testing and support for user acceptance testing. As well as a description of the approach to create and maintain documentation of application components and associated user guides.

This plan describes the approach to the implementation of the MMIS and POS, and it must be designed as the top level plan developed and used by managers to direct the development effort. It provides the project manager with the tools needed to plan the project schedule and resource needs and to track the progress against the schedule. This plan will provide to project team members an understanding of what they need to do, when they need to do it and what other activities they are dependent upon.

6.2.3.7.8 Interface Plan

The contractor(s) must deliver, to the Department a comprehensive plan implementing all required internal and external interfaces. The plan must address the methodology used to identify the data requirements for each interface. The execution of the interface plan will begin at the start of the implementation phase.

6.2.3.7.9 Change Management Plan

The contractor(s) must work with the Department to develop a change management plan that describes the roles and responsibilities, policies, processes and procedures necessary for controlling and managing the changes during implementation. This document must identify how changes are identified, defined, evaluated, approved and tracked through completion. This plan

must identify responsibilities and define the composition, function and procedures for a change management board. Additionally the plan must include a configuration management plan and version control procedures.

6.2.3.7.10 State Responsibilities

a. The Department will review and approve the PMO documents.

6.2.3.7.11 Contractor Responsibilities

Develop the following PMO documents for Implementation, Certification, Operations and

Turnover Phases unless otherwise indicated below:

a. Communications Management Plan (including stakeholder analysis).
b. Project Work Plans.
c. Project Work Plan Baselines.
d. Risk Management Plan for Implementation and Certification Phases.
e. Issues Management Plan.
f. Quality Management Plan.
g. Staffing Management Plan.
h. Applications Implementation Plan for the Implementation Phase.
i. Interface Plan for the Implementation Phase.
j. Change Management Plan.

6.2.3.7.12 Performance Standards

a. Submit the following PMO documents to the Department for review and approval with minor revisions within 45 days of the contract award. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.
b. Communications Management Plan (including stakeholder analysis).
c. Project Work Plans.
d. Project Work Plan Baselines.
e. Risk Management Plan for Implementation and Certification Phases.
f. Issues Management Plan.
g. Quality Management Plan.
h. Staffing Management Plan.
i. Applications Implementation Plan for the Implementation Phase.
j. Interface Plan for the Implementation Phase.
k. Change Management Plan.

6.2.3.8 Contract Deliverable Procedures

The Department must approve the content and format of all deliverables prior to the contractor(s) start on the deliverable. The Department reserves the right to reject any deliverable that is not in the proper format or does not appear to completely address the function of the deliverable requirement. Deliverables standards are described below. The contractor(s) is responsible to provide all additional documents and materials necessary to support its information systems development methodology (ISDM) which is the framework that is used to structure, plan and control the process of developing an information system. This includes the pre-definition of specific deliverables and artifacts that are created and completed by a project team to develop or maintain an application at the appropriate time.

As the contractor(s) provides deliverables, in written and electronic format, for each task to the Department, the Department will review the materials or documents within 10 business days after the receipt date. The receipt date is not counted as one of the review days. If the material or document is determined to be in non-compliance, the Department will send written notification to the contractor's project manager outlining the reason(s) for the rejection. The contractor(s), at no expense to the Department will bring work determined by the Department to be in non-compliance with the contract into conformance within 5 business days of notice and resubmit the deliverable to the Department at which time the Department will have 5 business days to approve or reject the deliverable. If the Department accepts the deliverable, deliverable material or documents, an acceptance letter, signed by the Department will be submitted to the contractor(s).

The Department will review deliverables in a timely manner. The contractor(s) must allow 10 business days for review by the Department staff for most deliverables. Weekly status reports, monthly status reports and project plans are not subject to a 10 day review cycle.

Upon receipt of a signed deliverable acceptance letter, indicating the Department agrees that a deliverable is approved or a milestone has been met and payment will be made, the contractor(s) may submit an invoice for that deliverable or milestone according to the payment schedule agreed upon in the contract.

6.2.3.8.1 Deliverable Standards

a. The contractor(s) must conduct participatory meetings with the Department staff, as documents are drafted and business and systems requirements are being ascertained, including concept discussions, design prototyping, Joint Application Design (JAD) sessions, meetings for requirements gathering and to receive the Department feedback on design and documents.

b. The contractor(s) must have open communication with the Department during the development of documents and systems. The contractor(s) must provide document drafts and allow the Department review of programs, screens and design concepts at any stage of development at the Department's request.

c. The contractor(s) must render all designs and itemized deliverables in writing for formal approval, in a format agreed on by the Department and the contractor(s) as part of the project management process.

d. The contractor(s) must supply professional deliverables, with proper spelling, punctuation, grammar, tables of contents and indices, where appropriate and other formatting, as deemed appropriate by the Department. The deliverable document must meet the business requirements it is intended to fulfill and be of professional quality. Documents must be

easily readable and written in language understandable by the Department staff knowledgeable in the area covered by the deliverable. The Department reserves the right to reject any deliverable that does not meet these standards. The contractor(s) cannot consider any deliverable complete before it is accepted formally by the Department.

e. All deliverables and correspondence produced in the execution of this RFP must be clearly labeled with, at a minimum, project name, deliverable title, deliverable tracking or reference number, version number and date.

f. The contractor(s) will conduct walk-through of deliverables at stages during the development of documents and systems. A final walk-through will be conducted at the delivery of the final deliverable.

6.2.3.9 Cost Management

The contractor(s) must determine the resources necessary to complete the project in a timely and efficient manner.

6.2.3.10 Project Execution and Control

During execution of every project, the contractor(s) must exert control to assure the completion of all tasks according to the project schedule and project budget. All variances must be reported to the Department and the contractor(s) must work with the Department to deal with any variance in a manner that will assure overall completion of the project within time and budget constraints. The Department will work with the contractor(s) to approve fast-tracking or reallocation of contractor(s) resources as necessary.

6.2.3.11 Status Meetings

The contractor(s) must participate in regularly scheduled meetings with the Department to discuss progress made during the reporting period as well as ongoing operations. Except as otherwise approved, status meetings will be held on a weekly basis. The IV&V and QA Services vendor may participate in meetings during project Start-up, Implementation and Certification Phases as requested by the Department. The meeting schedule will be proposed by the contractor(s) in its PMO and project management plans and will be mutually agreed upon between the contractor(s) and the Department. The contractor(s) must prepare an agenda for each meeting for approval by the Department and prepare and publish meeting minutes for the status meetings within five business days following the meeting, in a format approved by the Department.

6.2.3.11.1 Weekly Status Reports

The contractor(s) must prepare status reports on a weekly schedule or as approved by the Department throughout the life of the project. The status reports will be delivered electronically at the same time each week prior to the scheduled status meeting and on paper at the time of the meeting. The reports will include the following:

a. A report on the status of each task in the work breakdown structure (WBS) that is in progress or overdue.

b. Tasks completed during the week.

c. Tasks that were not started on the approved date, including:

    1. An explanation for late start.

2. A new revised start date.
3. Corrective actions taken to assure that the task will be started on the revised date.
4. Actions that will be taken to complete a delayed task on the original completion date.

d. Tasks that are in danger of not being completed by the original completion date, as defined by the Department, including:
   1. A corrective action plan.
   2. Explanation of action taken to assure the task is completed on the original scheduled date.

e. Tasks that were not completed on the originally scheduled date including:
   1. A projected completion date.
   2. An explanation of the reason for late completion.
   3. Corrective action taken to assure that the tasks will be completed on the revised date.

f. A report on issues that need to be resolved, progress to resolution and actions being undertaken to remedy or close the issue.

g. A report on the status of risks, with special emphasis on change in risks, risk triggers or the occurrence of risk items. Also included in the report will be progress toward resolution of the risk and actions being undertaken to remedy or alleviate the risk.

h. A schedule variance report showing the earned value of the work completed and the planned value of the work completed and the variance.

i. Status of deliverables.

6.2.3.11.2 Monthly Status Reports

The contractor(s) must submit an electronic monthly status report which is due to the Department by the close of business on the second business day following the end of each month throughout the life of the project. Monthly status reports must contain at a minimum the following:

a. A complete set of updated and current output from Microsoft Project, including an updated Gantt chart, along with a copy of the corresponding project schedule files in electronic version.

b. A description of the overall completion status of the project, in terms of the approved project schedule.

c. The plans for activities scheduled for the next month.

d. The deliverable status, with percentage of completion and time ahead or behind schedule for particular tasks.

e. Identification of contractor(s) employees assigned to specific activities.

f. Problems encountered, proposed resolutions and actual resolutions.

g. A list of all change requests.

h. The contractor(s) will establish a risk management committee to meet on a monthly basis. An analysis of risk anticipated, proposed mitigation strategies and resolved risks will be reviewed during the monthly meeting.

i. Any updates required in the change management strategy.

j. Testing status and test results.

k. Proposed changes to the project schedule if any.

l. Financial information related to expenses and billings for the project.

m. Executive summaries for presentation to management and oversight bodies.

n. The format for these reports shall be determined by the Department.

6.2.3.11.3 Quarterly Status Reports

The contractor(s) must submit an electronic quarterly status report, which is due to the Department by the close of business, the second business day following the end of each quarter throughout the life of the project.

a. A complete set of updated and current output from Microsoft Project including an updated Gantt chart, along with a copy of the corresponding project schedule files in electronic version.

b. A description of the overall completion status of the project in terms of the approved project schedule.

c. Produce a CMS report that meets the requirements as determined by the Department.

6.3 Implementation Phase

The implementation phase begins with requirements validation and identification of all necessary tasks to meet all MMIS and POS systems and operational requirements, development of interfaces and data conversion.

The following Implementation functions will be performed at the contractor's temporary office in Des Moines, Iowa. The Department will consider work performed at another location other than the contractor's temporary office located in Des Moines, Iowa during the Start-up and Implementation phases such as the contractor's permanent facility. The contractor must request prior approval from the Department.

6.3.1: Analysis and Design Activities

6.3.2: Development Activities

6.3.1 Analysis and Design Activities

The major analysis activities are as follows:

a. Conduct Joint Application Design (JAD) sessions to validate the current IME form, structure, timeframe and schedule are approved by the Department prior to beginning work to ensure the contractor(s) has a thorough, detailed understanding of the Iowa Medicaid program and business requirements.
    1. To validate and refine the requirements specified in this RFP with the Department staff.
    2. To validate the proposed solution meets Medicaid Information Technology Architecture (MITA) requirements.
    3. To document the purpose and results of each JAD session:
        i. Produce agendas for approval by the Department prior to distribution.
        ii. Prepare session minutes for approval by the Department prior to distribution.
        iii. Document and track all action items.
b. In addition, the JAD sessions will finalize the MMIS and POS system and operational requirements to ensure that responses to all RFP requirements are acceptable to the Department.
    1. Validate the capabilities of the proposed systems to meet the RFP requirements.
    2. Verify that the capabilities of the proposed additional Commercial off- the- shelf (COTS) solutions meet the RFP requirements.
    3. Verify that the capabilities of the proposed systems modifications will meet the RFP requirements.
    4. Verify that the capabilities of the proposed operational requirements will meet the RFP requirements.
c. Document the rules in the existing MMIS and POS systems for incorporation into the rules engine.
d. Elaborate and document the architectural and system requirements of the MMIS and POS described in this RFP.
e. Support and participate in requirements management.

f. Document the requirements validation.

The contractor(s) must ensure that the MMIS and POS technical system requirements are continually updated in the Requirements Specification Document (RSD) and the detailed system design (DSD) documents. This includes a desire to view rapid prototypes of requirements and design concepts, screens, content and application flow. Prototypes do not necessarily need to become operational or be reused during development. Workflow and performance simulation within the design task of the Implementation phase is also preferred.

a. Evaluate business model and process changes and approved changes to the current MMIS and POS after the RFP release date, and identify corresponding requirements.

b. Specify, for each system and operational requirement, the means of measuring that the requirement has been satisfied. This measurement will be used to generate the necessary test cases for system and user acceptance testing.

6.3.1.1 State Responsibilities

a. Provide the Department implementation team.

b. Participate in JAD sessions to ensure that the contractor(s) has adequate understanding of the Department role, contractor(s) role and system(s) and operational requirements for each business function.

c. Review and approve all requirements within 15 business days of delivery.

d. Review the scope, purpose and implications of each of the Department's requirements.

e. Review and approve the design deliverables.

f. Attend and approve all backup and recovery demonstrations.

6.3.1.2 Contractor Responsibilities

The contractor(s) must perform a detailed review and analysis of all system and operational requirements provided in the RFP and must develop the detailed specifications required to construct and implement the MMIS and POS. At a minimum, completion of this task must include the following activities:

a. These activities must result in the creation of a requirements specification document (RSD) and detailed system design (DSD) document for each module in the MMIS and POS.

b. Contractor(s) will develop a methodology for the development of the MMIS and POS systems for Department approval as set forth in the proposal. Provide the Department with an implementation plan that phases in major deliverables in the 6 to 12 month period prior to the operation begin date (e.g., document management, imaging, workflow, portals, provider subsystem, etc.).

c. The contractor(s) must work with the Department staff to fully understand the scope, purpose and implications of each requirement.

d. Thoroughly review, validate and update, if necessary, all requirements specified in the RFP.

e. Review all appropriate Iowa Medicaid programs and policies.

f. Document all rules, including benefit plan assignments, pricing rules, and the edit and audit rules in the current MMIS and POS for use in populating the rules engine during the development task of the Implementation phase.

g. Extract the rules in the existing MMIS and POS for incorporation into the rules engine.

h. Determine with the Department which of the existing rules are to be incorporated into the rules engine.

i. Identify and develop additional rules as needed to meet the requirements of the RFP such as an audit trail for transactions and changes as well as Geographical Information System (GIS) searches.

j. Identify all rules that will be incorporated in the rules engine within a timeframe determined by the Department.

k. The benefit plan assignments, pricing, edit, audit and benefit plan rules must be in a format approved by the Department.

l. Validate the capabilities of the proposed systems to meet the RFP requirements within a timeframe determined by the Department.

m. Verify that the capabilities of the proposed additional COTS solutions meet the RFP requirements within a timeframe determined by the Department.

n. Verify that the capabilities of the proposed systems modifications will meet the RFP requirements within a timeframe determined by the Department.

o. Requirements Specification Document (RSD) - the contractor(s) must develop a requirements specification document (RSD), the structure and format of which must be prior approved by the Department. This RSD must include system functional and non-functional requirements (e.g., quality attributes, legal and regulatory requirements, standards, performance requirements and design constraints). The requirements covered in this RFP are the bases for the systems and operations requirements. The contractor(s) must be further refined to arrive at the detailed design requirements and traced throughout the system development life cycle (SDLC). These detailed requirements must be traceable back to the requirements specified in section 7 MMIS and POS System Requirements and section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases.

   At a minimum, the contractor(s) must:

   1. Include the requirement exactly as it exists in section 7 MMIS and POS System Requirements and section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases including the reference numbers.
   2. Identify how and where the requirements are met in section 7 the MMIS and POS System Requirements design and section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases.
   3. A crosswalk or map of each requirement.
   4. Identification and verification of all internal and external interfaces.
   5. Linkages across the business model functions.
   6. The means of measuring that the requirement has been satisfied.

p. Requirements Traceability Matrix (RTM) - the contractor(s) must develop a Requirements Traceability Matrix (RTM), beginning with the system requirements list in section 7 MMIS and POS System Requirements and section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases, to track all requirements specified in the RSD. Requirements must be tracked through each stage of the development life cycle from requirement specification through production deployment and certification.

q. The requirements including the RFP requirements number must be stored in a requirements management repository, using a requirements management tool, which permits reporting of a specific requirement, selected requirements based on type or attributes and a complete detailed listing of all requirements. This matrix and the repository will be used throughout the project to assure all requirements are implemented, tested and approved by the Department. Reports from the RTM will be submitted to the Department on a schedule to be determined by the Department. The requirements management repository must be accessible by the Department and the IV&V and QA Services vendor.

r. Detailed System Design (DSD) - the contractor(s) must develop a detailed system design (DSD) document, the structure and format of which must be prior approved by the Department. The contractor(s) must document each activity to implement each RFP requirement including, but not limited to, requirements validation, system configuration and rules engine population, implementation of COTS products and design, development of missing functionality and interface development and data conversion. The contractor(s) must conduct a walk-through of the design documents with the Department and demonstrations during the development of the DSD to enhance the Department's understanding and to facilitate the approval process. The contractor(s) will develop the DSD during implementation and maintain the DSD with semi-annual updates throughout operations.

   At a minimum, the DSD document must be available in hardcopy and electronic media, in a format approved by the Department and must include:

   1. Documentation of all rules.
   2. A systems standards manual, listing all standards, practices and conventions, such as, language, special software, identification of all development, test, knowledge transfer and production libraries and qualitative aspects of data modeling and design.
   3. An identification of system files and processing architecture.
   4. Detailed documentation of all rules in the rules engine.
   5. A general narrative of the entire system and the flow of data through the system.
   6. A detailed description and diagram of the system architecture identifying how modules are integrated to meet RFP requirements.
   7. General and detailed module narratives describing each function, process and feature.
   8. A security design description for each business area that defines access control, including specifying roles, role locations and a matrix of roles by inputs and outputs.
   9. A flow diagram of each module, identifying all major inputs, processes and outputs.
   10. Lists of all inputs and outputs by module.
   11. A listing and brief description of each file or data table.
   12. A listing and brief description of reports to be produced by each module.
   13. Detailed screen and report layouts by module.
   14. Detailed screen and report narrative descriptions by module.
   15. Layouts for online, context-sensitive help screens for all IME functions, including web-based modules.
   16. Hardware and or software detail.

17. A high-level data model.
18. A detailed data model.
19. Entity relationship diagrams.
20. Use Cases.
21. High and medium level batch flow charts to the job, procedure and program level.
22. Detailed program logic descriptions and edit logic, including, at a minimum, the sources of all input data, each process, all editing criteria, all decision points and associated criteria, interactions with other programs and all outputs.
23. Final layouts for all inputs to include, at a minimum: input names and numbers, data element names, numbers and sources for each input field and examples of each input.
24. Final layouts for all outputs to include, at a minimum: output names and numbers, data element names, numbers and sources for each output field and examples of each output.
25. Final layouts for all files to include, at a minimum: file names and numbers, data element names, numbers, number of occurrences, length and type, record names, numbers and length and file maintenance data, such as number of records and file space.
26. A domain object model of the MMIS and POS for all contractor(s) developed modules of the IME solution.
27. Site maps for all web-based interface modules.
28. Application programming interfaces (APIs) used within the application to communicate between modules or with external systems must be defined in this document.
29. A detailed comprehensive data element dictionary (DED), including, at a minimum: data element names, numbers, and business area definitions, valid values with business area definitions, sources for all identified data elements and lists from the DED in multiple sort formats.
30. A glossary to define terminology specific to the MMIS and POS domain. It must explain terms and system usage that may be unfamiliar to the reader of project documents. In addition, it will be the repository for agreed upon definitions of terms open to various interpretations. This glossary should build upon the glossary of terms included in this RFP.
31. An update of the RTM to demonstrate how each requirement is addressed by the DSD.

s. Conversion Plan - The contractor(s) develop a conversion plan and must submit, for the Department review and approval, a conversion plan to successfully meet the Department business and technical requirements for implementation. The plan must be updated as necessary. The contractor(s) must provide a walk-through of the conversion plan before submitting to the Department for approval. The minimum requirements for the conversion plan are:

1. A description of the data conversion strategy and detailed conversion schedule.
2. A detailed plan for conversion of all files and images.
3. Methods for user validation of converted data and final conversion of files.
4. A list and definition of the universe of files to be converted.

5. Personnel assigned to the conversion of each file.
6. A discussion of the management of the conversion effort, including strategies for dealing with delays, contingencies, data reconciliation procedures, backup plan, backup personnel, process verification and other issues impacting data conversion.
7. A detailed contingency plan to identify and mitigate risks that may be encountered during conversion.
8. Procedures for tracking and correcting conversion problems when encountered and for documenting any revised procedures in the conversion plan.
9. Specifications for manually converting data and capturing missing or unreliable data elements that cannot be converted. All data must be cleansed from the legacy MMIS and POS.
10. Specifications for converting imaged documents.
11. Layouts of the reports produced as a result of conversion.
12. A definition of the metrics that will be generated by the conversion process.
    i. These metrics will be used to measure the completeness of the conversion.
    ii. These metrics must include record counts for each major grouping of data elements from both the legacy source systems and the new systems (i.e., number of members, cases, claims and claims paid).
13. A detailed description of all files to be converted and whether it will be a manual or an automated conversion or a combination of both.
14. Data element mappings, including values of the old systems data elements to the new systems data elements, and new data elements to old data elements, to ensure all data elements are addressed.
15. Identification of default values, where necessary.
16. Inputs for conversion.
17. Steps for conversion.
18. Expected results.
19. Detailed mapping of the conversion elements (Source Fields to Target Fields) for each module and data files.
20. Templates, procedures and schedules for all conversion reporting.
21. Copies of all conversion programs and program listings used during conversion tests.
22. Provide a walk-through with test results displayed in all screens of the new MMIS and POS.

t. Interface Plan - The contractor(s) must submit for the Department review and approval an Interface Plan to successfully meet the Department requirements for external interfaces. The plan must be updated as necessary throughout the life of the contract and be included as part of the operational procedures. The contractor(s) must provide a walk-through of the Interface Plan before submitting to the Department for approval. The minimum requirements for the Interface Plan are:

1. Identification of each external interface (see IME Resource Library at: *http://www.ime.state.ia.us/IMEResourceLibrary.html* for the current list).

2. Interface development strategy and detailed interface schedule.
3. Methods for user validation of interface functionality.
4. Personnel resources assigned to the development of each interface.
5. A discussion of the management of the interface effort, including strategies for dealing with delays, contingencies, backup plan and other issues impacting interface conversion.
6. A detailed contingency plan to identify and mitigate risks that may be encountered during interface implementation.

u. Test Management Plan - The contractor(s) must submit for the Department approval a test management plan for each phase of testing: unit, module, integration, regression, stress, user acceptance and operational readiness. The test management plan must describe the processes and tools proposed for successful testing. The plan must include:

1. A description of the test environments, methods, workflow and knowledge transfer required.
2. An organization plan showing contractor(s) personnel responsible for testing.
3. A discussion of management of the testing process, including strategies for dealing with delays in the testing effort, backup plan and backup personnel.
4. A contingency plan for risk mitigation.
5. Procedures and the Department approved tracking tool for tracking and correcting deficiencies and defects discovered during testing.
6. Procedures and the Department approved tracking tool for tracking status of test scenarios and individual test cases.
7. Process for updating the RTM based on test results.
8. Process for updating the DSD based on test results.
9. General description of the types of testing and the steps in each testing process.
10. COTS software tools used during testing.
11. Template of progress report.
12. Procedures for notifying the Department of problems discovered in testing, testing progress and adherence to the test schedule.
13. A plan for organizing all test results for Department review.
14. A plan for system performance, measuring and tuning.
15. A plan for operational readiness testing.

v. These deliverables must be provided to the Department based on the dates included in the approved WBS.

w. Business Continuity Plan (BCP) - develop a BCP that identifies the core business processes involved in the IME Medicaid Enterprise. The contractor(s) will develop during implementation and maintain throughout operations, a BCP that details how essential functions of the Core MMIS contract and or the POS contract will be handled during any emergency or situation that may disrupt normal operations, leaving office facilities damaged or inaccessible.

1. The BCP must be formally reviewed on a yearly basis and approved by the IME.

2. The BCP must identify potential system failures for each core business process.
3. The BCP must contain a risk analysis for each core business process.
4. The BCP must contain an impact analysis for each core business process.
5. The BCP must contain a definition of minimum acceptable levels of outputs for each core business process.
6. The BCP must contain documentation of contingency plans.
7. The BCP must contain definition of triggers for activating contingency plans.
8. The BCP must contain discussion of establishment of a business resumption team.
9. The BCP must contain a hierarchy of management, including a recall list, which must be updated quarterly and approved by the IME.
10. The BCP must address maintenance of updated disaster recovery plans and procedures.
11. The BCP must contain procedures for accessing necessary Electronic Protected Health Information (ePHI) in the event of an emergency and for continued protection of ePHI during emergency operations.
12. Submit the BCP for review and approval within a timeframe determined by the Department.
13. The BCP must address planning for replacement of personnel to include:
    i. Replacement in the event of loss of personnel before or after signing this contract.
    ii. Replacement in the event of inability by personnel to meet performance standards.
    iii. Allocation of additional resources in the event of the contractor's inability to meet performance standards.
    iv. Replacement and addition of personnel with specific qualifications.
    v. Time frames necessary for replacement.
    vi. Contractor's capability of providing replacements and additions with comparable experience.
    vii. Methods for ensuring timely productivity from replacements and additions.
    viii. How established tasks will continue to be performed by staff when disaster strikes.

x. Disaster Recovery Plan - The contractor(s) will develop during implementation and maintain throughout operations, a disaster recovery plan (DRP) and backup plan that addresses recovery of business functions, business units, business processes, human resources and the technology infrastructure. The IME must be protected against hardware and software failures, human error, natural disasters and other emergencies that could interrupt services. The contractor(s) must have onsite backup utilities and communications to support local operations until the recovery site is available. The contractor(s) will test said plan annually and report all findings to the IME. The contractor's DRP must be integrated with the IME's current DRP. The Department's expectation is for bidders to provide the hardware and software necessary to create the disaster recovery back-up solution to be located in a state data center.

1. In the event of a natural or man-made disaster all data and files must be protected in an offsite location. The contractor(s) must provide an alternate business site if the primary

business site becomes unsafe or inoperable. The business site must be fully operational within 72 hours from the time of the declaration or the primary business site becomes unsafe or inoperable. The contractor(s) shall provide the IME a hard and soft copy of the plan, including all revisions.

2. The disaster recovery and backup planning responsibilities of the contractor(s) are as follows:
    i. Establish and maintain, on a daily and weekly basis, an adequate and secure backup for all computer software and operating programs, databases and systems, operations and user documentation (in magnetic and non-magnetic form). The backups must be maintained at a secure offsite location in an organized and controlled manner.
    ii. Provide for offsite storage of backup operating instructions, procedures, reference files, system documentation, programs, procedures and operational files. This must begin during the Implementation task of the DDI phase. Procedures must be specified for updating offsite materials. The DRP must be in place before operations are assumed. All proposed offsite procedures, locations and protocols must be approved in advance by the IME.
    iii. Protect all data and files in an approved, secure offsite location. The contractor(s) must provide an alternate business site if the primary business site becomes unsafe or inoperable due to an event of a natural or man-made disaster. The business site must be fully operational within three business days of the primary business site becoming unsafe or inoperable. The contractor(s) must work and coordinate with the state of Iowa Information Technology Enterprise (ITE).
    iv. Maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications for voice and data circuits and disaster recovery.
    v. Prepare, maintain and test a DRP and provide the IME with up-to-date copies, at least once a year, during the term of the contract. The DRP must be submitted to the IME for approval prior to the systems implementation and whenever changes are required.

y. Ensure that each aspect of the DRP is detailed as to both contractor(s) and the IME responsibilities and that it satisfies all requirements for federal certification. Normal IME day-to-day activities and services must be resumed within three business days of the inoperable condition at the primary site(s).
    1. The DRP must address checkpoint and restart capabilities.
    2. The DRP must address retention and storage of backup files and software.
    3. The DRP must address hardware backup for the main processor(s).
    4. The DRP must address network backup for voice and data telecommunications circuits.
    5. The DRP must address contractor(s) voice and data telecommunications equipment.
    6. The DRP must address the Uninterruptible Power Source (UPS), at both the primary and alternate sites, with the capacity to support the system and its components, at a minimum:
        i. 30 minutes of run time.

ii. An alternate power source that automatically switches over from the UPS and furnishes at least 24 hours run time.

7. The DRP must address the continued processing of transactions (claims, eligibility, provider file, and other transaction types), assuming the loss of the contractor's primary processing site; this shall include interim support for the IME online component of the new MMIS and POS and how quickly recovery can be accomplished.

   i. The DRP must address backup procedures and support to accommodate the loss of online communication between the contractor's processing site and the IME.

   ii. The DRP must contain detailed file backup plan and procedures, including the offsite storage of crucial transaction and master files; the plan and procedures shall include a detailed frequency schedule for backing up critical files and (if appropriate to the backup media) their rotation to an offsite storage facility. The offsite storage facility shall provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage and environmental considerations.

   iii. The DRP must address the maintenance of current system documentation and source program libraries at an offsite location.

   iv. Provide and identify all backup processing capability at a remote site(s) from the contractor's primary site(s) to assure that all IME units continue to function as “normal,” in the event of a disaster or major hardware problem at the primary site(s).

8. Submit the DPR and backup plan for review and approval within a timeframe determined by the Department.

z. Configuration Management Plan - the Department requires software and hardware configuration that will support current operations and can accommodate future changes in programs, changes in standards and transactions and increased transaction volumes for the new MMIS and POS. The contractor(s) must:

   1. Provide a software and hardware solution that is upgradeable and expandable.
   2. Perform regular maintenance to ensure optimum performance.
   3. Perform resource capacity utilization and capacity planning.
   4. Implement needed expansions, at the contractor’s own expense, before ninety percent of maximum capacity is reached.

aa. Ensure all hardware, software or communications modules installed for use by the Department staff are compatible with the Department currently supported versions of the Microsoft Operating System, Microsoft Office Suite and Internet Explorer and current technologies for data interchange.

bb. Describe the planned system environments for testing, conducting knowledge transfer and production and the procedures and software tools for controlling the migration of software versions or releases between the environments. Refer to RFP Section 7 MMIS and POS System Requirements.

cc. Establish, implement and maintain a configuration management plan (CMP) that ensures support to all aspects of the life cycle of the project. The CMP shall address in detail the contractor’s organization, configuration identification, change management, internal audit procedures and other configuration aspects of the project.

6.3.1.3 Deliverables

a. The architectural and system requirements.

b. The results of the JAD sessions.

c. Methodology document for the development of the MMIS and POS systems.

d. Requirements Specification Document (RSD).

e. Requirements Traceability Matrix (RTM).

f. Detailed System Design (DSD).

g. Conversion Plan.

h. Interface Plan.

i. Test Management Plan.

j. Business Continuity Plan.

k. Disaster Recovery Plan (DRP).

l. Configuration Management Plan.

6.3.1.4 Performance Standards

a. Satisfactorily complete JAD sessions within the timeframe approved by the Department.

b. Provide the accurate analysis and design deliverables for review and approval within a timeframe determined by the Department.

c. The contractor must avoid multiple deliverable iterations and the deliverables will be complete and accurate within the first submission.

6.3.2 Development Activities

6.3.2.1 Data Conversion Task

All historical and active data, including all imaged documents in the current MMIS and POS, must be converted. The Department requires a sound conversion strategy and approach that addresses data conversion using conversion programs and manual data entry. The data conversion task involves planning, identifying and analyzing conversion requirements, preparing a conversion plan, with specifications for developing and testing conversion programs and converting the data. Objectives of this task are described below:

a. Data integrity which is the characteristics of the data including business rules, rules for how pieces of data relate, dates, definitions and lineage must be correct for data to be complete.

b. Data quality which is the characteristic of data that bears on their ability to satisfy stated requirements in this RFP.

c. Data verification process wherein the data is checked for accuracy and inconsistencies after data migration is completed.

d. Data loads for testing purposes.

e. Data load completion.

f. The contractor(s) must address the data conversion requirements described for this task. The data conversion task must begin early in the life cycle of the project and all existing data must be converted and approved by the Department prior to the beginning of User Acceptance Testing (UAT).

6.3.2.1.1 State Responsibilities

a. Provide Department implementation team with duties that include working with the contractor(s) on the data conversion of the MMIS and POS, advising on data reconciliation and participating in User Acceptance Testing (UAT) of converted data.

b. Review all data conversion checklists, reports, test plans and all deliverables defined in this section and provide quick response and comment. The standard turnaround for the Department review shall be 10 business days unless otherwise specified by the Department. The Department encourages early submission of draft documents to expedite the Department review.

6.3.2.1.2 Contractor Responsibilities

The contractor(s) must successfully convert all data elements in the current MMIS and POS. Additionally, the contractor(s) must provide resources to complete the loading and application functionality to allow for the initial loading of all information currently captured on paper that will be automated in the new MMIS and POS. The contractor(s) must review the current MMIS and POS documentation to determine which data elements are actually required for the conversion process. The only exceptions to this are those data elements that are identified as obsolete, redundant, calculated fields (as determined by the Department) and those strictly used for the internal processing of the current systems. Working with the Department the contractor(s) must establish the requirements for data conversion. The contractor(s) must write programs, use tools or utilize existing extract routines to extract data from the current MMIS and POS. The contractor(s) must develop or provide any knowledge transfer, documentation, maintenance or enhancement software identified in the conversion plan as being required to support the conversion from the existing systems to the new MMIS and POS. All source data must be synchronized with the converted data to ensure all records are tracked and validated.

The following documents must be submitted for review and approval within a timeframe determined by the Department with minor revisions for the conversion tasks:

a. Final Conversion Plans – The contractor(s) will update the conversion plan for the MMIS and POS.

b. Data Conversion Checklists -The contractor(s) must prepare data conversion checklists, provide a walk-through for the Department staff, and then submit the checklist for the Department review and approval.

c. Develop Data Reconciliation Procedures - The contractor(s) must prepare data reconciliation procedures and scripts. Walk-through must be conducted for the Department staff before submission of these procedures and scripts for the Department review and approval. Data conversion from existing complex data formats to relational database schema will require the application of conversion rules to transform the data. The contractor(s) must detail all procedures and develop scripts to reconcile the converted data back to its original content during the execution of parallel runs and regression testing between the new MMIS and POS and existing systems. These procedures and scripts will

be an integral part of the Contractor's approach to the regression testing requirements and the parallel runs between the existing systems and the new MMIS and POS.

d. Convert and Reconcile Data for Implementation - Before converting the data, the contractor(s) must perform trial conversions and conduct a walk-through of completed file and table conversions for all modules for the Department staff and submit the results for approval. The contractor(s) must convert and reconcile data and produce all necessary reports defined in the conversion test plan. The contractor(s) must review the results of each conversion run to ensure the correctness and completeness of the conversion before allowing user access to the system. The contractor(s) must verify the data selected for pilot implementation before any other use of the system. The contractor(s) must perform a final conversion of all data and provide reports defined in the conversion test plan for the Department review and approval. Upon approval by the Department, the converted data will be incorporated for UAT.

e. Conversion Testing - Conversion testing will follow the process and steps outlined in the conversion plan, as well as tests and processes described in the following sections. The contractor(s) must develop and use test scripts based on the design and specific functions included in the conversion process. These scripts will be step-by-step instructions addressing every activity in the conversion process for each data file converted.

f. Conversion Test Results - provide the Department an interim report on each file and table conversion test within one business day of each scheduled file and table conversion test; this interim report will include the following for each file and table conversion:

    1. All test results.
    2. Any problems encountered and the impact on the rest of the conversion schedule; and before and after versions of each converted table, including default values.
    3. A summary of the status of the test, including: Number of problems identified by type of problem, number of problems corrected and any significant outstanding issues, the effect of any findings on the implementation schedule and any other relevant findings.

g. Conversion Reports - At a minimum, the contractor(s) must produce the following reports to ensure adequate checks and balances in the conversion process:

    1. Detailed mapping of the conversion elements (Source Fields to Target Fields) for each module and data files.
    2. Weekly status reports on the conversion progress and any issues identified.
    3. Conversion progress by environment, by module.
    4. Statistics on conversion (e.g., % complete, % error, volume, exceptions):
        i. By module.
        ii. Time estimated versus actual time taken.
        iii. Data verification reports.
        iv. Manual spot check results.
        v. Automated check results.
        vi. Data reconciliation reports.
        vii. Capacity plans (if applicable).

h. UAT of Converted Data - The contractor(s) must conduct UAT to confirm that data conversion has been done correctly, including verification that the “new” data matches the “old” data. The UAT test for data conversion must actively use all of the conversion functions, process all types of input and interfaces, and produce all conversion reports. The Department may require that the contractor(s) include certain types of data in the conversion test.

6.3.2.1.3 Deliverables

a. Final Conversion Plans.

b. Data Conversion Checklists.

c. Data Reconciliation Procedures.

d. Conversion Test Results.

e. Conversion Reports.

f. UAT Test Results.

6.3.2.1.4 Performance Standards

a. The contractor(s) must provide evidence to the Department that one-hundred percent of all appropriate data has been successfully converted.

6.3.2.2 Configuration and Rules Engine

The contractor(s) is responsible for configuration of all software and for populating the rules engine.

6.3.2.2.1 State Responsibilities

a. Provide an implementation team with duties that include working with the contractor(s) on the design and development of the MMIS and POS.

b. Review all prototypes, screen designs, work plans and all deliverables defined in this section and provide quick response and comment. The standard turnaround for the Department review shall be 15 business days, unless otherwise specified by the Department. The Department encourages early submission of draft documents to expedite the Department’s review.

6.3.2.2.2 Contractor Responsibilities

The contractor(s) is responsible for developing, testing, and documenting all MMIS and POS applications for the IME. Key elements associated with this task are:

a. Demonstrate that all hardware, software and communication linkages are functional and will support the Department’s requirements.

b. Ensure that the developed solution meets design criteria and satisfies the intended purpose.

c. Install and enhance or modify modules of the proposed systems, according to the specifications developed and approved by the Department in the systems design task.

d. Provide module walk-through and demonstrations to the Department.

e. Present all standard output reports.

f. Demonstrate functionality of all interfaces.

g. Populate the rules engine.

h. Update the CMP.

6.3.2.2.3 Deliverables

a. Updated CMP.

b. Documentation of all rules in the rules engine.

c. Updated use cases.

d. Standard output reports.

e. Updated interface plan.

f. MMIS and POS documentation and user documentation manuals.

6.3.2.2.4 Performance Standards

a. All hardware, software, and communication linkages are functional and meet Department requirements.
b. Rules engine is populated in accordance with Department requirements.

6.3.2.3 Testing Tasks

Planning for the testing task must occur as early in the project as possible to ensure acceptable test results and a successful implementation. Test plans must be written during the requirements analysis and design tasks and be approved by the Department prior to the start of testing. Test scenarios, test scripts and test cases within each phase of testing must align with the RTM to verify all requirements are accounted for. Successful test results will confirm all requirements have been thoroughly tested. Separate test environments are required to perform unit, module, integration and UAT, with acceptable results approved by the Department, ensuring that all IME requirements have been satisfied and successfully tested.

A successful implementation and thorough testing of the new MMIS and POS will ensure a successful implementation, and provide an enterprise that will appropriately process and pay all claims transactions, process and report eligibility determinations and updates, enroll providers, process prior authorization requests, update all types of files, produce required reports and support all analytical requirements. The contractor will be working closely with the Department and the IV&V and QA Services vendor during all testing phases. The contractor(s) must permit complete systems access to the Department and the IV&V and QA Services vendor and offer timely assistance when requested.

6.3.2.3.1 State Responsibilities

a. Review and approve all test plans.

b. Review and approve all test results.

c. Maintain Department’s UAT plan and results for reference by CMS review team during on-site certification review.

d. Provide an implementation team with duties that include working with the contractor(s) on the UAT and Operational Readiness Testing (ORT) testing activities.

e. Approve MMIS and POS for implementation.

6.3.2.3.2 Contractor Responsibilities

The contractors' responsibilities include the following and are more fully described in the sections below:

a. Establish Environment.

b. Test Plans.

c. Test Cases and Scripts.

d. Test Results.

6.3.2.3.2.1 Establish Testing Environment

Implement Testing Environments - The unit and system testing may be done in the contractor's development environment. Establishment of these environments is to be identified as milestones in the applicable work plan, to be approved by the Department.

In addition, the contractor(s) must establish the following environments:

a. Conversion Testing Environment: A mirror image of the future production, including reports and financial records, an environment that will be used to load converted data resulting from the data migration process that allows business users to test the future business logic against converted data.

b. UAT Environment: Contractor(s) will provide a UAT environment to be a mirror image of the production environment, including reports and financial records that allow users to perform system testing to ensure the system meets the requirements for the user community. Users must be able to mimic production work to ensure the system performs as expected. The contractor(s) will provide a method to refresh the UAT environment with a full set of data from the production system at the Department's request.

6.3.2.3.2.1.1 Test Plans

The contractor(s) must use structured data tests to create test scenarios based on use cases. Actual test results will be supplied for all test cases including any scenarios submitted by the Department. All discrepancies, deficiencies and defects must be identified and explained, corrected and approved by the Department before moving to the next phase.

a. The contractor(s) will perform Automated Functional Testing in the conversion testing environment against the converted data (i.e., once the converted data is loaded and passes initial verification and validation, the contractor(s) will perform a series of tests to validate that the new system produces identical or expected results.) Six months after the new MMIS and POS are placed into full production; this environment is no longer needed.

b. Contractor (s) will perform UAT testing in the UAT environment and will include scenarios that test all modules and interfaces.

The contractor must establish a test plan and schedule for each phase of testing: unit, rules, conversion, integration, user acceptance, operational readiness and all components in the MMIS and POS. The plans must include the proposed path for a successful implementation and the contractor(s) must take responsibility for execution of the plans. The test plans must include:

a. A description of the test environments, methods, workflow and knowledge transfer required.
b. A description of test scenarios and expected test results.
c. An organization plan showing contractor(s) personnel responsible for testing.
d. A discussion of management of the testing process, including strategies for dealing with delays in the testing effort, backup plan and backup personnel.
e. A contingency plan for risk mitigation.
f. Procedures and Department approved tracking tool for tracking and correcting deficiencies and defects discovered during testing.
g. Procedures and Department approved tracking tool for tracking status of test scenarios and individual test cases.
h. A plan for updating the RTM based on test results.
i. A plan for updating the DSDs based on test results.
j. List of inputs to the tests.
k. Steps in the testing process.
l. COTS software tools used during testing.
m. A template progress report which will be issued at intervals approved by the Department as well as the content within the progress report.
n. Procedures for notifying the Department of problems discovered in testing, testing progress and adherence to the test schedule.
o. A plan for organizing test results for Department review.
p. A plan for system performance measuring and tuning, based on the results of load and stress testing.
q. A description of how the development of the test scenarios ensures that all modules, rules and functions of the new MMIS and POS for UAT are evaluated and accepted.

6.3.2.3.2.1.2 Test Cases and Scripts

The contractor(s) must deliver test case and scripts for each phase of testing, unit, rules, module, integration, user acceptance and operational readiness for each module in the MMIS and POS. These test cases and scripts will fulfill all contract requirements and provide very thorough testing for all enterprise functionality. Test cases will be tracked for all requirements and the status of each test will be traced through the RTM until all requirements are successfully met. Additionally, these scripts must provide step-by-step instructions for executing the tests. The test cases and scripts must address all business processes of the new MMIS and POS. All test scenarios and cases will be tracked using the Department approved tracking tool.

6.3.2.3.2.1.3 Test Results

The contractor(s) must deliver test results for each phase of testing: unit, rules, module, integration, user acceptance and operational readiness and for every core module and ancillary module. The test results must be submitted to the Department for review, accepted as passed and approved by the Department before proceeding to the next phase; and must follow the proposed path for a successful implementation. The test results must:

a. Be submitted on a schedule to be determined by the Department.

b. Contain references to which requirements are fulfilled.

c. Provide an updated RTM weekly.

d. Be in a format acceptable to the Department (not Portable Data File (PDF)).

6.3.2.3.2.1.4 Test Tracking

The contractor(s) must track all test scenarios, cases and all defects must be tracked through successful testing using the Department approved tracking tool. This tool must be identified as a milestone in the test work plan to be approved by the Department. All tests results must be acceptable to the Department and approved before testing is considered complete. The contractor(s) must make the changes necessary to the system to meet all contract requirements. Reports of metrics from the testing will be reported weekly from the test scenario and defect tracking tool on the status of all test scenarios until test results are accepted and approved by the Department. At a minimum, the automated tracking tool reports must include:

a. Capture or assign a unique ID for each test scenario and case.

b. Organize test scenarios, cases and results by business process (module).

c. Cross-reference test scenarios and cases to the RTM.

d. Report metrics for test scenarios and cases, to include, but not be limited to number of test scenarios and cases per module, status of test scenarios and cases (i.e., passed, failed, retested, percentage passed and or failed).

e. Report metrics for defects, to include but not be limited to:

    1. Number of defects per module.

    2. Severity of defects.

    3. Status of defects.

6.3.2.3.2.1.5 Final Testing Reports

At the end of each phase of testing, the contractor(s) must summarize the results of the testing in a final testing report, which will include but not be limited to:

a. A summary of the testing process, including but not limited to: number of test scenarios and cases tested, pass and or fail ratio.

b. Number of defects identified and corrected by module.

c. Number of defects identified and not corrected by module.

d. Description of issues outstanding at the end of acceptance testing, the plan for resolution and the impact on the Implementation tasks.

6.3.2.3.2.1.6 Testing Activities

a. Unit Testing - The contractor(s) responsibilities for this deliverable include programming and unit testing on all IME functions. The contractor(s) must develop the application software for the required interfaces as defined in the completed DSD document. The contractor(s) must develop any bridges and integration code necessary for the IME to interface with other software and systems. The contractor(s) must test all modules (i.e., programs) as stand-alone entities. Unit testing ensures that a single module is resilient and will function

correctly on a stand-alone basis (e.g., the modified module can take inputs and produce expected outputs). Submit successful unit test results to the Department for approval.

b. Rules Testing - The contractor(s) must test all rules populated into the rules engine. The testing function must be automated through test scenarios and test scripts and during the course of module and integration testing. Rules testing ensure the Department policy is accurately reflected in the rules engine. Additionally, the contractor(s) must update the DSD to reflect changes or additions to the rules.

c. Module Testing - The contractor(s) must update the RTM and repository, verifying that all requirements have been addressed through test scenarios and test scripts. The contractor(s) must also verify that during the course of module and integration testing that the MMIS and POS systems successfully meet the requirements of the contract.

d. Integration Testing - The contractor(s) must test modifications within the context of the integrated modules in which it functions. Integration testing helps ensure that a defined set of interconnected modules will perform, as designed, after additions and or modifications to modules. The testing must also ensure that interfaces with external systems are exchanging data correctly. These tests must use a sample of preliminary converted files. Additionally, the contractor(s) must update the RTM and repository, verifying that all requirements have been addressed through test scenarios and test scripts. The contractor(s) must also verify that during the course of Module and Integration testing that the MMIS and POS systems successfully meet the requirements of the Contract.

e. User Acceptance Testing - The User Acceptance Testing (UAT) demonstrates that the contractor(s) is ready to perform all required functions for the MMIS and POS; that the enterprise satisfies all contract requirements and CMS certification criteria; and that all reported defects have been corrected and accepted by the Department. All MMIS and POS systems and modules will be tested before the start of operations.

f. This will also include, but not be limited to, testing of all: business processes, COTS products and business rules engines. Modules of the testing will require that the contractor(s) demonstrate readiness to perform all Core MMIS and POS functions and contractual requirements, including manual processes. UAT will be conducted in a controlled and stable environment and no modifications to the software or files in the acceptance test library will be made without prior written approval from the Department. The UAT is designed to: test the existence and proper functioning of edits and audits; confirm accounting and federal reporting; verify the coding accuracy of claim records payment and file maintenance; and validate the format and content of all MMIS and POS outputs, including, but not limited to: outputs to the DW/DS. These tests must use all or select parts of preliminary converted files.

g. The contractor will provide during UAT few, if any, errors will be found. The MMIS and POS systems should have already been thoroughly debugged by the contractor(s) and perform as required by the requirements.

6.3.2.3.2.1.7 Data Certification Letter

The contractor(s) must provide a letter certifying that all data, user manuals, testing facilities and security accesses necessary to perform UAT have been provided.

6.3.2.3.2.1.8 Operational Readiness Testing (ORT)

The ORT is designed to ensure that the contractor(s) is ready to process all inputs, price claim records correctly, meet all reporting requirements, incorporate workflow management and have

a demonstrated backup capacity. The contractor(s) also must assess the operational readiness of the contractor(s) staff performing activities, such as: customer service, correspondence management, drug rebate, financial operations, quality assurance and workflow and electronic document management.

Operational Readiness Testing will include parallel testing, load and stress testing, beta testing and a pilot test of actual claims processing in a full operational environment, starting with the submission of electronic data interchange (EDI) transactions into the translator through the payment process, including, but not limited to, document imaging and workflow management. ORT must be done with full data volumes. The success of the operational readiness tests, as determined by the metrics developed by the Department and the IV&V and QA Services vendor, will determine the implementation date for the new MMIS and POS. A capacity analysis report will be included with the results of each ORT testing area.

Operational Readiness must include Provider Readiness and Organizational Readiness tesing

a. Parallel Test: The MMIS and POS parallel test is designed to ensure that the contractor(s) is ready to process claims input and adjudicate claims correctly, upon termination of the current systems and conversion to the new MMIS and POS. This will be executed in the production mode using a representative dataset of claims to ensure inclusion of claim variations that are likely to occur. The contractor(s) will adjudicate three months of claims in the new MMIS and POS that were previously adjudicated and paid by the current MMIS and POS. These tests must make use of converted files. The three months dataset of claims to be parallel tested must be selected from the nine month period prior to the MMIS and POS production installation date. This claims adjudication and payment parallel processing must include claims paid successfully, claims denied and claims suspended from the legacy system. The denied claims in this parallel test must contain equivalent error codes to the codes received previously from the current MMIS and POS processing. The parallel run reconciliation process must include an electronic match of dollar amounts paid for each of the claims paid and or denied in both files. Where there is no dollar amount for a payment status due to the claim being denied or placed in a suspended status, the claim status and reason and remark code(s) must be electronically matched and reported.

b. Load and Stress Test: The contractor(s) performs this test using a load testing tool, such as Mercury Interactive or an equivalent Department approved tool, to document the MMIS and POS will function within the normal business day, business week and business month schedule of the Department. The contractor(s) must conduct load and stress testing to determine online, web-access and batch performance levels under expected system loading conditions with production-sized databases. Load and stress testing must also be conducted to evaluate how the systems performs under maximum stress conditions and to determine the maximum capacity within specified performance levels. The results of the load test may also result in re-work and systems tuning if the processing schedule negatively impacts the Department's ability to work a normal business day. These tests must use converted files.

c. Beta Tests: For system modules that affect external users (including providers), such as web portals, web-based claims submission and data; the contractor(s) must have a beta testing plan, allowing external users to participate in the testing process. The contractor(s) must describe its approach to beta testing in response to this RFP. Beta Testing is a part of the ORT Period.

d. Disaster Recovery and Business Continuity Test: The contractor(s) performs this test to demonstrate that the DRPs and BCPs have been correctly implemented and operational.

e. Operational Readiness Test Report: The contractor(s) must submit a report that details the results of the operational readiness tests and assessments; and certifies that the new MMIS and POS, its modules, functions, processes, operational procedures, staffing, telecommunications and all other associated support is in place and ready for operation. The metrics, developed by the Department and the IV&V and QA Services vendor, on the contractor(s) staff performance during the operational readiness test, must also be included in this report.

6.3.2.3.3 Deliverables

Listed below are deliverables to be submitted and approved by the Department for each phase of testing unit, rules, module, integration, user acceptance, operational readiness and each module in the MMIS and POS.

a. Test Plans.
    1. Unit.
    2. Rules.
    3. Module.
    4. Integration.
    5. UAT.
    6. ORT.
b. Test Cases and Scripts.
    1. Unit.
    2. Rules.
    3. Module.
    4. Integration.
    5. UAT.
    6. ORT.
c. Test Results.
    1. Unit.
    2. Rules.
    3. Module.
    4. Integration.
    5. UAT.
    6. ORT.
d. Test Tracking (execution and defect tracking).
e. Performance tuning document.
f. Letter certifying that UAT data has been provided.
g. Final testing reports.
h. Operational readiness test report.

i. Update of the RTM.

6.3.2.3.3.1 Performance Standards

a. Provide the Department with a testing schedule.

b. Provide the Department with a testing plan.

c. Provide updated RTM and DSD.

6.3.2.4 Knowledge Transfer Activities

6.3.2.4.1 State Responsibilities

a. Work with the contractor(s) to identify staff knowledge transfer needs.

b. Make staff available for knowledge transfer activities.

c. Review and approve all knowledge transfer materials.

6.3.2.4.2 Contractor Responsibilities

The contractor(s) will be responsible for developing knowledge transfer plans and knowledge transfer documentation for identified Department and IME contractor users and trainers supporting the new MMIS and POS functionality, business processes and other knowledge transfer needs. The contractor(s) must provide knowledge transfer to the Department and professional services contractor staff, including but not limited to: Core MMIS and POS users, trainers, administrators, managers and test teams. The contractor must develop a knowledge transfer curriculum based and segmented toward specific security levels and role-based groups. The contractor(s) must develop all knowledge transfer documentation and knowledge transfer curriculum for user and provider knowledge transfer sessions. The contractor(s) must also train and prepare the IME staff to present and conduct provider knowledge transfer sessions. The contractor(s) must develop a knowledge transfer plan to ensure just-in-time knowledge transfer activities.

Knowledge transfer will begin during the development part of the Implementation phase. Prior to UAT, the Department staff and the IME units involved in testing must be trained on the use of the complete enterprise. The contractor(s) must also create knowledge transfer plans for IME units and implement knowledge transfer with other IME staff prior to ORT. The contractor(s) must support a call center for functional and technical assistance during all phases of DDI to ensure the IME unit's ability to utilize the new system to address these calls as part of the knowledge transfer effort.

6.3.2.4.3 Staff and Management User Knowledge Transfer

The contractor(s) must provide knowledge transfer to IME personnel who have varying computer skills and who perform different functions within their respective units. The contractor(s) must provide classroom instruction for each enterprise job function with job aids. The contractor(s) must provide various levels of knowledge transfer, such as users, super users, and train-the-trainer. The Department staff knowledge transfer must be role-based, structured to support all system security levels for the new MMIS and POS business model, business processes and sub-business processes, as identified in this RFP, such as, but not limited to:

a. System Features and System Interoperability.
b. Process and Operations.
c. Reporting.
d. Document Management and Workflow.
e. Security.
f. Authentication and Registration.
g. System Tutorials and System Navigation.
h. Rules-Based Engine.
i. Provider Enrollment and Management.
j. Claims Processing.
k. Prior Authorization.
l. TPL Module.
m. Member Module.
n. Web Portal.

6.3.2.4.4 Knowledge Transfer Plan

The contractor(s) must create, maintain, and update, as required, an approved Knowledge Transfer Plan. The Knowledge Transfer Plan must include at least the following:

a. Provide an overview of the knowledge transfer methodology for a security and role-based enterprise environment and knowledge transfer objectives for Department and IME users.
b. Ensure all staff has security access to the knowledge transfer environment prior to the session.
c. Identify the knowledge transfer courses and associated course objectives, competency level, and skill set assessment tools, including the format and content of all knowledge transfer material to be developed by the contractor(s).
d. Identify procedures to ensure a working production environment exists for conducting knowledge transfer.
e. Identify the knowledge transfer presentation style, as approved by the Department.
f. Identify the number of role-based knowledge transfer sessions necessary to train all identified Department and IME staff per designated security levels.
g. Identify the number of users to receive the knowledge transfer.
h. Identify the length of each knowledge transfer course.
i. Describe the online real-time knowledge transfer on electronic communications and claims and other documentation.
j. Define procedures for implementing and maintaining a knowledge transfer database.
k. Provide for evaluation of knowledge transfer sessions and feedback to the Department.
l. Provide milestones for knowledge transfer.

6.3.2.4.5 Provider Knowledge Transfer Documentation and Materials

The contractor(s) must develop the provider knowledge transfer documentation, such as Frequently Asked Questions and instructions, by provider type. The contractor(s) must also develop web seminar and video-based provider knowledge transfer materials to be distributed through the Provider Services unit.

The knowledge transfer must be structured to address the new MMIS and POS functionality, to include: claim submission, claim processing and edits, prior authorization, provider enrollment and use of the web portal. There must be specialization of knowledge transfer tailored to meet the needs of providers that do not currently use the new MMIS and POS.

6.3.2.4.6 Develop, Provide and Maintain Knowledge Transfer Documentation

The contractor(s) must develop and update all knowledge transfer e-documentation, manuals, materials, knowledge transfer guides, speaker notes and course curricula including knowledge transfer objectives and outcomes. The contractor(s) must develop a document version control plan and allow for the version control and maintenance for knowledge transfer documentation to include all user and provider knowledge transfer e-documentation.

The contractor(s) also must incorporate online help, online policy and procedure manuals and hard copy user manuals for the delivery of conducting knowledge transfer. All knowledge transfer materials must be reviewed and approved by the Department before the start of the knowledge transfer. The contractor(s) must provide sufficient copies of all knowledge transfer materials for all Department staff and IME units. The contractor(s) must provide all electronic source documents and graphics used in the development and presentation of all aspects of knowledge transfer.

Upon completion of implementing a knowledge transfer database, the contractor(s) must submit a letter certifying the knowledge transfer database is built and software is operational.

6.3.2.4.7 Online Tutorial

The Contactor(s) must provide an online tutorial capability for each module in the MMIS and POS. This tutorial must provide basic "dummy" data, and allow the user to enter or modify information to simulate actual use of the system. This tutorial must be used for knowledge transfer and made a part of the final new MMIS and POS, so that new users accessing the enterprise will have an online tutorial to assist in learning the system’s functionality. Users must be allowed to click their way through the entire process, including, but not limited to:

a. Mass adjustment processing.

b. Financial transaction processing.

c. Prior authorization.

d. Benefit packages.

e. Edits and audits.

f. Rules engine.

g. Reporting.

h. Account and Federal report coding.

i. Web portal application.

j. Drug rebate processing.

k. Electronic document and workflow management.

6.3.2.4.8 Knowledge Transfer Schedule

The contractor(s) must create and maintain ongoing knowledge transfer schedules. Sessions are to begin during the development part of the Implementation phase and be completed prior to UAT for Department staff and IME units and prior to ORT for other IME staff. The contractor(s) must provide knowledge transfer throughout the operations and maintenance stage for new staff and staff who change positions. Knowledge transfer must be provided at a contractor(s) facility and the contractor(s) must schedule knowledge transfer with the Department and IME units. The knowledge transfer will be conducted Monday through Friday, excluding the state holidays, between the hours of 9:00 a.m. and 4:00 p.m. Central Time. The contractor(s) is responsible for furnishing the trainees with knowledge transfer materials, as necessary.

6.3.2.4.9 Certificate of Completed Knowledge Transfer

Knowledge transfer must be implemented in accordance with the Contractor's approved knowledge transfer plans. Upon completion of the knowledge transfer, the contractor(s) must submit a letter certifying that all initial knowledge transfer has been completed for Department staff and IME units.

6.3.2.4.10 Prepare Evaluation Tool

The contractor(s) must specify the performance and the outcomes of each type of knowledge transfer in the Knowledge Transfer Plan. In conjunction with this, the contractor(s) must develop evaluation survey tools to determine whether the knowledge transfer sessions produced the expected results. The evaluation must consist of various tests administered to trainees at each knowledge transfer session. This evaluation survey tool must be used to identify weaknesses in the knowledge transfer program and specific revisions that need to be made. This survey tool must also be used for implementation of knowledge transfer to assess the effectiveness of the knowledge transfer sessions. The trainers for all knowledge transfer sessions must implement the evaluation survey tool.

6.3.2.4.11 Knowledge Transfer Reports

The contractor(s) must develop knowledge transfer reports that include information, such as, but not limited to: target group, the number of knowledge transfer sessions, type of knowledge transfer, knowledge transfer locations, number of trainees, results of the evaluation survey testing and recommendations for follow-up knowledge transfer.

6.3.2.4.12 Deliverables

The following documents must be submitted for review and approval within a timeframe determined by the Department:

a. Knowledge transfer plan and knowledge transfer schedule including train-the-trainer plan and schedule.
b. Electronic knowledge transfer documentation.
c. Knowledge transfer database and application software.
d. Letter certifying the knowledge transfer database is built and software is operational.
e. Document version control plan.
f. Knowledge transfer schedule and conduct knowledge transfer.
g. Letter certifying completion of knowledge transfer.
h. Evaluation survey tools.
i. Knowledge transfer reports.

6.3.2.4.13 Performance Standards

a. Provide the Department a list of all attendees that successfully completed the knowledge transfer courses. 100 percent of all required staff must successfully complete the knowledge transfer courses.

6.4 Transition to Operations

The contractor(s) will plan and prepare to assume all responsibilities of the MMIS and POS contractors. The contractor(s) must convert all data necessary to operate the new MMIS and POS and meet all requirements. The Transition to Operations tasks will end upon successful assumption of all contractors' responsibilities and resolution of startup issues.

6.4.1 Activities

The contractor(s) must produce a Transition to Operations Plan at least six months prior to the planned implementation date. The contractor(s) must update the Implementation Plan, as necessary, to reflect all project activities that directly impact implementation. The most critical update to the plan during this task is the development of a contingency plan for identifying, mitigating and resolving those risks that have been identified as impacting implementation. It must address the strategies for business and system continuity planning, as a result of implementation issues. The contingency plan must include one or more alternate solutions for each risk that are acceptable to the Department and must include back-out criteria and plan. The contractor(s) must execute the contingency plan as issues arise during implementation, upon approval of the Department. The contractor(s) upon approval of the Department must implement the MMIS and POS solution in accordance with the contractor's approved Implementation Plan.

6.4.1.1 State Responsibilities

a. Participate in Transition to Operations Planning sessions.
b. Provide the Implementation Team.
c. Review all implementation deliverables related to Transition to Operations. The standard turnaround for the Department review shall be 10 business days. The Department encourages early submission of draft documents to expedite the Department review.

d. Approve the new MMIS and POS for operations, upon successful conclusion of all activities described in this phase.

6.4.1.2 Contractor Responsibilities

The contractor(s) will have the following responsibilities for the Transition to Operations task including, at a minimum:

a. Development of a Transition to Operations Plan.

b. Establish a production environment.

c. Develop and obtain the Department approval of the back-out strategy.

d. Produce and update all system, testing, user, provider, operations and security documentation.

e. Produce and distribute report distribution schedule.

f. Establish hardware, software and facility security procedures.

g. Develop and obtain the Department approval of the production schedule.

h. Develop and implement backup and recovery procedures.

i. Develop and maintain a Business Continuity Plan (BCP).

j. Ensure complete and accurate final data conversion.

k. Complete knowledge transfer for all Department staff and IME units.

l. Ensure that communications between the Department and IME users and the MMIS and POS contractor(s) that the systems have been established and meet communication performance requirements.

m. Establish and begin all ancillary operations (e.g., IVRS and mailroom).

n. Repeat portions of the ORT, as requested by the Department.

o. Obtain written approval from the Department to start operations.

p. Begin operations.

6.4.1.3 Correction and Adjustment Activities

The contractor(s) must monitor the implemented MMIS and POS for quality control and verification that all activities are functioning properly. The contractor(s) must expeditiously repair or remedy any function that does not meet standards set during system definition and the quality planning process. The contractor(s) must inform the Department within one hour of its awareness of any significant implementation problem that would indicate a possible need to execute the back-out plan. The contractor(s) must provide the Department with a daily or weekly report, as determined by the Department of any problems identified; the proposed repair or remedy, impact of the repair or remedy and the implementation date.

6.4.1.4 Execution of Contingency Plans

If any part of the MMIS and POS does not perform according to specifications, the contractor(s) must execute the appropriate section of its emergency back-out strategy according to the contingency plan and BCP.

6.4.1.5 Final Implementation Report

The contractor(s) must produce an implementation report detailing the results of all implementation activities.

6.4.1.6 Implementation Certification

The contractor(s) must provide an implementation certification letter that certifies that the system is ready for production. The certification letter must confirm, at a minimum:

a. All knowledge transfer activities required have been completed and approved as successful by the Department.

b. All staff has completed non-technical knowledge transfer.

c. All data has been converted, cleaned, tested and accepted.

d. All site preparation requirements have been met.

e. A help desk is established.

f. All user and system supports are in place.

g. All production jobs have been through the version control process and locked down in production libraries.

h. All production databases have been appropriately sized and are ready for production processing to begin.

6.4.1.7 Final Data Conversion and Transfer

The contractor(s) must ensure that the MMIS and POS are ready to be implemented and that the Department approvals have been obtained to begin operations of the new MMIS and POS solution. To be ready for implementation, the systems must satisfy all the functional and technological requirements specified in the RFP and documented during the requirements analysis and systems design activities. The Department staff must be given sufficient time to review all system, testing, user, provider, operations and security documentation for completeness prior to implementation. The systems response time and all user and automated interfaces must be clearly assessed and operational. A complete file transfer plan must be developed and executed. This plan must identify:

a. The name of each file, table or database.

b. Destination of transferred data.

c. Transfer start and completion times.

d. Location and phone numbers of person(s) responsible to execute the transfer.

e. A complete back-out plan, if the file transfer does not go as planned.

6.4.1.8 Deliverables

The following documents must be submitted to the Department for review and approval within a timeframe determined by the Department with minor revisions:

a. Implementation report.

b. Updated contingency plan.

c. Production schedule.

d. Backup and recovery procedures.

e. Hardware, software and facility security manual.

f. Final implementation checklist.

g. File transfer plan.

h. Final implementation report.

i. Implementation certification letter.

6.4.1.9 Performance Standards

The following documents must be submitted to the Department for review and approval within a timeframe determined by the Department with minor revisions:

a. Implementation report.

b. Updated contingency plan.

c. Production schedule.

d. Backup and recovery procedures.

e. Hardware, software and facility security manual.

f. Final implementation checklist.

g. File transfer plan.

h. Final implementation report.

i. Implementation certification letter.

6.4.2 Post Implementation Activities

The contractor(s) will be required to assign contractor(s) resources to conduct a post-implementation evaluation.

6.4.2.1 Systems Documentation

The contractor(s) is responsible for providing to the Department complete, accurate and timely documentation of all system modules. Once development is complete, the contractor(s) must prepare updates to the system documentation to incorporate all system enhancements and modifications that have resulted from the completion of open items and defects noted during UAT.

All MMIS and POS systems documentation must be maintained online with access for the Department authorized personnel. Provide the Department a complete electronic copy of the MMIS and POS systems documentation with versions of date changes. Each previous copy must be available and viewable online and on demand.

The contractor(s) shall provide all existing vendor documentation for each COTS System Component (as appropriate) to the Department. The list of documentation to be included (if available) shall include:

- Product Roadmap

- Product Business Rules and Controls
- Product Graphical User Interface (GUI), Features and Functions
- Product Hardware (Optimal Performance) Specifications
- Product Software Components/ Third-party Components
- Product Training Curricula/Services
- Product Technical Services
- Product Support Services
- Product Definition of Terms/Glossary
- Product Desktop/Browser Specifications
- Product Operating System Specifications
- Product Crosswalk to Documentation Base

The contractor(s) shall provide the Department all supporting documentation supplied by each equipment or commercial software vendor.

The contractor(s) shall provide any additional documentation, such as system administration manuals, related to the external system and its interface to the MMIS and POS.

The contractor(s) shall ensure that the MMIS and POS Documentation is complete and available in the specified forms, both hardcopy and electronic. The contractor(s) agreement with Department shall include an unlimited right to copy, both for softcopy and hardcopy, all MMIS related documentation for internal use by the Department. This shall include all product documentation provided by the contractor(s) to Department, unless otherwise restricted by the original vendor. The contractor(s) shall work with Department to establish MMIS and POS documentation update procedures that allow authorized Department representatives to update and add documentation to the MMIS and POS processing environments as needed.

The contractor(s) shall establish that the documentation is current, that it accurately and completely reflects the existing MMIS and POS, and that it meets all contractual documentation requirements. The contractor(s) shall submit the completed assessment report for DHS's written approval. The contractor(s) shall provide the Department one corrected copy in a Department-approved secure electronic media and if requested two hard copies of each corrected document with the MMIS and POS Documentation Inventory List.

The MMIS and POS Documentation Inventory List shall include a complete assessment report for each of the following, but not be limited to:

1. Architectural Design.
2. System Functional Design.
3. Detailed Program Design.
4. Detail Program Specifications.
5. Data Descriptions.
6. Data Element Dictionaries.
7. Database Descriptions.
8. Job and Process Scheduling.
9. Computer Operations Procedures.
10. User and System Documentation.
11. Master List of all MMIS manuals.
12. An assessment of all system software.

13. Documentation to facilitate prospective successor contractors understanding of overall standards, network bandwidth needs, hardware capacity, software needs, and network topology to transfer, operate, and maintain the current MMIS and POS.
14. Master index of all records maintained by the contractor(s) pursuant to its records retention responsibilities that shall, for each record, include the name, span of dates covered, and volume and medium.
15. Pursuant to the cost reimbursement provisions of the contract, lists of all cost-reimbursed:
    a. Purchased or leased equipment and software.
    b. Print shop supplies, forms, and specifications used within the MMIS and POS.
    c. Reports for the end-of-contract payments.
16. List of post office boxes, telephone numbers, facsimile numbers, and any other Department-approved method of accessing the contractor(s) to receive information, including but not limited to, MMIS and POS forms, data, and inquires; and a description of the purpose of each method listed above.

The contractor(s) is responsible for providing any copies requested by CMS.

The systems documentation must:

a. Be available and updated on electronic media storage and must be maintainable after turnover.
b. Have all narrative created and maintained in Microsoft Word (compatible with Department version) and be provided to the Department on request on CD-ROM or other designated media.
c. Have all narrative also maintained in .html or .htm format for online use.
d. Be organized in a format which facilitates updating and any revisions must be clearly identified.
e. Include system, program and application narratives that are understandable by non-technical personnel.
f. Contain an overview of the system including:
    1. A narrative of the entire system.
    2. A description and flowcharts showing the flow of major processes in the system.
    3. Multiple sets of hierarchical, multi-level charts that give a high, medium and detail view of the systems for both online and batch processes.
    4. A description of the operating environment.
    5. The nomenclature used in the overview must correspond to nomenclature used in module documentation. All modules must be referenced and documentation must be consistent from the overview to the specific modules and between modules.
g. Module level documentation for each module must contain:
    1. Module name and numeric identification.
    2. Module narrative.
    3. Module flow, identifying each program, input, output and file.

4. Process flows within each module, identifying programs, inputs and outputs, control, process flow, operating procedures and error and recovery procedures.
5. Name and description of input documents, example of documents and description of fields or data elements on the document.
6. Listing of the edits and audits applied to each input item and the corresponding error messages.
7. Narrative and process specifications for each program or module.
8. Screen layouts, report layouts and other output definitions, including examples and content definitions.
9. A list and description of all control reports.
10. File descriptions and record layouts with reference to data element numbers for all files, including intermediate and work files.
11. A list of all files by identifying name, showing input and output with cross-reference to program identifications.
12. Facsimiles or reproductions of all reports generated by the modules.
13. Instructions for requesting reports must be presented with samples of input documents and or screens.
14. Narrative descriptions of each of the reports and an explanation of their use must be presented.
15. Definition of all fields in reports, including a detailed explanation of all report item calculations.
16. Desk level procedures.

h. Documentation of all rules in the rules engine. The rules engine solution must meet the same Federal standards established by CMS related to Medicaid eligibility rules engine to ensure federal enhanced matched rates. This includes both a technical definition of the rule and a business definition of the rule. Additionally, our preference is for a rules engine where it links to policy, state law, and federal law can be established and maintained within the rules engine solution.

i. Program documentation, to include, at a minimum:

1. Program narratives, including process specifications for each, the purpose of each and the relationships between the programs and modules.
2. A list of input and output files and reports, including retention.
3. File layouts.
4. File names and dispositions.
5. Specifics of all updates and manipulations.
6. Program source listing.
7. Detailed program logic descriptions and edit logic or decision tables including, at a minimum, the sources of all input data, each process, all editing criteria, all decision points and associated criteria, interactions and destination links with other programs and all outputs.

8. Physical file definitions.
9. File descriptions and record layouts with reference to file names and numbers for all files including intermediate and work files. Data element names, numbers, number of occurrences, length, type, record names, numbers, lengths, file maintenance data, such as number of records, file space and any other data necessary to manage the data or utilize the documentation. Lists by identifying name of all files inputs and outputs with cross-references to the programs in which they are used.

j. Service Oriented Architecture (SOA) documentation will include:
   1. Unified Modeling Language (UML) 2.0 with the following structural diagrams:
      i. Class diagram.
      ii. Object diagram.
      iii. Module diagram.
      iv. Deployment diagram.
   2. Behavioral diagrams:
      i. Use Case diagram.
      ii. Sequence diagram.
      iii. Collaboration diagram.
      iv. Department chart diagram.
      v. Activity diagram.
   3. Three types of model management diagrams:
      i. Package diagram.
      ii. Model diagram.
      iii. Module diagram.

k. Other documentation, to include: Extensible Markup Language (XML) Metadata Interchange (XMI), XML Schema Definitions (XSDs), Business Process Modeling Notation (BPMN) where appropriate, Abstract and Concrete Web Services Description Language (WSDL), and Business Process Execution Language (BPEL) Code.

6.4.2.2 User Documentation

The contractor(s) must prepare user documentation and user manuals including: web-published materials for external use such as provider manuals, program materials, procedure updates and EDI billing instructions. The structure and format must be prior approved by the Department. The contractor(s) must prepare draft user documentation during the development task for use during the testing task, with updates made during the testing and implementation tasks, as appropriate. The contractor(s) will be responsible for the production and distribution of all user documentation updates in a timely manner. The following are minimum requirements for MMIS and POS user documentation:

a. Must be rules-based driven, using metadata where ever possible, allowing for automatic updates to the documentation when system or requirement changes occur. The documentation must also include online, context-sensitive help screens for all MMIS and POS functions, including web-based modules.

b. Must include the use of content and document management capability to link, track and update all documentation affected by a system or requirement change.

c. Must be available online via the MMIS and POS application and provide an online search capability with context-sensitive help; the Department requires one paper copy using 8-1/2" x 11" pages in three-ring binder form, pages numbered within each section and a revision date on each page. Revisions must be clearly identified in bold print.

d. Must be created and maintained in Microsoft Office 2007 Suite or higher (consistent with the current Department standard) and Visio and must be provided on request to the Department on external media storage and be accessible via the web to users during the Operations Phase.

e. Must be written and organized so that users not trained in data processing can learn from reading the documentation on how to access the online windows and screens and read module reports and perform all other user functions.

f. Must be written in a procedural step-by-step format and should be aligned with the business transformation documents.

g. Instructions for sequential functions must follow the flow of actual activity that is, balancing instructions and inter-relationship of reports.

h. User manuals must contain a table of contents and an index.

i. Descriptions of error messages for all fields incurring edits must be presented and the necessary steps to correct such errors must be provided.

j. Definitions of codes used in various sections of a user manual must be consistent.

k. Acronyms used in user instructions must be identified and must be consistent with windows, screens, reports and the DED.

l. All system errors must be handled by a standardized error handling module that translates technical messages into commonly understood terminology.

m. Abbreviations must be consistent throughout the documentation.

n. Field names for the same fields on different records must be consistent throughout the documentation.

o. Each user manual must contain "tables" of all valid values for all data fields (e.g., provider types, claim types) including codes and an English description, presented on windows, screens and reports.

p. Each user manual must contain illustrations of windows and screens used in that module, with all data elements on the screens identified by number.

q. Each user manual must contain a section describing all reports generated within the module which includes the following:

    1. A narrative description of each report.

    2. The purpose of the report.

    3. Definition of all fields in the report, including detailed explanations of calculations used to create all data and explanations of all subtotals and totals.

    4. Definitions of all user-defined, report-specific code descriptions; a copy of one page of each report and number of pages of each report.

r. Instructions for requesting reports or other outputs must be presented with examples of input documents and or screens.

s. All functions and supporting material for file maintenance (e.g., coding values for fields) must be presented together and the files presented as independent sections of the manual.

t. Instructions for file maintenance must include both descriptions of code values and data element numbers for reference to the DED.

u. Instructions for making online updates must clearly depict which data and files are being changed.

v. A desktop guide must include appropriate instructions from this section and that provides users with all the information they need for role-based access to the screens and functions that are necessary to perform their jobs.

w. Draft user documentation, as well as final versions, will be used as the basis for UAT and for knowledge transfer before the start of operations, unless otherwise specified by the Department.

6.4.2.3 State Responsibilities

a. Provide the Implementation Team.

b. Identify deficiencies and review corrective action plans.

c. Review all post implementation deliverables. The standard turnaround for the Department review shall be 10 business days. The Department encourages early submission of draft documents to expedite the Department review.

6.4.2.4 Contractor Responsibilities

Contractor(s) responsibilities for the post implementation evaluation task will be to:

a. Provide unobstructed access to the evaluation team to review operational and system areas.

b. Prepare a corrective action plan (CAP) for problems or deficiencies identified by the evaluation team for review and obtain approval by the Department.

c. Develop the post implementation evaluation report for review by the Department.

d. Execute the CAP.

e. Archive all first-run federally required reports for inclusion in the CMS certification documentation.

6.4.2.5 Deliverables

Deliverables to be produced by the Contractor for the post Implementation task must include the following:

a. All required CAPs.

b. CMS certification documentation including archived versions of all first-run federally required reports.

c. System documentation.

d. User documentation.

6.4.2.6 Performance Standards

The following documents must be submitted to the Department for review and approval within a timeframe determined by the Department with minor revisions:

a. All required CAPs.

b. CMS certification documentation including archived versions of all first-run federally required reports.

c. The contractor(s) must implement and maintain MMIS and POS systems documentation. The contractor(s) must provide one copy of systems documentation within 60 calendar days prior to the Operations Phase. Additionally any updates to the systems documentation must be submitted to the Department during the Operations Phase on a quarterly basis.

d. The contractor(s) must implement and maintain MMIS and POS user documentation. The contractor(s) must provide one copy of the user documentation within 60 calendar days prior to the Operations Phase. Additionally all updates to the user documentation must be submitted to the Department during the Operations Phase on a quarterly basis.

e. The electronic version of the approved systems documentation and user documentation for the MMIS and POS must be posted to the web site within three business days of the Department's approval.

7 MMIS AND POS SYSTEM REQUIREMENTS

This section includes the following topics:

7.1: Requirements Instructions

7.1.1: Table Descriptions

7.1.2: MMIS System Requirements

7.1.3: MMIS and POS Infrastructure Requirements

7.1.4: MMIS Infrastructure Requirements

7.1.5: Current MMIS External Interfaces

7.1.6: Pharmacy Point-of-Sale (POS) System Requirements

As result of the system requirements, it is the Department's intention to replace the following current ancillary systems which will become part of the new MMIS:

Buy-In, HIPP, MEPD, MIPS, ISIS and Title XIX

7.1 Requirements Instructions

The requirements set forth are for the functional, infrastructure and interface requirements for the MMIS and the POS.

Complete Columns A-E below using the following information for each column.

COLUMN	DESCRIPTION	VALUE
A	Agree to meet the requirement as stated	Yes or No
B	Existing capability	Yes or No
C	Requirement will be met with system modification (SM) or Commercial off- the-shelf (COTS) solution (Required entry for any Requirement with a "No" in Column B)	SM or COTS
D	DDI Hours (Required entry for any Requirement with a "No" in Column B)	# of DDI Hours for SM or scheduled Product Releases for COTS
E	Reference to Proposal Section for proposed solution	Proposal Reference

The proposal description referenced by Column E should have a description of how the requirement will be met. COTS solutions should address the description of the product and the implementation process; system modifications should explain the type of modification (i.e., change rules engine, modification and addition to system code). The reference number in the table below will be used to track the requirement throughout the project. System Requirements are grouped for convenience only and may apply to more than one module or group.

The numbering scheme for the requirements indicates if the requirement is from the CMS certification checklist or is a state-specific requirement:

Certification requirements are numbered: XX1.01 (e.g., BE1.01).

Additional state criteria for a CMS business objective are numbered: XX1.01.01 (e.g., BE1.01.01).

State-specific criteria for a CMS business objective are numbered: XX1.SS.01 (e.g., BE1.SS.01).

Added business requirements that are state-specific objectives are numbered XXSS.01 (e.g., BE.SS.01).

7.1.1 Table Descriptions

The system requirements are divided into 5 different sections as defined below.

7.1.2 MMIS System Requirements

Member Management (BE)

Provider Management (PR)

Claims Receipt (CR)

Claims Adjudication (CA)

Prior Authorization (CA)

Reference Data Management (RF)

Third-Party liability Management (TP)

Health Insurance Premium Payment (HP)

Program Management Reporting (PM)

Federal Reporting (FR)

Financial Management (FI)

Program Integrity Management (PI)

Managed Care (MC, ME, MG)

Waiver, Facility and Enhanced State Plan Services Management (WA)

Optional Waiver, Facility and Enhanced State Plan Services Management for the ISIS Replacement System (OWA.SS)

Immunization Registry Interface (RI)

7.1.3 MMIS and POS Infrastructure Requirements

Rules Engine System Requirements (RE)

General Architectural Requirements (AR)

HIPAA Transaction Requirements (HP)

MITA Technical Requirements (MT)

Service Oriented Architecture (SOA) Requirements

Programming Language Requirements (PL)

Security & Privacy requirements (SP)

Software Licenses and Maintenance Requirements (SL)

Data Quality Control Requirements (DQ)

Environment Requirements (EV)

7.14 MMIS Infrastructure Requirements

Web Portal (WP)

Workflow Requirements (WM)

Electronic Data Management (ED)

Automatic Letter Generation Requirements (ED)

7.1.5 Current MMIS External Interfaces

External Interfaces

7.1.6 Pharmacy Point-of-Sale (POS) System Requirements

Pharmacy Point-of-Sale (POS)

7.1.2 MMIS System Requirements

Member Management Business Area – MMIS

This business area includes the system requirements for member management including medically needy spenddown requirements.

BE	Member Management Requirements - MMIS	A	B	C	D	E
BE1.01	Support a member data set that contains all required data elements.					
BE1.01.02	Maintain member demographic data, including, but not limited to the following: a. Mailing address. b. Residential address. c. County of residence. d. Multiple instances of county of legal settlement. e. Guardian name and address. f. Custodian name and address. g. Representative payee name and address. h. Zip plus four on all addresses. i. Date of birth. j. Date of death. k. Pregnancy date of delivery. l. Race(s). m. Gender. n. Marital status. o. Ethnicity or tribal designation. p. Emancipated youth indicator. q. Deprivation code. r. Primary language spoken. s. Primary language for correspondence. t. Benefit address. u. Custody status. v. Telephone numbers such as home, cell, work, guardian and individual ownership of phone) – must store multiple numbers. w. Fax number. x. Email address example, attach e-mail address to member. y. Text number or pager number. z. Head or member of household. aa. Foster care indicator. bb. Foster care for Early and Periodic Screening Diagnosis and Treatment (EPSDT) mailing indicator. cc. Immunization Registry data received and displayed in the Medicaid Management Information System (MMIS). dd. Social Security Number. ee. State ID from the eligibility system. ff. Multiple indicators of disability, chronic or other condition as identified by Iowa Medicaid Enterprise (IME). gg. Member name, legal and preferred.					

BE	Member Management Requirements - MMIS	A	B	C	D	E
	hh. Eligibility span. ii. Case Number. jj. Others as determined by IME.					
BE1.02	Process all transactions that update the member data set on a timely basis as determined by IME, edit fields for reasonableness and control and account for transactions with errors.					
BE1.02.01	Provide controls to assure that records received from the eligibility system were properly applied.					
BE1.02.02	Provide a weekly listing, in electronic form, "Notices of Decision (NOD)" to recipients for non-payable Medicaid service claims, combined with the ambulance notice of decision listing, that contains the following information in alphabetical order by member last name: a. Member name and member number. b. Provider name and provider number. c. TCN and denial notice number. d. Date of service and date of NOD. e. Exception code. f. Written reason for denial. g. Same format as current ambulance NOD.					
BE1.02.03	Provide the capability to generate NODs for denials of selected services such as therapy services, rehabilitation therapy service, claims for occupational therapy, physical therapy and speech therapy.					
BE1.03	Support management of member information, including archives, reports, transaction and transaction error tracking.					
BE1.04	Generate notification when member information is received from external sources to update member records.					
BE1.05	Receive and process member eligibility information from external sources such as, IME's Integrated Eligibility System or Social Security Administration (SSA's) state data exchange, for a given period of time; produce total and detail information that supports error correction and synchronization. Apply reconciliation changes to master file. Produce a file of changed records to be sent to originating source.					
BE1.06	Archive member data sets and update transactions according to IME provided parameters.					
BE1.07	Provide member data to support case identification, tracking and reporting for the EPSDT services covered under Medicaid.					
BE1.07.01	Provide the capability to meet the business requirements of EPSDT.					
BE1.07.02	Provide the capability to track screenings, referrals and treatments for EPSDT members.					
BE1.07.03	Identify all members eligible for EPSDT services within the benefit plan administration rules engine.					
BE1.07.04	Provide the capability for recording all case activity including, but not limited to: a. Logs of notices.					

BE	Member Management Requirements - MMIS	A	B	C	D	E
	b. Recommended dates of service from the periodicity table. c. Actual dates of services. d. IME and contractor contacts. *e.* Case notes.					
BE1.07.05	Use the workflow management process to provide and log notices, track services provided and enter case notes for each eligible member in a program (such as EPSDT) and at a minimum, include processes listed below: a. Automatically generate notification letters or electronic communications, according to specifications set by IME. Identify the family head of household or foster care worker and generate screenings letters and or electronic communications to this individual, even if the child resides at a different address. b. Retrieve data from the MMIS claims and encounter data (if applicable) to compare to services recommended from the periodicity table. c. Provide for the inclusion of claims attachments. d. Automatically compare and report claims to the periodicity table, to determine if the member received the health checkup examination and related services at the recommended intervals.					
BE1.08	Provide an indicator to suppress generation of documents containing member identification for confidential services or other reasons.					
BE1.09	Maintain indicators such as clinical or utilization and special needs status for such programs as lock-in, disease management, outcomes and high-dollar case management files.					
BE1.09.01	Provide the capability to maintain date-specific data necessary to support long term care claims processing, such as level of care (LOC), patient financial responsibility, admit and discharge dates, home-leave days and hospital-leave days.					
BE1.09.02	Support the processing of nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR), Home and Community Based Waiver and other long-term care (LTC) claims through the maintenance of member specific LTC data.					
BE1.09.03	Support the processing of nursing facility, ICF/MR, Home and Community Based Waiver and other long term care claims through the maintenance of provider specific certification and rate data.					
BE1.10	Maintain record and audit trail of a member's requests for copies of personal records (including time and date, source, type and status of request).					
BE1.11	Maintain record and audit trail of errors during update processes, accounting for originating source and user.					
BE1.11.01	Provide the capability to produce daily audit trail					

BE	Member Management Requirements - MMIS	A	B	C	D	E
	reports and allow inquiries showing all member data updates applied to the member management module.					
BE1.11.02	Provide the capability to maintain an audit trail to document date, time and user who accessed a member record through the real-time interface.					
BE1.12	Allow authorized users to update member records online.					
BE1.12.01	Provide the capability for authorized users to have online inquiry into the member module with access, at minimum, by case number, member state identification number (SID), social security number (SSN) and member name or partial name.					
BE1.13	Support and track the identification of duplicate recipient records based on state-defined criteria.					
BE1.SS.01	Provide the capability to generate file of new and changed eligible members to the contractor responsible for generating eligibility cards as directed by IME including production on demand.					
BE1.SS.02	Provide the capability to generate an alert when a member gives birth or when a pregnancy is terminated.					
BE1.SS.03	Eligibility segments must be date driven and provide accurate eligibility information at any point in history.					
BE1.SS.04	Provide an online change-correction process, which allows the database record to be modified according to users' security access levels.					
BE1.SS.05	Provide links between all modules, such that the user can easily navigate with one "click" according to users' security access levels.					
BE1.SS.07	Provide the capability to maintain current and historical information, with inquiry and update capability, for authorized IME users, on Medicare Part A, B, C, D coverage, including but not limited to: a. Effective dates. b. Termination dates. c. Medicare identification number. d. Medicare advantage plan information. e. Part D coverage. f. Other health plan information. g. Medicare buy-in information. h. Part C coverage. i. Other information as defined by IME.					
BE1.SS.08	Provide a monthly extract of members that are dually eligible for Medicare and Medicaid, to the Medicare Part A, Part B and Part D carriers, or coordination of benefits carrier and CMS.					
BE1.SS.09	Provide the capability to periodically archive member records using criteria approved by IME.					
BE1.SS.10	Provide the capability to void and retain member information as determined by IME.					
BE1.SS.11	Provide the capability to perform reconciliation of the member module with 100% accuracy, approved by IME to all eligibility files in the eligibility system on a					

BE	Member Management Requirements - MMIS	A	B	C	D	E
	schedule to be determined by IME.					
BE1.SS.12	Provide the capability to generate Medicare eligibility files for the Medicare claims processor to use in processing crossover claims.					
BE1.SS.13	Provide address type and effective dates for each address maintained in the member management module. Provide the capability to select the type of address when mailings are prepared for members, example Third-Party Liability (TPL), Explanation of Medical Benefits (EOMBs), EPSDT letters and prior authorization determinations.					
BE1.SS.14	Provide a robust search capability in the member database using minimal steps and keystrokes to search for all available member data elements.					
BE1.SS.15	Provide the capability to view a single eligibility episode that is comprised of multiple eligibility segments for example see “the beginning and end date” for all contiguous eligibility segments.					
BE1.SS.16	Provide the capability to accept and send data using various media options such as, online, Internet Direct Data Entry (DDE), Electronic Data Interchange (EDI) and reports to other state agencies and other external sources, in the format required by IME.					
BE1.SS.17	Provide the capability to provide authorized staff with real-time access to all modules of the MMIS, for inquiries during normal business hours.					
BE1.SS.18	Provide the capability to identify the name(s) of the provider(s) to which the member is locked-in.					
BE2.01	Provide data storage and retrieval for TPL information; support TPL processing and update of the information.					
BE2.01.01	Support the assignment of members to benefit plans based on rules in the rules engine and provide the capability to set the effective date of enrollment in a Benefit Plan on the date of enrollment, a default date or any state defined date.					
BE2.01.02	Provide the capability to determine if a member is enrolled in multiple benefit plans for example HCBS, Medically Needy, PG (Pregnancy), ICF-MR, QMB and SLMB. Provide the capability to distinguish which benefit plan will fund the service based on the hierarchy as established by IME.					
BE2.01.03	Support a universal identifier for members across all benefit plans and cross-reference that identifier with all prior established benefit plan identifiers.					
BE2.01.04	Maintain the benefit package associated with each benefit plan, including the rules that apply to provider enrollment, claims processing, reporting and any other processing rules.					
BE2.01.05	Provide the capability to maintain insurance coverage data in the member management module including, but not limited to: a. Carrier.					

BE	Member Management Requirements - MMIS	A	B	C	D	E
	b. Policy number. c. Group number. d. Pharmacy Benefit Manager (PBM) ID and member identification number. e. Sponsor, subscriber or policy holder name and identification number(s). f. Type(s) of coverage. g. Dates of coverage. h. Date the coverage was added to the database. i. Date the coverage was updated. j. Court order including date ranges and responsible payer. k. Part D enrollment indicator - The record should indicate the member is enrolled in Medicare Part D and identify the plan the member is enrolled. l. Allow for multiple insurance policies.					
BE2.02	Supports the assignment of members to Medicaid benefits and benefit packages based on federal and or IME-specific eligibility criteria.					
BE2.02.01	Provide the capability to maintain a historical record of benefit assignment(s) for a member, including identifying dual-eligibility spans.					
BE2.02.02	Provide the capability to create new benefit plans by configuring through the rules engine using a defined process for testing and promoting changes.					
BE2.02.03	Provide the capability to create new benefit plans by a business analyst without involvement of programmers.					
BE2.02.04	Provide the capability to maintain a historical record of benefit assignment(s) for a member, including identifying dual-eligibility spans.					
BE2.03	Apply appropriate benefit limitations for members based on federal and or IME-specific criteria.					
BE2.04	Maintain record of member benefit limitation information.					
BE2.05	Calculate and apply member cost-sharing, including premiums and co-pays, for particular benefits based on federal and or IME-specific criteria.					
BE2.06	Maintain record of member cost-sharing and provide the capability to retain "to date" accumulations for cost sharing if a client moves between benefit plans.					
BE2.07	Maintain record audit trail of any notice of benefit(s) sent to members including time and date, user source and reason for notice.					
BE2.SS.01	Provide the capability of real time updates to the member module as directed by IME.					
BE2.SS.02	Provide the capability to perform mass re-assignment of members prior to the end of the month or on an as needed basis.					
BE2.SS.03	Provide the capability to maintain a real time interface with the POS to verify member eligibility as directed by IME.					

BE	Member Management Requirements - MMIS	A	B	C	D	E
BE2.SS.04	Provide the capability to identify and report data exchange transactions that fail either fatal and or non-fatal update edits back to the originating module and user area.					
BE2.SS.09	Provide the capability to lock-in a member to a certain physician, hospital, pharmacy or all.					
BE2.SS.08	Provide the capability to report on the number of members in lock-in status, the reason for the lock-in, the number of unauthorized providers billing for services during lock-in time segments.					
BE3.01	Provide eligibility status for date(s) queried in response to an eligibility inquiry made through the MMIS. Track and monitor responses to queries.					
BE3.02	Provide notification of third-party payers who must be billed prior to Medicaid in response to an eligibility inquiry made through the MMIS.					
BE3.03	Provide notice of participation in a managed care program in response to an eligibility inquiry made through the MMIS.					
BE3.04	Provide notification of program and service restrictions, such as lock-in or lock-out, in response to an eligibility inquiry made through the MMIS.					
BE3.05	Maintain record and audit trail of responses to eligibility inquiries.					
BE4.01	Support system transmission and receipt of all current version X12N eligibility verification transactions. System is required to support future standards through the life of the contract at no charge to the State of Iowa.					
BE4.02	Support production of X12N 270 transactions to query other payer eligibility files and ability to process responses.					
BE4.SS.01	Provide the capability to produce Health Insurance Portability and Accountability Act (HIPAA) certificates of creditable coverage on a scheduled and ad-hoc basis.					
BE4.SS.02	Provide the capability to produce HIPAA privacy notices on a scheduled and ad hoc basis.					
BE4.SS.03	Track disclosure of protected health Information (PHI) and have the capability to indicate persons authorized to discuss PHI for a member.					
BE5.01	Identify and track potential Medicare buy-in members according to IME and CMS-defined criteria.					
BE5.02	Transmit IME-identified buy-in member information for matching against CMS-specified federal Medicare member database(s).					
BE5.03	Accept buy-in member response information from CMS-specified federal Medicare member database(s).					
BE5.04	Process change transactions to update buy-in member information. Identify and track errors or discrepancies between IME and federal buy-in member information.					

BE	Member Management Requirements - MMIS	A	B	C	D	E
BE5.05	Provide buy-in member information for program or management use including: a. Transactions processed. b. Errors identified. c. Error correction status. d. Medicare premiums to be paid by member.					
BE5.06	Track buy-in exceptions for those members who are identified as eligible, but whose premiums have not been paid.					
BE5.SS.01	Provide the capability to send an alert of all buy-in transactions that may affect eligibility status or cost shares for buy-in members.					
BE5.SS.02	Provide the capability to generate buy-in premiums and provide the information required to support IME payment of premiums.					
BE5.SS.03	Provide the capability to send a file to CMS of all buy-in deletions due to Medicaid and or Medicare eligibility termination or death and changes.					
BE5.SS.04	Provide an alert and a weekly report of when Centers for Medicare and Medicaid Services (CMS) notifies the IME that another state has bought into Medicare for a member.					
BE5.07	Support automated data exchange process or processes, as specified by CMS, in order to identify and track Medicare Part D dual-eligible and Medicare Low-Income Subsidy (LIS) eligible members for the purposes of cost-avoidance on prescription drug claims and calculating spenddown payments.					
BE5.07.01	Provide the capability to maintain an interface with CMS to assure the timely accretion of Medicare eligible members for Part A and Part B benefit buy-in.					
BE.SS.01	Maintain historical date-specific spenddown information.					
BE.SS.02	Allow for providers to submit claims electronically for spenddown application for the member and family of the members.					
BE.SS.03	Allow for providers to submit inquiries concerning spenddown requirements for a member.					
BE.SS.04	Allow members to view spenddown information on the web portal including claims that were submitted and used toward spenddown.					
BE.SS.05	Generate notice to provider and member of claims that were applied to spenddown and amount of unmet spenddown.					
BE.SS.06	Apply the amount of claims that are denied for unmet spenddown to the spenddown balance.					
BE.SS.07	Provide the capability to prevent duplicate use of claims for spenddown.					
BE.SS.08	Provide capability to manually deduct claims originally applied to unmet spenddown as directed by IME.					
BE.SS.9	Support edits which prevent payment of claims that					

BE	Member Management Requirements - MMIS	A	B	C	D	E
	were applied to spenddown in whole or part.					
BE.SS.10	Return spenddown met indicator (fund code) to eligibility system once the spenddown amount is met.					
BE.SS.11	Ensure claims are applied to spenddown in the Medically Needy file on a first in, first used basis.					
BE.SS.12	Allow claims for household members and or relatives of the member, to be applied against the spenddown amount per Iowa rules.					
BE.SS.13	Provide online screens showing the Medically Needy spenddown amount, the amount of claims that have accumulated towards the spenddown amount, information for each certification period, the date spenddown is met and information about claims used to meet spenddown.					
BE.SS.14	Provide a summary screen of the member's certification history.					
BE.SS.15	Apply the unpaid portion of Medicare Crossover Claims to the Medically Needy spenddown amount if the amount is greater than zero.					
BE.SS.16	Transmit the following information to the IME each time MMIS loads file transfers from the external systems: a. Confirmation of the date each file is received and loaded. b. The number of files and or records that were successfully transmitted and posted. c. The number and detailed information of the records that were rejected. d. The rejection reason code for each record rejected.					
BE.SS.17	Reversals of claims should automatically adjust spenddown.					
BE.SS.18	Spenddown balances should be made available real-time to the pharmacy point-of-sale system and should be verified before claims are paid.					
BE.SS.19	Process and maintain inputs and outputs including but not limited to the following: **Inputs:** a. Data from the eligibility systems. b. Provider data. c. EPSDT data. d. Federal and state enrollment rules. e. Data entered and uploaded by professional service contractors. **Outputs:** a. Notices of Decision and appeal rights to members on denied ambulance claims and denied rehabilitation therapy service claims as directed by the Department. b. Notices of Decision to members for denied and modified prior authorizations. c. State Supplementary Assistance checks to the address on file for each Residential Care					

BE	Member Management Requirements - MMIS	A	B	C	D	E
	Facility (RCF) member. d. Weekly file listing the state ID numbers, names, dates of service, amount paid and date paid of all Medicaid clients for whom a Medicare crossover claim has been paid, but for whom Medicare eligibility is not indicated on the eligibility record. e. Data entry and edit exception reports to the Department for reconciliation with eligibility data. f. Run a monthly report showing any possible duplicates that exist on the MMIS member eligibility file. g. Histories for inquiries with dates of service for which data has been archived. h. All IME specified reports. i. Data extracts for Medicaid Statistical Information System (MSIS), Payment Error Rate Measurement (PERM) and Office of Inspector General (OIG) audits or any federal or state audits.					

Provider Management Business Area – MMIS

This business area includes the system requirements for provider management.

PR	Provider Management Requirements - MMIS	A	B	C	D	E
PR1.01	Provide secure access to provider applications.					
PR1.01.01	Have security to maintain control over all data pertaining to provider enrollment.					
PR1.01.02	Provide authorized IME and contractor user inquiry access to provider data stored within the system.					
PR1.01.03	Provide update access only to authorized IME and contractor staff to make updates to the provider data.					
PR1.01.04	Provide the ability to recall provider applications by several different key fields such as name or reference number as defined by IME.					
PR1.01.05	The provider module must process provider data in an online, real-time mode and produce audit trails of all updates.					
PR1.02	Provide capability to route provider applications, collect and processes provider enrollment and status information.					
PR1.02.01	Provide edits, in the provider enrollment and update process, to track and identify errors and inconsistencies.					
PR1.02.02	Accept electronic signature on enrollment without hard copy as allowed by IME, state and federal regulations.					
PR1.02.03	Provide capability to upload provider enrollment files electronically and create electronic audit trail with ability to review applications.					
PR1.02.04	Edit appropriate provider applications and existing					

PR	Provider Management Requirements - MMIS	A	B	C	D	E
	providers against the CMS excluded provider list.					
PR1.02.05	Provide capability to manually exclude providers and mark the provider as "Terminated by Medicaid Authority". Providers marked as "Terminated by Medicaid Authority" must be manually released for participation in Medicaid prior to any claims payment. Providers marked as terminated by Medicaid authority must be terminated on the date provided.					
PR1.02.06	Provide the capability to suspend a provider application in pending status, until additional information is received from the provider.					
PR1.02.07	Assign a unique tracking number to each provider enrollment application or correspondence document.					
PR1.02.08	Provide the capability to tie provider correspondence documents to appropriate enrollment application when applicable.					
PR1.02.09	Identify and report providers (individual or group) that have initiated the enrollment process but have failed to return required information necessary to complete the enrollment into the Medicaid Program.					
PR1.02.10	Provide the capability to identify sanctioned providers and facilities to prevent the enrollment of members in sanctioned facilities.					
PR1.03	Produce notices to applicants of pending status, approval or rejection of their applications. Provide online real-time update capability for the provider file.					
PR1.03.01	Automatically generate notices to providers including but not limited to status change, approvals, denials and license expiration as determined by IME.					
PR1.03.02	Provide the capability for a provider to choose to receive provider communications by secure encrypted email, fax or combination or as directed by the IME.					
PR1.04	Maintain a provider numbering system with unique numbers that may be used to identify a provider's type and ensure that appropriate provider number ranges are allowed to prevent system problems in processing. Map NPI numbers to internal assigned numbers. Assign and maintain provider numbers for providers not eligible for an NPI number.					
PR1.04.01	Perform an automated duplicate checking process prior to adding applications to the file.					
PR1.05	Flag and route for action if multiple internal provider numbers are assigned to a single provider.					
PR1.06	Support communications to and from providers. Track and monitor responses of communications.					
PR1.06.01	Support mailings to multiple provider addresses as requested by the provider electronically or as directed by IME.					
PR1.06.02	Support different notifications to be sent to providers by program area or benefit plan (e.g., LTC, Home and Community Based Services (HCBS) and EPSDT).					
PR1.07	Support a provider appeals process in compliance					

PR	Provider Management Requirements - MMIS	A	B	C	D	E
	with federal guidelines contained in 42 CFR 431.105.					
PR1.08	Provide for date-specific provider enrollment and demographic data.					
PR1.08.01	Enable provider application processing statistics by type, month, year and processor.					
PR1.08.02	Provide the capability to track all provider enrollment denials in the provider tracking database.					
PR1.09	Generate information requests, correspondence or notifications based on the status of the application for enrollment.					
PR1.10	Track the sending of IME furnished information to enrolled providers.					
PR1.11	Produce responses to requests and or inquiries on the adequacy of the Medicaid provider network based on provider and or member ratios by geographic region and or provider type.					
PR1.12	Provide for consistent provider naming conventions to differentiate between first names, last names and business or corporate names to allow flexible searches based on the provider name.					
PR1.SS.01	Support editing for address standardization, according to United States Postal Service (USPS) standardization.					
PR1.SS.02	Enrollment tracking process must be fully integrated with the MMIS and Point-of-Sale (POS) so that information can be tracked from enrollment request through provider enrollment without requiring duplicate entries in systems.					
PR2.01	Track and support the screening of applications and ongoing provider updates for NPIs, state licenses and specialty board certification as appropriate. Review team visits when necessary and any other state and or federal requirement.					
PR2.02	Track and support any established provider review schedule to ensure providers continue to meet program eligibility requirements.					
PR2.02.01	Maintain the capability to place a provider on either prepayment or post payment review including the capability to identify whether the status is no review, prepayment review, post payment review, or both pre-and-post payment review and include an indicator to identify the reason the provider was placed on review.					
PR2.03	Verify provider eligibility in support of other system processes (e.g., payment of claims).					
PR2.04	Capture Clinical Laboratory Improvement Amendments (CLIA) certification information and the specific procedures each laboratory is authorized to cover. Link the information for use in claims adjudication.					
PR2.04.01	Receive updates to CLIA numbers and certification information. The CLIA and certification information must be maintained by date segment, including an audit trail of the changes made.					

PR	Provider Management Requirements - MMIS	A	B	C	D	E
PR2.04.02	Use CLIA information from the national data site in the enrollment process.					
PR2.05	Cross-reference license and sanction information with other state or federal agencies.					
PR2.05.01	Provide the capability of matching providers based on a file of sanctioned providers received from the appropriate state licensing authority and other provider licensing boards, as well as other licensing and certification boards and flagging and updating the provider's record for termination.					
PR2.06	Generate notices to providers of expiring Medicaid agreements and or state licenses.					
PR2.06.01	Automatically generate letters to providers requesting license certification renewal prior to end date of current certification or license as directed by IME.					
PR2.06.02	Automatically generate an alert and a provider termination notice when the provider fails to respond within 30 days with updated license renewal information.					
PR2.06.03	Have the capability to edit the provider master file for license end date.					
PR2.07	Maintain multiple provider specific reimbursement rates with beginning and ending dates consistent with IME policy including but not limited to: a. Per Diem. b. Percentage of charges. c. Fee-for-Service (FFS). d. Ambulatory Payment Calculations (APC). e. Diagnosis Related Groups (DRG). f. Other.					
PR2.07.01	Provide the capability to store and maintain provider rates including historical rates and date changes.					
PR2.SS.01	Maintain the capability to limit billing and providers to certain benefit plans, services, by procedure codes, ranges of procedure codes, member age or by provider type(s) or as otherwise directed by IME.					
PR2.SS.02	Provide data elements to capture provider contact information.					
PR2.SS.03	Provide online view of all provider specific rates.					
PR2.SS.04	A data element must exist to capture the facility bed size.					
PR2.SS.05	Ensure all end dates are linked, so they can be synchronized to the end date of the licenses of the state of servicing location or other licenses as directed by IME.					
PR2.SS.06	Provide a mechanism to identify provider types not required to have a license.					
PR2.SS.07	Ensure the billing provider is enrolled and has a provider number. Individual practitioners associated with the billing provider will be linked to the billing provider ID.					
PR2.SS.08	Support automated criminal background checks for all providers as specified by IME.					

PR	Provider Management Requirements - MMIS	A	B	C	D	E
PR2.SS.09	Store geographic codes for provider locations.					
PR2.SS.10	Enable different provider enrollment rule definitions by provider, provider type, program, geographic area and other areas, as defined by IME.					
PR3.01	Accept, validate and process transactions or user entries to update and maintain provider information.					
PR3.01.01	Provide for the collection and maintenance of additional data in the provider database, including, but not limited to: a. Sanction information. b. Accreditation information. c. Provider links to Taxpayer Identification Number (TIN) and parent organizations. d. Inactive and active filter. e. Care management and or lock-in restrictions. f. Case load assignments. g. License number and licensure status. h. Pay for performance (P4P) indicator. i. Restrictions for payments (no payment for surgeries). j. Flag for Electronic Funds Transfer (EFT) information. k. Flag for electronic claim submission. l. Drug Enforcement Administration (DEA). m. County. n. Email contact information.					
PR3.02	Provide user access to provider data and allow extraction of information. The extracts or reports could include such items as: a. The current status of providers' records. b. An alphabetical provider listing. c. A numeric provider listing. d. A provider rate table listing. e. An annual re-certification notice. f. A provider "group affiliation" listing. g. A provider specialty listing. h. A provider listing by category of service.					
PR3.02.01	Provide the functionality to produce a variety of standard production reports, as well as user-defined, parameter-driven reports and listings of data contained in the Provider Master file.					
PR3.03	Track and control the process of reconciliation of errors in transactions that are intended to update provider information.					
PR3.04	Maintain current and historical multiple address capabilities for providers.					
PR3.05	Maintain an audit trail of all updates to the provider data for a time period as specified by IME.					
PR3.05.01	Provide an online audit trail that is easily queried for all transactions applied to provider record(s), with the date of the transaction, time of the transaction, type of transaction (e.g., add, change) and the identification of the person applying the transaction.					
PR3.07	Update and maintain financial data and all necessary					

PR	Provider Management Requirements - MMIS	A	B	C	D	E
	information to track consolidate and report 1099 information including current and prior year 1099 reported amounts.					
PR3.08	Maintain links from providers to other entities such as groups, Managed Care Organizations (MCO), chains, networks, ownerships and partnerships.					
PR3.09	Provide capability to do mass updates to provider information based on flexible selection criteria.					
PR3.09.01	Maintain the capability to apply mass updates to provider-specific rates based on IME's specified criteria.					
PR3.10	Maintain indicators to identify providers that are Fee-for-Service (FFS), MCO network only and other state health care program participants.					
PR3.11	Maintain a flag for providers who are eligible to use EFT and electronic claims submission.					
PR3.SS.01	Provide the capability to match the data received from the death registry interface and create an alert when there is a match with an active provider name. Verify the match and disenroll the provider if match is accurate.					
PR3.SS.02	Provide the capability to reactivate a previously enrolled provider without complete reenrollment.					
PR3.SS.03	Maintain a minimum of five years of provider demographic information, rates and claim payment history data for online inquiry by the contractor and authorized IME staff. All demographic information and rates must be maintained by date segments.					
PR3.SS.04	Enable a process to suspend, terminate or withhold payments from providers under investigation.					
PR3.SS.05	Provide the capability for automated disenrollment procedures according to IME defined criteria.					
PR3.SS.06	Ability to identify if the provider uses electronic health records (EHR) and the CMS certification number of the EHR system.					
PR4.01	Require (when appropriate), capture and maintain the ten digit NPI.					
PR4.02	Accept the NPI in all standard transactions mandated under HIPAA.					
PR4.03	Interface with the National Plan and Provider Enumeration System (NPPES) to verify the NPI of provider applicants once the Enumerator database is available.					
PR4.04	Do not allow atypical provider to be assigned numbers that duplicate any number assigned by the NPPES.					
PR4.05	Provide ability to link and de-link to other Medicaid provider IDs for the same provider (e.g., numbers used before the NPI was established, erroneously issued prior numbers, multiple NPIs for different subparts). Capture and crosswalk subpart NPIs used by Medicare, but not Medicaid, to facilitate Coordination of Benefits (COB) claims processing.					
PR4.SS.01	Provide the capability to process an NPI, taxonomy					

PR	Provider Management Requirements - MMIS	A	B	C	D	E
	and other fields as specified by IME including secondary NPI.					
PR4.SS.02	Be capable of producing a random sample of providers for audit purposes based on IME established selection criteria.					
PR4.SS.03	Send alert if multiple provider numbers are assigned to a single atypical provider.					
PR4.SS.04	Process actions and responses to B Notices from Internal Revenue Service (IRS) as determined by IME.					
PR.SS.01	Provide online inquiry to summary information regarding provider year-to-date claims submittal and payment data.					
PR.SS.02	Maintain the flexibility to change provider type categories and convert history records to reflect new provider type categories.					
PR.SS.03	Provide the capability to store multiple provider addresses per provider and a corresponding e-mail address for each of the mailing addresses on the provider file. Addresses include but are not limited to a location address, pay- to address, corporate address and correspondence address.					
PR.SS.04	Capture and maintain vendor code field in MMIS for HMO or MediPASS providers.					
PR.SS.05	Provide the capability to add new provider types with situational parameters for data such as rates, types, service limitations as directed by IME.					
PR.SS.06	Provide the capability to support periodic provider re-enrollment.					
PR.SS.07	Provide the capability to produce a provider file audit report to document the processing of all update transactions for the previous day, showing a facsimile of the old record, the new record and the ID of the staff updating the files.					
PR.SS.08	Produce provider mailing labels based on specific provider attributes and merge with letters as directed by the IME.					
PR.SS.09	Provide the capability to identify the entity that holds a lien against the provider if applicable, total lien amount, periodic payment amounts withheld, cumulative payment amounts withheld, and lien balance.					
PR.SS.10	Provide the capability to produce alphabetic and numeric provider lists with totals and subtotals that can be restricted by selection parameters such as provider type, provider specialty, county, zip code and enrollment status.					
PR.SS.11	Provide capability to provide data required for rate setting.					
PR.SS.12	Provide the capability to update licensure data based on electronic files from occupational licensing entities.					
PR.SS.13	Synchronize data with statewide provider directory Health Information Exchange (HIE) and licensing					

PR	Provider Management Requirements - MMIS	A	B	C	D	E
	boards.					
PR.SS.14	Accept and upload enrollment information, including NPI if required on providers from external source.					
PR.SS.15	Accept and upload rate information from external sources including excel spreadsheets.					
PR.SS.16	Provide the capability to identify providers whose licenses, certifications, provider agreements and permits are set to expire ninety (90) days prior to the end date of current certification, licensing or permit period and notify the contractor of the pending expiration.					
PR.SS.17	Perform automated checks of national databases and bulletin boards for exclusions, sanctions or license revocation in other states or by CMS.					
PR.SS.18	Identify providers that have a foreign mailing address and provide the capability to not send payment to a foreign mailing address.					
PR.SS.19	Provide the functionality to allow multiple provider status codes to be valid for the same or overlapping timeframes.					
PR.SS.20	Process and maintain inputs and outputs including but not limited to the following: **Inputs:** a. Provider enrollment data. b. Provider demographic changes. c. Provider rate changes. d. State and federal licensing and certification documentation. e. Provider sanction listings. **Outputs:** a. Daily, monthly and on request reports and address labels. b. Daily provider files. c. Produce and deliver to the IME all reports requested by the IME from the provider data maintenance function, at the specified frequency, medium and delivery destination. d. Remittance advices in electronic format and X12N 835. e. Annual 1099s, on federally approved forms and mail to providers. f. Group mailings and provider labels based on selection parameters such as provider type, zip code, specialty, county and special program participation. g. Report identifying any providers who have changed practice arrangements (e.g., from group to individual of from one business to another) by provider type as requested by the IME. h. Data required for rate setting as required by IME.					

Operations Management Business Area - MMIS

This business area includes the system requirements for claims receipt and adjudication, reference data management, prior authorization management and third party liability management**.**

CR	Claims Receipt Requirements - MMIS	A	B	C	D	E
CR1.01	Capture accurately all input into the system in the timeframe required by IME.					
CR1.02	Provide and maintain interfaces with designated entities as required by IME.					
CR1.02.01	Assign each claim a unique identifier upon its entering the system.					
CR1.03	Accept and use the common hospital paper billing form developed by the National Uniform Billing Committee (NUBC) for non-electronic claims.					
CR1.04	Accept and use the common non-institutional paper claim form developed by the National Uniform Claim Committee (NUCC) for non-electronic claims.					
CR1.05	Accept and use the common dental paper billing form developed by the American Dental Association (ADA) for non-electronic claims.					
CR1.06	Control, track and reconcile captured claims to validate that all claims received are processed.					
CR1.07	Provide the ability to identify claims input for control and balancing hardcopy and electronic media.					
CR1.08	Provide and maintain a data entry system that includes but is not limited to hardcopy claims and claim adjustment and or voids which provide for field validity edits and pre-editing for: a. Provider number. b. Member ID number. c. Procedure codes. d. Diagnosis codes.					
CR1.09	Produce an electronic image of hardcopy claims and claims-related documents and perform quality control procedures to verify that the electronic image is legible and meets quality standards.					
CR1.10	Screen and capture electronic images, date-stamps, assign unique control numbers, batch hardcopy claim forms and attachments, adjustment and or void forms and updated turnaround documents.					
CR1.11	Log each batch into an automated batch control system.					
CR1.12	Provide the ability to identify claim entry statistics to assess performance compliance.					
CR1.13	Provide a unique submitter number for each billing service or submitter that transmits electronic or paper claims to the MMIS for a single provider or multiple providers.					
CR1.14	Provide an attachment indicator field on all electronic media claims to be used by the submitter to identify claims for which attachments are being submitted separately.					
CR1.14.01	Provide the ability to tie the electronic claim to all					

CR	Claims Receipt Requirements - MMIS	A	B	C	D	E
	related paper claim images, attachments and adjustments that are submitted for the claim.					
CR1.14.02	Receive and process electronic attachments and apply them to one or more claims based on IME rules.					
CR1.14.03	Provide the capability to accept attachments to any transactions (e.g., claim, prior authorization, eligibility) and apply an attachment indicator in the MMIS.					
CR1.16	Support testing of new provider claims submission systems by allowing providers to submit electronic claims test files that are processed through the adjudication cycle without impact on system data.					
CR1.17	Identify any incomplete claim batches that fail to balance to control counts.					
CR1.17.01	Provide a return transmission that verifies the number of claims received and accepted.					
CR1.17.02	Maintain electronic data interchange (EDI) transmission logs of all transactions (i.e., successful or failed).					
CR1.18	Provide and maintain the capability to process standard financial transactions, including recoupments and payouts which cover more than one claim and or service.					
CR1.SS.01	Accept pharmacy claims from the POS.					
CR1.SS.02	Provide the capability for authorized IME users to directly enter a claim online when IME deems necessary.					
CR1.SS.03	Record time and date and user in the record for any online updates.					
CR1.SS.04	Provide the edit capability to check for correct provider number when the provider submits the claim (e.g., at the front end).					
CR1.SS.05	At a minimum, accept the following types of electronic claims: electronic batch, individual electronic, DDE and paper claims converted to electronic by an imaging process.					
CR1.SS.06	Provide the capability to edit for potential duplicate services across all claim types as defined by IME.					
CR1.SS.07	Report all claim lines billed by a provider as a single claim, or HIPAA transaction, by a provider, as a single claim document, to users and providers.					
CR1.SS.08	Provide the ability to process all claims real-time.					
CR1.SS.09	Support a customized (reduced data requirements) online claim submission feature for waivered services, and other entities not covered by HIPAA.					
CR1.SS.10	Provide and maintain a data entry system that accepts and stores all data elements deemed necessary by IME including but not limited to the following: a. Provider type. b. Specialty. c. Sub-specialty. d. Member age and or gender restrictions.					

CR	Claims Receipt Requirements - MMIS	A	B	C	D	E
	e. Prior authorization required. f. Modifiers. g. Place of service. h. Co-payment indicators (overrides). i. Eligibility aid category. j. Family planning indicator. k. Claim type. l. Emergency indicator. m. Units of service. n. Tooth number or letter and or quadrant. o. National billing uniform editor code set. p. Care management authorization number.					
CR1.SS.11	Produce a summary of EDI transmissions daily.					
CR1.SS.12	Provide the capability to respond with appropriate acknowledgement transactions such as the TA1, 997, 999 and 277CA as directed by IME.					
CR2.01	Accept, record, store and retrieve documents submitted with, or in reference to, claim submission activity including but not limited to the following: a. Operative reports. b. Occupational, physical and speech therapy reports. c. Durable Medical Equipment (DME) serial number, cost and warranty data. d. Manufacturer's tracking data for implants. e. Waivers and demonstration specific requirements.					
CR2.02	Receive claim attachments associated with electronic media or paper claims and auto-archives or forwards to appropriate operational area for processing.					
CR2.03	Accept Medicare crossover claims for Medicare coinsurance and deductible or Medicare Explanation of Benefits (EOB) claims attachments.					
CR2.03.01	Provide the capability to accept and process Medicare and other carrier crossovers electronically at the claim and line level.					
CR2.04	Accept prior authorization attachments such as: a. Surgical and or anesthesia reports. b. Medical records. c. X-rays and or images. d. Orthodontic study models. e. LTC prior authorizations. f. Other items required by IME.					
CR2.05	Accept other claim related inputs to the MMIS including but not limited to the following: a. Sterilization, abortion and hysterectomy consent forms. b. Manual or automated medical expenditure transactions which have been processed outside of the MMIS (e.g., spenddown). c. Non claim-specific financial transactions such as fraud and abuse settlements, insurance recoveries and cash receipts.					

CR	Claims Receipt Requirements - MMIS	A	B	C	D	E
	d. Electronic cost reports. e. Disproportionate share reports. f. Any other inputs required for services under the state's approved plan.					
CR2.05.01	Accept and process all standard data that can be submitted on any claim or claim type.					
CR3.01	Provide system support for the sending and receiving of electronic claims transactions containing valid codes required by 45 CFR Parts 160 and 162 as follows: a. Retail pharmacy drug claims (NCPDP) in POS only. b. Dental health care claims 12N 837D including voids and replacements. c. Professional health care claims 12N 837P including voids and replacements. d. Institutional health care claims 12N 837I including voids and replacement. e. Coordination of benefits data when applicable. f. Future claims attachments required under HIPAA.					
CR3.01.01	Receive standardized managed care encounters in 837 formats.					
CR3.02	Provide secure HIPAA compliant software and documentation for use by providers to submit electronic claims.					
CR3.03	Process batch 837 claims rejecting only individual bad claims and accepting all others.					
CR3.04	Employ an electronic tracking mechanism to locate archived source documents or to purge source documents in accordance with HIPAA security provisions.					
CR3.SS.01	Provide capability to perform front-end edits to claims prior to acceptance with IME-defined edits that include but are not limited to the following: a. Checking provider enrollment. b. Member enrollment. c. Revenue codes. d. Prior authorization number. e. Procedure codes. f. Diagnosis codes. g. Send rejection notification to the provider if the claim fails any of these edits and create a log of all rejected claims.					
CR3.SS.02	Provide capability to ensure that all electronic claims submitters are enrolled within the system and every provider for whom claims are submitted is registered as having an agreement with the submitter.					
CR3.SS.03	Provide the capability to track and document all changes to system edits.					
CR3.SS.04	Provide the capability to produce a claim in hardcopy and electronic format.					
CR.SS.01	Provide an Enterprise Application Integration (EAI)					

CR	Claims Receipt Requirements - MMIS	A	B	C	D	E
	translator and EDI integrated mapping software that: a. Offers flexible mapping functionality supporting all required formats and transactions. b. Allow for both structure and information to be extracted directly from database tables. c. Provide the ability to assemble, validate, encrypt and transport batches of data to and from providers and other interface partners. d. Accept, code, decode and transmit all mandated HIPAA healthcare transactions. e. Provide support for automatically re-submitting the transaction in the event that it encounters an error. IME will define the number of attempts that the system will process before the transaction is considered failed. f. Capture any errors that result during transmission, store the information and notify the sender that the transaction failed. g. Analyze and reject improperly formatted HIPAA healthcare transactions. h. Allow for the quick implementation of all new transactions.					
CR.SS.02	Provide capability to produce custom EDI reports regarding: a. Transactions submitted by transaction type. b. Transactions received by transaction type. c. Cumulative reports over time to support forecasting.					
CR.SS.03	Accept and use the state targeted medical care paper billing form for non-electronic claims.					
CR.SS.04	Assign a unique transaction control number to each transaction and control all transactions throughout the processing cycle. Assign the transaction control number of the claim to all associated attachments such as consent forms, documentation showing medical necessity, claim adjustments and prior authorization requests in a timely manner.					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
CA1.01	Track all claims within the processing period paid, suspended, pending or denied.					
CA1.01.01	Reconcile prepaid services with actual expenses for Consumer Choice Option (CCO) and automatically generate adjustment claim.					
CA1.02	Suspend claims with exceptions and or errors and routes for correction to the organizational entity that will resolve the exception and or error unless automatically resolved. The organizational entity will resolve the claim based upon the state's criteria.					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
CA1.02.01	Suspend and review as required by IME those specific members, providers, procedure codes or provider types placed on prepayment review by IME.					
CA1.02.02	Allow for the user defined suspension of claims by variable parameters (e.g., member, provider, date range, procedure, benefit limits, benefit plans).					
CA1.03	Verify that suspended transactions have valid error and or exception codes.					
CA1.04	Track claims flagged for investigative follow-up because of third party discrepancies.					
CA1.05	Generate audit trails for all claims and maintain audit trail history.					
CA1.05.01	Generate and maintain audit trails for all claims activity including add, update, inquiry and or delete.					
CA1.06	Verify that all claims for services approved or disallowed are properly flagged as paid or denied.					
CA1.07	Document and report on the time lapse of claims payment flagging or otherwise noting clean claims (error free) that are delayed over 30 days. See 447.45 CFR for timely claims payment requirements.					
CA1.08	Provide prompt response to inquiries regarding the status of any claim through a variety of appropriate technologies, track and monitor responses to the inquiries. Process electronic claim status request and response transactions ANSI Accredited Standards Committee (ASC) X12N 276 277) required by 45 CFR Part 162.					
CA1.09	Provide claims history for use by Program Management and Program Integrity.					
CA1.10	Assign claim status (i.e., approved, denied, pended, rejected) based on the state's criteria.					
CA1.11	Verify that claim correction activities have entered only valid override code(s) or manual prices.					
CA1.11.01	Process payment for any specific claim(s) as directed by IME on an exception basis using edit override codes and a security system approved by IME.					
CA1.11.02	Provide the ability to accumulate and report statistics on why claims edits are overridden.					
CA1.11.03	Provide the capability to track payments for each member in total and to limit payments to any combination of benefit plans based on total services or an overall dollar ceiling as set by rules in the benefit plan administration rules engine.					
CA1.12	Identify and hierarchically assigns status and disposition of claims (i.e., suspend or deny) that fail edits based on the edit disposition record.					
CA1.13	Identify and track all edits and audits posted to the claim in a processing period.					
CA1.13.01	Provide the capability to configure and apply all edits and audits with a rules engine.					
CA1.13.02	Allow unlimited edits to any claim as defined by IME. Provide the capability to limit the number of errors on a single claim before denying the claim.					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
CA1.14	Provide and maintain for each error code, a resolution code, an override, force or deny indicator and the date that the error was resolved, forced and or denied.					
CA1.SS.01	Provide the ability to process a claims payment file daily, weekly and as specified by IME.					
CA1.SS.02	Provide the capability to stamp the date, federal report code and state account code at the claim and line level of each claim.					
CA1.SS.03	Apply edits to prevent payments for services covered under a waiver program to a Medicaid provider who does not have a provider agreement.					
CA1.SS.04	Provide the ability to process a corrected claim through all edits and audits after corrections are applied to a rejected claim.					
CA1.SS.05	Provide the ability to store in the MMIS claims processed through the POS.					
CA2.01	Verify all fields defined as numeric contain only numeric data.					
CA2.01.01	Support claim adjudication based on HIPAA standard code sets in effect on the date of service.					
CA2.02	Verify all fields defined as alphabetic contain only alphabetic data.					
CA2.02.01	Support claim adjudication based on HIPAA procedure modifiers in effect on the date of service (i.e., the ability to bring in all modifiers and use a hierarchy defined by IME).					
CA2.03	Verify all dates are valid and reasonable.					
CA2.04	Verify all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.					
CA2.05	Verify all coded data items consist of valid codes (e.g., procedure codes, diagnosis codes, service codes) that are within the valid code set under HIPAA Transactions and Code Sets (TCS) and are covered by the state plan.					
CA2.06	Verify any data item that contains self-checking digits (e.g., member ID number, NPI number) passes the specified check-digit test.					
CA2.07	Verify numeric items with definitive upper and or lower bounds are within the proper range.					
CA2.08	Verify required data items are present and retained including all data needed for state or federal reporting requirements (See State Medicaid Manual (SMM) 11375).					
CA2.08.01	Retain and transmit to data warehouse all data elements on an all paper and electronic claims even if data element is not used for adjudication on the date the claim is adjudicated.					
CA2.09	Verify the date of service is within the allowable time frame for payment.					
CA2.10	Verify the procedure is consistent with the diagnosis.					
CA2.11	Verify the procedure is consistent with the member's age.					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
CA2.12	Verify the procedure is consistent with the member's gender.					
CA2.13	Verify the procedure is consistent with the place of service.					
CA2.14	Verify the procedure is consistent with the category of service.					
CA2.15	Flag and route for manual review claims with individual procedures and combinations of procedures which require manual pricing in accordance with state parameters.					
CA2.16	Verify the billed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage (either above or below) then the claim is flagged and routed for manual review for the following: a. Possible incorrect procedure. b. Possible incorrect billed amount. c. When too high possible need for individual consideration.					
CA2.17	Verify the claim is not a duplicate of a previously adjudicated claim including a prior one in the current processing period.					
CA2.18	Verify the dates of service of an institutional claim do not overlap with the dates of service of an institutional claim from a different institution for the same member.					
CA2.19	Verify the dates of service for a practitioner claim do not overlap with the dates of service for another claim from the same practitioner for a single member unless the additional services are appropriate for the same date of service.					
CA2.20	Utilize data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.					
CA2.20.01	Provide the capability to pay different rates for the same service based on the program or benefit plan as specified by IME.					
CA2.21	Flag for review claims from a single provider for multiple visits on the same day to a single member.					
CA2.22	Verify the provider type is consistent with the procedure(s).					
CA2.23	Flag and route for manual intervention or automatically re-cycles claims based on IME rules that do not contain prior authorization if the services require prior authorization or require prior authorization after state-defined thresholds are met.					
CA2.24	Flag and route for manual intervention claims that fail state-defined service limitations including once-in-a-lifetime procedures and other frequency, periodicity and dollar limitations.					
CA2.25	Have the capability to pay claims per capita from encounter data or FFS.					
CA2.26	Price out-of-state claims according to state policy (i.e., at the local rate, at the other state's rate or flags					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
	and routes for manual pricing).					
CA2.27	Record and edit that all required attachments, per the reference records or edits have been received and maintained for audit purposes.					
CA2.28	Price claims according to pricing data and reimbursement methodologies applicable on the date(s) of service on the claim.					
CA2.29	Deduct TPL paid amounts and Medicare paid amount as defined in the state plan when pricing claims.					
CA2.29.01	Provide the capability to account for cost recovery at either the claim or line level as specified by IME.					
CA2.29.02	Ensure that the claims payment process accurately reads the TPL resource file including the benefit coverage.					
CA2.30	Deduct member co-payment amounts as appropriate when pricing claims.					
CA2.30.01	Allow as directed by IME, payment of co-pay on behalf of the member when IME is not the primary payer, if co-pay is less than IME allowed amount and member has other insurance (including Medicare).					
CA2.31	Price Medicare coinsurance or deductible for crossover claims depending on IME policy at the lower of the Medicaid or Medicare allowed amount.					
CA2.32	Price services billed with procedure codes with multiple modifiers.					
CA2.33	Edit claims for consistency and payment limitations using the Medicare Correct Coding Initiative (CCI) or similar editing criteria based upon the state plan.					
CA2.34	Price claims according to the policies of the program the member is enrolled in at the time of service and edits for concurrent program enrollment.					
CA2.35	Provide and maintain test claim processing capabilities including testing with providers.					
CA2.35.01	Provide IME the ability to submit test data on hard copy forms, online or electronic media to the Integrated Test Facility (ITF).					
CA2.35.02	Produce each output of ITF including files, reports, tapes and images separate from the corresponding routine MMIS output and identify as a test output.					
CA2.35.03	Support the selection of pended and paid claims from the production files to create or append to test files. Provide access to inquire and update claims by authorized IME users.					
CA2.35.04	Process a sample of claims through the ITF weekly. The sample of claims will test each edit in the production MMIS. The results of this test must be verified for correctness and maintained by the contractor for the duration of the Contract period.					
CA2.35.05	Provide authorized IME users as specified by IME, inquiry access to the ITF. There must be two separate distinct environments that mirror the production environment in which testing can be done.					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
CA2.35.06	Provide in the ITF, the ability to model mass void and replace impacts through complete adjudication before running the void and replacements in a production cycle.					
CA2.SS.01	Assign a federal report code on all transactions processed through an adjudication cycle based on IME provided business rules. The federal report code must cross walk to the correct report, report page, report line and report column.					
CA2.SS.02	Provide the capability to set maximum payment amounts for specified revenue and procedure codes and apply this to payment methodologies.					
CA2.SS.03	Provide for automatic bundling and unbundling of claim lines based on rules established by IME.					
CA2.SS.04	Provide claims editing software for detection of claims for which service is not in compliance with generally accepted standards of medical practice.					
CA2.SS.05	Provide the capability to apply edits related to IME's responsibility for nursing facility payments for a Medicare member (days 21-100) as defined by IME.					
CA2.SS.06	Provide the capability to adjudicate claims based on criteria established in treatment plans including attachments to those treatment plans as defined by IME.					
CA2.SS.07	Provide the capability to create gross adjustments to make payments to members, providers and other entities for services for which a claim is not submitted by the provider (e.g., disproportionate share and EHR incentives).					
CA2.SS.08	Make payments from multiple benefit plans and track such payments for reporting using the account code stamped on each claim line and financial transaction.					
CA2.SS.09	Determine the extent to which authorized benefits are payable under Title XIX using Medicare, Qualified Individual 1 (QI-1), SLMB and or QMB guidelines and procedures, from the appropriate Medicare fiscal intermediary or carrier, both in-state and out-of-state.					
CA2.SS.10	Provide the capability to accumulate and report statistics on why claims are denied.					
CA2.SS.11	Support claims edits, using a rules engine that are date sensitive and retain the date parameters for historical reference.					
CA2.SS.12	Provide the ability to replace or add codes and have existing edits apply to the new codes, using a rules engine.					
CA2.SS.13	Determine the deductible, coinsurance allowed and adjusted amounts applied, for each line on a claim.					
CA2.SS.14	Support an online process to view every edit that applies to a data element (e.g., stand-alone entry of member, procedure.) or a combination of elements.					
CA2.SS.15	Provide the ability to reduce, or increase, the amount allowed, by a specified amount or percentage, as defined by IME, at the time a claim is priced as					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
	defined by IME.					
CA2.SS.16	Use the Clinical Laboratory Improvement Amendments (CLIA) data in claims processing.					
CA2.SS.17	Process and adjudicate all Medicare crossover claims received from the Medicare COB contractor(s), ensuring that all Medicare benefits are expended before Medicaid payment is made.					
CA2.SS.18	Provide the ability to inquire on payment status of claim lines, associated voids, adjustments and payments (by provider and authorized user).					
CA2.SS.19	Provide the ability to process for outlier payments.					
CA2.SS.20	Allow the ability to cutback the amount to be paid on a claim based on criteria set by IME. When line cutback occurs, claims history and the remittance advice for claims that were cutback, will include, but not be limited to: a. Date billed. b. Submitted Units. c. Units Paid. d. Original payment calculation. e. Actual payment amount. f. Other criteria, as defined by IME.					
CA3.01	Verify the provider is eligible to render service(s) during the period covered by the claim.					
CA3.02	Verify the provider is eligible to render the specific service covered by the claim.					
CA3.02.01	Provide the capability to perform prepayment reviews on providers, as defined by IME.					
CA3.02.02	Verify the referring provider is not excluded for the period covered by the claim.					
CA3.03	Verify the provider is eligible to provide the specific service covered by the plan to the specific member.					
CA4.01	Verify the member was eligible for the particular category of service, at the time it was rendered.					
CA4.02	Flag for review, claims for the same member, with a diagnosis and procedure which indicate an emergency that occurs within one day of a similar claim from the same provider.					
CA4.03	Identify, by member, the screening and related diagnosis and treatment services the member receives for EPSDT.					
CA4.04	Route and report on claims that are processed that indicate the member's date of death for follow-up by the member eligibility TPL personnel.					
CA4.05	Provide and maintain the capability to monitor services for suspected abusers using a "pay and report," lock-in or some equivalent system function that will provide report the claim activity for these members as scheduled or requested.					
CA4.06	Provide and maintain the capability to pend or deny claims for members assigned to the member lock-in program based on state guidelines.					
CA4.07	Provide and maintain the capability to edit claims for members LTC facilities to ensure that services					

CA	Claims Adjudication Requirements - MMIS	A	B	C	D	E
	included in the LTC payment rate are not billed separately by individual practitioners or other providers.					
CA4.08	Provide and maintain the capability to process member cost sharing (e.g., co-payments, LTC patient liability) on any service specified by the state using a fixed amount or percent of charges.					
CA4.09	Edit claims for newborns' eligibility based upon state-defined newborn enrollment policies and procedures.					
CA4.10	Edit for member participation in special programs (i.e., waivers) against program services and restrictions.					
CA4.11	Limit benefits payable by member eligibility category or other member groupings.					
CA4.SS.01	Update service limits for members when claims are voided or replaced and allow online access to member service limit data.					
CA4.SS.02	Process claims when members have multiple benefit plans, according to the hierarchy determined by IME.					
CA4.SS.03	Provide the capability to enable a bed hold payment process for members in facilities according to rules established by IME.					
CA4.SS.04	Provide the capability to identify claims for overlapping service dates between waiver and institutional claims and send alert to workflow process, according to rules established by IME.					
CA4.SS.05	Support claims edits by benefit plan, age limitations, gender limitations and service limitations.					
CA4.SS.06	Provide the capability to generate payments on demand outside of normal payment cycles.					
CA4.SS.07	Provide MMIS inquiry and reporting capabilities to authorized IME staff.					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
CA5.01	System will process and retain all prior authorization request data.					
CA5.01.01	Provide the ability to edit claims against prior authorization data and track activity against approved prior authorizations.					
CA5.01.02	Allow either a group or individual provider to be entered as the servicing provider on the prior authorization record. Claims processed against the prior authorization should pay for only a match to the provider listed on the prior authorization record.					
CA5.02	Ensure there is a field for authorization or identification when an override indicator (force code) is used.					
CA5.03	Support receiving, processing and sending of electronic health care service review, request for review and response transaction required by 45 CFR Part 162, as follows: a. Retain pharmacy drug referral certification and authorization. b. Dental, professional and institutional referral certification and authorization ASC X12N 278. c. Support Web or Internet submission or prior authorization request.					
CA5.03.01	Support interface with prior authorization contractor or vendor for the exchange of HIPAA compliant transactions ASC X12N 278.					
CA5.04	Support the prior authorization staff's ability to send requests for additional information on paper or electronically.					
CA5.04.01	Provide access to authorized IME staff and authorized contractors to the prior authorization module to create, edit and delete prior authorization information. System must track changes, time and users who complete the change.					
CA5.05	Support searching for prior authorizations based on: a. Provider name. b. Provider ID. c. Member name. d. Member Medicaid ID Number. e. Date of submission range. f. Dates of service requested range. g. Service requested. h. Status of the request. i. Prior Authorization ID number.					
CA5.06	Support entry of retroactive prior authorization requests.					
CA5.07	Assign a unique prior authorization number as an identifier to each prior authorization request.					
CA5.08	Edit prior authorization requests with edits that mirror the applicable claims processing edits.					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
CA5.08.01	Provide the capability to edit for ineligible member and do not allow processing of prior authorization if the service dates of the prior authorization are outside the member eligibility period or benefit program.					
CA5.09	Establish an adjudicated prior authorization record indicating: a. Single member or members. b. Status of the request. c. Services authorized. d. Number of units approved. e. Service date range approved. f. Cost approved. g. Provider approved (unless approved as non-provider-specific). Indicate if the authorization of units is daily, monthly, quarterly or if the units may be used at any time over the time period.					
CA5.10	Edit to ensure that only valid data is entered on the prior authorization record and denies duplicate requests or requests that contain invalid data.					
CA5.11	Capture and maintain both the requested amount and authorized amount on the prior authorization record.					
CA5.12	Provide and maintain the capability to change the services authorized and to extend or limit the effective dates of the authorization. Maintain the original and the changed data in the prior authorization record.					
CA5.13	Accept update from claim processing that “draw down” or decrement authorized services.					
CA5.13.01	Update prior authorization records based upon claims processing results indicating that the authorization has been partially used or completely used. These activities include processing of original claims, adjustments and voids that “draw down” (decrement) and or “add back” authorized services (units, dollars, authorized dollar amount per unit).					
CA5.15	Generate automatic approval and denial notices to requested and assigned providers, case managers and members for prior authorizations. Denial notices to members including the reason for the denial and notification of the member’s right to a fair hearing.					
CA.SS.5.01	Support a prior authorization process that is flexible across numerous programs, benefit plans and claim types.					
CA.SS.5.02	Provide the capability to perform mass updates of prior authorization records (e.g., globally change provider ID numbers or procedure codes and or modifiers for pending or approved but unutilized services).					
CA.SS.5.0	Allow a cutback on payment amounts instead of a					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
3	denial once the prior authorized limit is reached.					
CA.SS.5.04	Provide capability to identify services that have different procedure codes, but that are subject to the same prior authorization limitation and accumulate all like services against the prior authorization.					
CA.SS.5.05	Maintain an audit trail of prior authorization file updates accessible through online inquiry. Maintain control totals and provide balance information in response to online requests.					
CA.SS.5.06	Provide the capability to produce, control and balance reports for prior authorization requests received from authorization entities and provide the reports to the state accessible online and in hardcopy upon state request.					
CA.SS.5.07	Receive prior authorization request data through electronic data file, 278 transactions and manually keyed based on requests received by fax or mail.					
CA.SS.5.08	Support manual entry of prior authorization approvals.					
CA.SS.5.09	Provide ability to allow approved service (e.g. private duty nursing) on one prior authorization to be used by multiple providers during overlapping dates of service based on IME rules.					
CA.SS.5.10	Provide ability to process X12n 278 transaction real time using the rules engine for decision where applicable.					
CA.SS.5.11	Provide capability to relate prior authorizations to subsequent claims requiring such authorization.					
CA.SS.5.12	Produce statistical reports on prior authorization requests (e.g., received, approved, approved with modifications and denied).					
CA.SS.5.13	Produce statistical reports on utilization of prior authorized services.					
CA.SS.5.14	Produce statistical reports on the data source (e.g., X12n 278, electronic file, manually entered) of prior authorization requests.					
CA.SS.5.15	Process and maintain inputs and outputs including but not limited to the following: **Inputs:** a. Files from external prior authorization systems. b. Reports. **Outputs:** a. Prior authorization requests to approving entity for X12N 278 transactions.					
CA.SS.01	Provide for ad hoc reporting, as appropriate, based on data needs.					
CA.SS.02	Provide the capability to download data for statistical data manipulation. This refers to report data, file extract data and billing information.					
CA.SS.03	Provide help screens, help tabs or drop down help windows, for all modules of the system, including COTS products.					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
CA.SS.04	Provide mass adjustment capabilities for any period of time specified by IME, based on criteria including, but not limited to: cost report data, price adjustments.					
CA.SS.05	Reference any void and replacements (paper or electronic) to original claims.					
CA.SS.06	Provide the ability to allow voids and replacements to update an accounts receivable (AR).					
CA.SS.07	Allow all designated users to perform the following mass void and replace actions, including, but not limited to: a. Select and review. b. Release all. c. Release selected claims. d. Start over. e. Cancel.					
CA.SS.08	Allow selection criteria for and mass void and replacements to be applied by, at least the following: a. Internal Control Number (ICN). b. Codes. c. Provider number or name. d. Provider type. e. Provider specialty. f. Date(s). g. Member. h. Other criteria, as defined by IME.					
CA.SS.06	Support a mass void and replace process that will allow adjustments by a specified amount or a percentage (e.g., based on an audit result from a sample of claims).					
CA.SS.10	Provide the capability to void claims using the mass functionality (i.e., not replace the voids).					
CA.SS.11	Provide a mass void and replace process when third party resource is recognized retroactively.					
CA.SS.12	Support online void and replacements to previously adjudicated claims.					
CA.SS.13	Allow history only claims adjustments.					
CA.SS.14	Provide the capability to create financial transactions for the purpose of making non-claim based payments and recoveries from providers, members and other entities and provide the ability to indicate whether the payment is subject to offset against outstanding AR balances.					
CA.SS.15	Provide the ability to identify uncollectable credit balances and flag all related financial balances as uncollectable.					
CA.SS.16	Accept non-claim payment for the flagged uncollectable balances.					
CA.SS.14	Provide the ability to indicate whether the recovery is to be offset against claims or gross adjustments payments.					
CA.SS.17	Provide a summary screen that presents for each provider previous year, current year month-to-					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
	date, year-to-date and most recent payment information and number of pended claims.					
CA.SS.18	Deny all claims submitted by providers other than the designated lock-in provider(s), unless emergency or referral consultation criteria are met. Ensure rules for referrals/claims for services outside of the medical home are followed e.g., medical home and or Primary Care Case Manager (PCCM).					
CA.SS.19	Provide the capability to process institutional claims for PMIC at the line level in accordance with IME rules.					
CA.SS.20	Create and process capitation payments for non-emergency medical transportation broker and other contractors who are paid using capitation rates based on rules in the rules engine.					
CA.SS.21	Receive and store non-emergency medical transportation and other managed care contractor encounter data.					
CA.SS.22	Provide capability to retrieve electronic images by control number, date of service, member number or provider number.					
CA.SS.23	Identify any inactivated claims or batches on daily control logs.					
CA.SS.24	Provide capability to relate prior authorizations to subsequent claims requiring such authorization. Provide capability to add new procedures requiring prior authorization as part of routine file maintenance.					
CA.SS.25	Make payment only if an approval certification (validation number indicating Quality Improvement Organization (QIO) approval) is present on the claim and only for the approved number of days and at the specified LOC.					
CA.SS.26	Support multiple methodologies for pricing claims, as established by the IME.					
CA.SS.27	Edit billed charges for reasonableness and flag any exceptions (high or low variance).					
CA.SS.28	Provide online inquiry access to the status of any related limitations for which the member has had services.					
CA.SS.29	Provide the capability to hold for payment, for a time period determined by IME, all claims or claims for one or more providers.					
CA.SS.30	Provide security reports.					
CA.SS.31	Edit each data element of the claim record for required presence, format, consistency, reasonableness and or allowable values.					
CA.SS.32	Establish dollar and or frequency thresholds for key procedures or services; identify any member or provider whose activity exceeds the thresholds during the history audit cycle and suspend the claim for review prior to payment.					
CA.SS.33	Update the prior authorization record to reflect the					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
	service paid and to update the number of services or dollars remaining to be used on the record.					
CA.SS.34	Provide the online capability to change the disposition of edits to (1) pend to a specific location, (2) deny or (3) print an explanatory Message on the provider remittance advice.					
CA.SS.35	Provide a methodology to detect unbundling of service codes, including lab codes and reassign the proper code to the service (McKesson Claim Check, Bloodhound or similar product).					
CA.SS.36	Edit to ensure that FFS claims for out-of-plan services (e.g., outside coverage limits of managed care plans) are paid and claims covered by managed care plans are not paid.					
CA.SS.37	Maintain a user-controlled remittance and Message text data set with access by edit number, showing the remittance advice Message(s) for each error and the EOB Message(s), with online update capability.					
CA.SS.38	Deny claims submitted more than 365 days from the last date of service appearing on the claim. Override the edit, if the failure to meet the timely filing requirements is due to retroactive member eligibility determination, delays in filing with other third parties or because the claim is a resubmitted claim and this information is documented on the claim or claim attachment. Exceptions may be granted by the Department for other reasons, such as court ordered payment, member or provider appeal, after the claim has been denied and the provider has made an inquiry.					
CA.SS.39	Allow institutional claims to be processed in accordance with IME rules concerning multiple home health providers billing overlapping date spans for prior services.					
CA.SS.40	Support program management and utilization review by editing claims against the prior authorization file to ensure that payment is made accurately.					
CA.SS.41	Edit claims requiring prior authorization (PA) but without a PA number for a match on the PA file of member, provider, service code and a range of dates. If a match is found, insert the PA number from the file into the claim record.					
CA.SS.42	Provide capability to produce a file of paid claims that include HCPCS J codes.					
CA.SS.43	Produce the following reports: a. Specific reports required for federal participation in LTC programs as defined by the Department. This requirement includes the Minimum Data Set (MDS). b. Analysis of leave days. c. Discrepancies between client participation amounts on the claim and on the LTC					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
	member data. d. LTC facility rosters. e. Tracking of non-bed-hold discharge days. f. Client participation amount and effective dates. g. Hospital claims and bed-hold analysis and comparison.					
CA.SS.44	Produce the following reports: a. Report of claims inventory, processing activity and average age of claims. b. Report of adjustment claims and resubmitted claims. c. Inventory trend reports. d. Report of claims and payments after each payment cycle. e. Report of processed claims, tapes and EMC transmissions input into the semi-monthly payment cycle. f. Error code analysis by claim type, provider type, provider and or input media. g. Suspense file summary and detail reports. h. Edit and audit override analysis by claim type, edit and audit and staff ID. i. Processing cycle time analysis by claim type, input media and provider type. j. Report of specially handled or manually processed claims. k. Report of claims withheld from payment processing.					
CA.SS.45	Produce reports that segregate and identify claim-specific and non-claim-specific adjustments by type of transaction (payout, recoupment or refund) and provider type, on a monthly basis.					
CA.SS.46	Produce a weekly report listing the state ID numbers, names, transaction control numbers, date of service, amount paid and date paid of all Medicaid members for whom a Medicare crossover claim has been paid, but for whom Medicare eligibility is not indicated on the eligibility record.					
CA.SS.47	Calculate the assessment fee as an add-on to rates paid to providers designated by IME. Automatically set up an AR to recover all or a portion of the assessment fee as directed by IME. The AR can be satisfied as an off-set to future payments or through receipt of payment from the provider as directed by IME.					

CA5	Prior Authorization Requirements - MMIS	A	B	C	D	E
CA.SS.48	Process and maintain inputs and outputs including, but not limited to: **Inputs:** The current claim forms that are input in the system include: a. UB-9204. b. HCFACMS-1500. c. American Dental Association (ADA) form. d. Pharmacy Universal claim form. e. Long Term Care Turnaround Document (TAD) form. f. Targeted Medical Care (Waiver) form. g. ANSI 837 Transactions. h. Medicare crossover claims for deductible and coinsurance may be input to the system from hardcopy or in electronic format from Coordination of Benefits Carrier (COBC). **Outputs:** a. Produce all reports in the format and schedule required by IME. b. Send files of adjudicated claims and encounter data to entities as directed by IME. c. Produce user-requested ad hoc reports from adjudicated information. d. Member and provider history printouts of adjudicated and or suspended claims, which include, at a minimum, a description of procedure, drug, DRG, diagnosis and error codes. e. 1099 data. f. Standard accounting balance and control reports. g. Remittance Advices. h. Remittance summaries and payment summaries.					
CA.SS.49	Ability to customize and make changes to CCI edits as required by the IME.					
CA.SS.50	CCI edits are applied to claims after the adjudication process.					
CA.SS.51	System must have the ability to apply the CCI edits to the adjusted claim.					
CA.SS.52	System must support all current and future national standards for code sets recognized by CMS.					
CA.SS.53	System must have capability to apply CCI messages.					

RF	Reference Data Management Requirements - MMIS	A	B	C	D	E
RF1.01	Maintain reasonable and customary charge					

RF	Reference Data Management Requirements - MMIS	A	B	C	D	E
	information for Medicaid and Medicare to support claims processing: a. Reimbursement under the Medicaid program for other than outpatient drugs, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Indian Health Services (IHS) and hospital inpatient and outpatient reimbursement is to be the lower of the provider's "usual and customary" charge, the rate established by the state, or the amount, which is allowed under the Medicaid program. "Usual and customary" charges are calculated from the actual charges submitted on provider claims for Medicaid payment. b. Reimbursement for outpatient prescription drugs are processed by the lowest of a) Federal Upper Limit (FUL) plus a dispensing fee b) State Maximum Allowable Cost (MAC) plus a dispensing fee c. Estimated Acquisition Cost (EAC), currently defined as the Average Wholesale Price (AWP) less 12%, 17 for specialty drugs, plus a dispensing fee d. The provider's usual and customary charge					
RF1.01.01	Maintain all pricing files to ensure that claims are paid in accordance with IME Medicaid policy.					
RF1.01.02	Provide a reliable and flexible system to maintain the reference data required for claims processing. The system must be configurable to adapt to changes in pricing policies and services and must allow for centralized control over data modifications.					
RF1.01.03	Provide for the capability to apply the following pricing methodologies, including, but not limited to: a. DRG with multiple base rates. b. Ambulatory Patient Classification (APC) with multiple conversion factors. c. Lab Panel vs. Automated Test Panel (ATP). d. Edits and or limits. e. All-inclusive rates. f. Negotiated rates. g. Geographic rates. h. Waiver rates. i. Long Term Care rates. j. Resource-Based Relative Value Scale. (RBRVS) with Provider type. k. Bundling and or unbundling. l. Pharmacy pricing as defined by IME. m. Pay for Performance (P4P). n. Funding source. o. Per Diem. p. Fee schedule pricing as determined by IME. q. Present on Admission (POA). r. Medicare Fees.					

RF	Reference Data Management Requirements - MMIS	A	B	C	D	E
	s. By Report. t. Cut Back. u. 340B pricing list. v. Dental rates. w. Modifiers. x. Place of service. y. Specific provider rates. z. Federal medical assistance percentage (FMAP) share only of any rate. aa. Other methodologies as specified by IME.					
RF1.01.04	Accept updates from a variety of software programs including but not limited to: Excel, Word or Access.					
RF1.02	Support Payment for Services by providing reference data including procedure, diagnostic and formulary codes 42 CFR 447.					
RF1.02.01	Maintain the capability to limit payments to providers for specific services based on procedure codes or ranges of procedure codes, member age or by provider type(s).					
RF1.02.02	Support the use of revenue codes and procedure codes as appropriate including but not limited to: inpatient and outpatient hospital, hospice, home health, dialysis, nursing facility, ICF/MR, Psychiatric Medical institutions for Children (PMIC) claim types submitted.					
RF1.03	Process change transactions to procedure, diagnosis, formulary codes and other data. Ability to respond to queries and report requests.					
RF1.03.01	Produce reports as specified by IME of updates applied to the procedure, drug and diagnosis files, including an error report to identify codes that did not update the appropriate procedure, drug and diagnoses files.					
RF1.04	Archive all versions of reference information and update transactions.					
RF1.05	Process update transactions to the reasonable and customary charge data and respond to queries and report requests.					
RF1.05.01	Provide capability to generate upon request hard copy listings on all data elements used in the reference management.					
RF1.05.02	Produce a comprehensive fee schedule for all procedure codes (i.e., Produces standard, program specific codes) that is available online in an IME designated downloadable format. IME will define parameters (e.g., quantify, # of variations, by code) and frequency.					
RF1.06	Retrieve as needed archived reference data for processing of outdated claims or for duplicate claims detection.					
RF1.07	Generate a summary of history file transfers.					
RF1.08	Maintain current and historical reference data used in claims processing.					

RF	Reference Data Management Requirements - MMIS	A	B	C	D	E
RF1.08.01	Accommodate retroactive rate changes.					
RF1.09	Maintain online access to all reference tables with inquiry by the appropriate code.					
RF1.09.01	Provide the capability to maintain and display online multiple pricing segments, status and effective dates for unlimited history segments.					
RF1.09.02	Provide for role-based security to limit update access to reference tables to IME specified staff.					
RF1.10	Maintain an audit trail of all information changes including errors in changes and suspended changes.					
RF1.10.01	Provide and maintain the following data fields for all reference data elements: a. Effective date. b. End date. c. Date when last changed. d. Who changed it. e. Source of change.					
RF1.11	Maintain revenue codes and provide online update and inquiry access including: a. Coverage information. b. Restrictions. c. Service limitations. d. Automatic error codes. e. Pricing data. f. Effective dates for all items.					
RF1.12	Maintain date sensitive parameters for all Reference Data Management data.					
RF1.12.01	Maintain edit indicators for each procedure code in the Procedure File to allow for the inclusion or exclusion of the service and or procedure for the provider type and or specialty or any combination of the above, based on date of service.					
RF1.12.02	Provide the capability to accommodate variable date sensitive pricing methodologies for identical procedure codes based on modifiers, benefit plans, member data, provider types and specialties. Provider specific data, HCPCS codes, place of service, member age and other criteria as defined by IME.					
RF1.14	Support code sets for the payment of Medicaid-covered non-health care services (e.g., waiver services).					
RF1.16	Maintain the trauma indicators to identify potential TPL cases.					
RF1.17	Maintain diagnosis and procedure code narrative descriptions of each code contained in the files.					
RF1.18	Update all procedure, diagnosis and drug files if required prior to each payment cycle.					
RF1.SS.01	Maintain and update the service frequency limitations for each procedure or for range of procedure codes contained on the edit.					
RF1.SS.02	Maintain relationship edits on procedure and diagnosis codes.					

RF	Reference Data Management Requirements - MMIS	A	B	C	D	E
RF1.SS.03	Provide capability to link from the claim detail line to the pricing table.					
RF1.SS.04	Maintain current and historical coverage status for physician administered drugs.					
RF1.SS.05	Maintain current and historical coverage status for biologic drugs.					
RF2.01	Manage all HIPAA-required external data sets (e.g., ICD-9, ICD-10, HCPCS and CPT).					
RF2.02	Maintain all data sets defined by the HIPAA implementation guides to support all transactions required under HIPAA administrative simplification rule (e.g., gender, reason code).					
RF2.02.01	Provide the capability to maintain and update edits, limits and restrictions to all codes that are included in any standard HIPAA transaction (e.g., procedure codes, discharge status codes, NDC); Provide online update and inquiry access including but not limited to the following: a. Coverage information. b. Restrictions. c. Service limitations. d. Automatic error codes. e. Pricing data. f. Effective dates for all items. g. Benefit plan. h. Pricing data. i. Other as defined by IME.					
RF2.02.02	Provide capability to have an IME specific value for all indicators on any NDC code.					
RF2.02.03	Provide the capability to capture the NPPES information file received from CMS to be easily extractable and reportable.					
RF2.02.04	Place edit and or audit criteria limits on types of service by procedure code, revenue code, diagnosis code and drug code and therapeutic class, based on: a. Member age, gender, eligibility status, benefit plan and program eligibility. b. Diagnosis. c. Provider type and specialty. d. Place of service. e. Tooth and surface codes. f. Floating or calendar year period. g. Time periods in months or days.					
RF2.02.05	Maintain a user-controlled remittance and message text dataset with access by edit number, showing the remittance advice message(s) for each error and the EOB message(s), with online update capability.					
RF2.02.06	Provide capability to add new procedures requiring prior authorization as part of routine rules engine maintenance.					
RF2.02.07	Process and maintain inputs and outputs including, but not limited to the following: **Inputs:**					

RF	Reference Data Management Requirements - MMIS	A	B	C	D	E
	Update to all HIPAA code sets a. Fee schedule updates. b. Update to revenue codes. c. Drug formulary file updates. d. CLIA laboratory designations. e. Any other reference data as required by the Department. **Outputs:** a. Reference data including fee schedules to the web portal as directed by the IME. b. File of reference data for use by other applications.					

TP	Third-Party Liability (TPL) Requirements - MMIS	A	B	C	D	E
TP1.01	Provide the storage and retrieval of TPL information including, but not limited to: a. Name of insurance company. b. Address of insurance company. c. Policy number. d. Group number. e. Name of policyholder. f. Relationship to Medicaid member. g. Services covered. h. Policy period. i. Employer of policy holder. j. Multiple resources under one member. k. Group health plan participants. l. Health Insurance Premium Payment (HIPP) participant. m. Long term care insurance.					
TP1.01.01	Accept file updates of carrier information from electronic files, excel spreadsheets and manually.					
TP1.01.02	Provide the capability to identify the type of TPL recovery in the MMIS.					
TP1.01.03	Allow for mass update of TPL information on carrier plans.					
TP1.01.04	Generate TPL letters to members when a claim identifies a third party payment and there is no TPL span on the member record.					
TP1.01.05	Provide online notes capability for narrative about each TPL information data field.					
TP1.01.06	Accommodate specific types of TPL coverage based on procedure codes, drug codes or IME-defined service categories, with sufficient detail for automatic cost-avoidance, pay and bill or pay and report, without manual review.					
TP1.01.07	Automatically identify previously paid claims when TPL resources are identified or verified retroactively.					
TP1.01.08	Provide the capability to adjust claims history to reflect					

TP	Third-Party Liability (TPL) Requirements - MMIS	A	B	C	D	E
	TPL recoveries that are claim-specific.					
TP1.01.09	Provide the capability to account for TPL recoveries that are non-claim-specific at the provider and member level.					
TP1.01.10	Adjust previously reported cost-avoided payments for subsequent resubmission and payment amounts.					
TP1.04	Identify claims with trauma diagnosis codes, accident codes and indicators and route them for follow-up to see if there is TPL and generate a trauma lead letter sent to the member.					
TP1.07	Accept and process verification data from employers, insurance companies, providers, members, attorneys and others. Verification data should include the 'type of insurance coverage' for each policy (e.g., inpatient, outpatient, physician and dental).					
TP1.07.01	Accept and process verification data from long term care insurance - nursing home.					
TP1.08	Maintain all TPL resource information at the member-specific level.					
TP1.08.01	Identify TPL resources that are liable for some, or all, of the member's medical claim by member, including absent parent.					
TP1.09	Maintain multiple TPL coverage information for individual members for all of their periods of eligibility.					
TP1.09.01	Carry unlimited TPL resource information segments for each member and historical resource data for each member that are date and benefit coverage specific.					
TP1.10.01	Generate eligibility matches with other payers using the HIPAA 270/271 transactions or proprietary format, if needed.					
TP1.10.02	Support the use of the 270/271 transaction between entities.					
TP1.10.03	Provide the capability for online inquiry and updates to the TPL module (e.g., resource and carrier). Online access is by member ID number, member name, carrier name and carrier ID number.					
TP1.11	Edit TPL data updates for validity and for consistency with existing TPL data.					
TP1.12	Edit additions and updates to the member insurance information to prevent the addition of duplicates.					
TP1.13	Provide a mechanism to correct outdated TPL information.					
TP1.14	Generate and maintain an audit trail of all updates to the member insurance data, including those updates that were not applied due to errors, for a time period specified by the state.					
TP1.14.01	Generate monthly or as directed by IME audit reports of TPL data additions, changes or deletions. The report must identify what was changed, when the change was made and the user making the update.					
TP1.14.02	Contain an audit trail for all records and track the time, date and person who made the update to the record.					
TP1.15	Cross-reference the health insurance carriers to the					

TP	Third-Party Liability (TPL) Requirements - MMIS	A	B	C	D	E
	employers.					
TP1.15.01	Maintain employer data that identifies employers and the health care plans they provide to employees.					
TP1.16	Allow only authorized staff members to do manual deletes and overrides of alerts and or edits.					
TP1.16.01	Allow authorized users to adjust claims and enter settlements against claims as needed to account for TPL recoveries.					
TP1.17	Identify claims designated as “mandatory pay and chase”, make appropriate payments and flag such claims for future recovery (i.e., identify services provided to children who are under a medical child support order and flag diagnosis information to identify prenatal care services provided to pregnant women and preventive pediatric services provided to children).					
TP1.SS.01	Provide IME with the capability to update member TPL Resource by batch interface or online real-time.					
TP1.SS.02	Produce a file of all paid claims monthly for revenue collections contractor.					
TP1.SS.03	Accept automated updates to the TPL Management module.					
TP1.SS.04	Generate accurate user defined TPL reports in the format and media determined by IME.					
TP1.SS.05	Produce appropriate TPL reports on schedule and in a media as determined by IME.					
TP1.SS.06	Generate formatted TPL correspondence with all fields displayed accurately.					
TP1.SS.07	Allow authorized users print capability to generate TPL reports in hardcopy.					
TP1.SS.08	Report on all TPL recoveries by claim type.					
TP1.SS.09	Generate a report of all pended claims in the TPL Management module. The report must group claims by type of recovery (e.g., drug, health and casualty) and identify the claim disposition.					
TP1.SS.10	Incorporate TPL information on the CMS-64.					
TP1.SS.11	Enable the web portal to accurately display TPL information for providers, including carrier addresses.					
TP1.SS.12	Maintain accurate reporting to track cost-avoidance by private insurance, Medicare and other TPL resources.					
TP1.SS.13	Account for TPL recoveries at the provider and member level for non-claim specific recoveries.					
TP1.SS.14	Receive, process and update medical Support information received from child support enforcement agency.					
TP1.SS.15	Produce files to send to all eligibility systems for TPL coverage identified by the Revenue Collections contractor.					
TP1.SS.16	Allow for online entry of TPL and COB rules by IME staff or contractor staff as defined by IME.					
TP1.SS.17	Generate alerts to IME recovery units and others designated by IME when retroactive third party coverage has been identified.					

TP	Third-Party Liability (TPL) Requirements - MMIS	A	B	C	D	E
TP1.SS.18	Support the productions of claims history for the purpose of establishing receivables from members and automatically generate any claim payments or adjustments affecting the amount of the receivable.					
TP2.01	Screen claims to determine if claims are for members with TPL coverage, if service is covered and if the date of service is within coverage period. Deny or suspend as provided in state rules, claims that are for products or services that are covered. Notify the provider of claims denied because of TPL coverage.					
TP2.03	Account for TPL payments to providers in determining the appropriate Medicaid payment.					
TP2.04	Track and report cost avoidance dollars.					
TP2.05	Allow for payment of claims that would have been rejected due to TPL coverage if provider includes override codes that indicate that benefits are not available.					
TP2.11	Associate third party recoveries to individual claims.					
TP2.11.01	Process revenue collection contractor file and update claims history.					
TP2.13	Designate portions of claims amounts collected to reimburse CMS and the state with any remainder paid to the recipient.					
TP2.14	Prepare retroactive reports (reverse crossover) to Medicare Part A and B or the provider, as appropriate, for all claims paid by Medicaid that should have been paid by Medicare Part A and B.					
TP2.14.01	Provide for the storage and retrieval of Medicare information for the proper administration of Medicare crossover claims and ensure maximum cost avoidance when Medicare is available.					
TP2.SS.01	Identify, at the claim line level, the amount paid by the third party and the reason for adjustments applied by the third party. If the claim is not adjudicated at the line level, identify the amount paid by the third party and the reason for adjustments applied by the third party at the header level.					
TP2.SS.02	Accept, process and respond to the HIPAA standard 837 TPL segment on a claim transaction.					
TP2.SS.03	Process and maintain inputs and outputs including, but not limited to: **Inputs:** a. Plan and coverage file from third parties. b. HIPP eligibility file. **Outputs:** a. Required Reports.					

HP	Health Insurance Premium Payment (HIPP) Requirements - MMIS	A	B	C	D	E

HP	Health Insurance Premium Payment (HIPP) Requirements - MMIS	A	B	C	D	E
HP.SS.01	Receive and process daily incoming transactions that identify members enrolled in HIPP.					
HP.SS.02	Receive and process incoming transactions that identify premium payments to be made to members, payees, insurers or employers on behalf of HIPP enrollees.					
HP.SS.03	Generate payments and remittance advices to members, payees, insurers or employers on behalf of HIPP enrollees.					
HP.SS.04	Produce state defined reports for premium payments made associated with HIPP.					
HP.SS.05	Produce state defined reports for monitoring cost avoidance associated with HIPP coverage based on TPL data.					
HP.SS.06	Prevent HIPP enrollees from enrollment in managed care programs.					
HP.SS.07	Accept a tax ID number for tracking and distributing HIPP payments.					
HP.SS.08	Provide for payment to be made by either check or electronic means.					
HP.SS.09	Provide for payments to be made on a daily basis or as directed by IME.					
HP.SS.10	Maintain online information related to HIPP cases including HIPP premium payout data and employer data, based on state specifications.					
HP.SS.11	Create a member file for HIPP enrollees who are not Medicaid members (i.e., AIDS/HIV HIPP).					

Program Management Business Area – MMIS

This business area includes the system requirements for program management reporting, federal reporting and financial management.

PM	Program Management Reporting Requirements - MMIS	A	B	C	D	E
PM1.01	Provide capability to support the production of information and or reports to assist management in fiscal planning and control.					
PM1.01.01	Provide parameter-driven capability to download data required for management analysis to excel spreadsheet or other format required by IME data.					
PM1.02	Provide capability to support the production of information and or reports and reports required in the review and development of medical assistance policy and regulations.					
PM1.03	Provide capability to support the production of information and or reports to support the preparation of budget allocations by fiscal years.					
PM1.04	Provide capability to support the production of information and or reports for projection of the cost of program services for future periods.					
PM1.05	Provide capability to support the production of					

PM	Program Management Reporting Requirements - MMIS	A	B	C	D	E
	information and or reports to compare current cost with previous period cost to establish a frame of reference for analyzing current cash flow.					
PM1.06	Provide capability to support the production of information and or reports to compare actual expenditures with budget to determine and support control of current and projected financial position.					
PM1.07	Provide capability to support the production of information and or reports to analyze various areas of expenditure to determine areas of greatest cost.					
PM1.08	Provide capability to produce reports that provide data necessary to set and monitor rate-based reimbursement (e.g., institutional per diems and MCO capitation).					
PM1.09	Maintain provider, recipient, claims processing and other data to support agency management reports and analyses.					
PM1.10	Provide capability to support the production of information and or reports concerning: a. Service category (e.g., days, visits, units, prescriptions). b. Unduplicated claims. c. Unduplicated members. d. Unduplicated providers. e. Participation in waivers by county. f. Expenditures by service category. g. Other data elements as directed by IME. h. Age. i. Gender. j. Ethnicity. k. Premium collections, refunds and payments.					
PM1.11	Support online real-time summary information such as but not limited to: number and type of providers, members and services.					
PM1.12	Track claims processing financial activities and provide reports on current status of payments.					
PM1.13	Provide capability to support the production of information and or reports on unduplicated counts, within a type of service and in total by month.					
PM1.14	Provide capability to support the production of information and or reports on the utilization and cost of services against benefit limitations.					
PM1.15	Assist in determining reimbursement methodologies by providing expenditure data through service codes including: a. HCPCS, previous and current versions. b. ICD, clinical modifier, previous and current versions. c. NDC, previous and current version. d. Future code sets as defined by industry standards and federal rules.					
PM1.16	Provide capability to support the production of information and or reports on hospice services					

PM	Program Management Reporting Requirements - MMIS	A	B	C	D	E
	showing a comparison of hospice days versus inpatient days for each enrolled hospice member and for all hospice providers.					
PM1.17	Provide capability to support the production of information and or reports to analyze break-even point between Medicare and Medicaid payments.					
PM1.18	Provide capability to support the production of information and or reports to analyze cost-effectiveness of managed care programs versus FFS.					
PM1.19	Provide capability to support the production of information and or reports to track impact of Medicare drug program.					
PM1.20	Provide capability to support the production of information and or reports on any change from baseline for any program or policy change.					
PM2.01	Provide capability to support the production of information and or reports to review errors in claim and payment processing to determine areas for increased claims processing knowledge transfer and provider billing knowledge transfer.					
PM2.02	Provide claim processing and payment information by service category or provider type to analyze timely processing of provider claims according to requirements (standards) contained at 42 CFR 447.45.					
PM2.03	Provide capability to support the production of information and or reports to monitor third party avoidance and collections per state plan.					
PM2.04	Retain all information necessary to support state and federal initiative reporting requirements.					
PM2.05	Provide access to information such as, but not limited to, paid amounts, outstanding amounts and adjustment amounts to be used for an analysis of timely reimbursement.					
PM2.06	Display and maintain information on claims at any status or location such as, but not limited to, claims backlog, key entry backlog, pend file status and other performance items.					
PM2.07	Identify payments by type such as, but not limited to, abortions and sterilizations.					
PM2.08	Provide capability to support the production of information and or reports to third party payment profiles to determine where program cost reductions might be achieved.					
PM2.09	Maintain information on per diem rates, DRG, Resource Utilization Groups (RUG) and other prospective payment methodologies according to the state plan and monitor accumulated liability for deficit payments.					
PM2.10	Automatically alerts administration when significant change occurs in daily, weekly or other time period payments.					
PM3.01	Provide capability to support the production of					

PM	Program Management Reporting Requirements - MMIS	A	B	C	D	E
	information and or reports to review provider performance to determine the adequacy and extent of participation and service delivery.					
PM3.02	Provide capability to support the production of information and or reports to review provider participation and analyze provider service capacity in terms of member access to health care.					
PM3.03	Provide capability to support the production of information and or reports to analyze timing of claims filing by provider to ensure good fiscal controls and statistical data.					
PM3.04	Provide access to information for each provider on payments to monitor trends in accounts payable such as, but not limited to, showing increases and decreases and cumulative year-to-date figures after each claims processing cycle.					
PM3.05	Produce information on liens and providers with credit balances or AR balances including periodic and accumulative payment amounts used to offset total lien amount					
PM3.06	Provide capability to support the production of information and or reports to produce provider participation analyses and summaries by different select criteria such as, but not limited to: a. Payments. b. Services. c. Types of services. d. Member eligibility categories.					
PM3.07	Provide capability to support the production of information and or reports to assist auditors in reviewing provider costs and establishing a basis for cost settlements.					
PM3.08	Provide capability to support the production of information and or reports to monitor individual provider payments.					
PM4.01	Provide capability to support the production of information and or reports to review the utilization of services by various member categories to determine the extent of participation and related cost.					
PM4.02	Provide capability to support the production of information and or reports to analyze progress in accreting eligible Medicare buy-in members.					
PM4.03	Provide capability to support the production of information and or reports to analyze data on individual drug usage.					
PM4.04	Provide capability to support the production of information and or reports for geographic analysis of expenditures and member participation.					
PM4.05	Provide capability to support the production of information and or reports on member data (including LTC, EPSDT and insurance information) for designated time periods.					
PM4.06	Provide capability to support the production of					

PM	Program Management Reporting Requirements - MMIS	A	B	C	D	E
	information and or reports summarizing expenditures, based on type of federal expenditure and the eligibility and program of the member.					
PM4.07	Provide capability to support the production of information and or reports on eligibility and member counts and trends by selected data elements such as, but not limited to, aid category, type of service, age and county.					
PM4.08	Provide capability to support the production of information and or reports for member enrollment and participation analysis and summary, showing utilization rates, payments and number of members by eligibility category.					
PM4.09	Provide the ability to request information online and to properly categorize services based on benefit plan structure.					
PM4.10	Provide capability to support the production of information and or reports on dual eligible's pre and post Medicare Part D implementation.					
PM5.01	Support report balancing and verification procedures.					
PM5.02	Maintain a comprehensive list of standard program management reports and their intended use (business area supported).					
PM5.03	Provide reports or access to reports for users designated by the IME.					
PM5.04	Maintain online access to at least four (4) years of selected management reports and five (5) years of annual reports.					
PM5.05	Meet state defined time frames and priorities for processing user requests.					
PM5.SS.01	Provide the capability to store and retrieve all reports per IME requirements.					
PM5.SS.02	Provide users easy and quick access to MMIS produced reports from their workstations, including, but not limited to: a. Query all MMIS reports. b. View all MMIS reports online. c. Export data and reports to desktop packages such as Excel, Word, ACCESS, text files and other software packages available on the State Local Area Network (LAN) and or the Wide Area Network (WAN). d. View online documentation, including dictionary of data and data fields for each report. e. Ability to print the report or selected portions of the report.					
PM5.SS.03	Provide the capability to archive all MMIS production reports for permanent storage in electronic media approved by IME.					
PM5.SS.04	Provide the capability to run any report at any time.					
PM5.SS.05	Maintain the uniformity and comparability of data through reports including reconciliation between					

PM	Program Management Reporting Requirements - MMIS	A	B	C	D	E
	comparable reports and reconciliation of all financial reports with claims processing reports.					
PM5.SS.06	Provide capability to support the production of information and or reports for county billings, on a monthly basis, identify paid claims for ICF/MR, Intellectual Disability (ID) and Brain Injury (BI) waivers and other services based on a report with details of the transactions and the client's "county of legal settlement" (which may differ from their "county of residence") and a billing for each county that lists each client and their related charges.					
PM5.SS.07	Provide capability to report on the timely delivery of all scheduled reports.					
PM5.SS.08	Process and maintain inputs and outputs including, but not limited to the following: **Inputs:** a. IME policy and rules. b. Budget information. **Outputs:** a. The financial, statistical and summary reports required by the state in managing the Iowa Medical Assistance Programs.					

FR	Federal Reporting Requirements - MMIS	A	B	C	D	E
FR1.01	Maintain data sets for Medical Statistical Information System (MSIS) reporting as required.					
FR1.02	Merge into MSIS data from outside sources if required: a. Capitation payment records from enrollment process. b. Eligibility characteristic data from eligibility intake-process. c. Medicaid services processed by non-MMIS state departments, such as mental health services. d. Utilization based on managed care encounters.					
FR1.03	Provide and maintain MSIS data for the following adjudicated claims: a. Inpatient hospital. b. Long term institutional care. c. Prescription drugs. d. Other, not included in the above categories.					
FR1.04	Provide and maintain encounter data in appropriate claim(s) file.					
FR1.05	Follow the eligibility reporting guidelines of the MSIS tape specifications and data dictionary documents from CMS.					
FR1.06	Meet MSIS reporting timeliness, providing MSIS tapes for submission in accordance with the tape delivery					

FR	Federal Reporting Requirements - MMIS	A	B	C	D	E
	schedules.					
FR1.SS.01	Provide data to support the production of SF269 Federal Financial Status Report.					
FR1.SS.02	Support Payment Error Rate Measurement (PERM) processing in compliance with CMS quarterly claims sample frequency requirements as directed by IME.					
FR2.01	Produce the CMS-416 report in accordance with CMS requirements. The report must include: a. The number of children provided child health screening services. b. The number of children referred for corrective treatment. c. The number of children receiving dental services. d. The state's results in attaining goals set for the state under section 1905(r) of the Act provided according to a state's screening periodicity schedule.					
FR3.01	Produce the CMS-372 and CMS-372S annual reports on HCBS, Reports for any HCBS waivers that exist in accordance with CMS requirements.					
FR4.01	Provide data to support the production of CMS-37 and CMS-64 quarterly estimates and expenditure reports.					
FR4.01.01	Report drug rebate collections on the CMS-64 and CMS-21, as applicable.					
FR4.01.02	Report the top ten manufacturers with outstanding drug rebate invoices on quarterly CMS-64 data.					
FR4.01.03	Produce CMS-64 variance and CMS-21 variance reports, as specified by IME, for the current and three prior quarters. The variance reports must be made available within time frames and formats required by IME.					
FR4.SS.01	Provide the ability to support on-demand and scheduled generation of information for the CMS-21 report – Quarterly State Children's Health Insurance Program (SCHIP) statement of expenditures for Title XXI and supporting data required by CMS, within time frames and formats required by IME, including the CMS-21B and the CHIP Statistical Enrollment Report.					
FR4.SS.02	Provide a full audit trail, as defined by IME, to support all transactions used to generate any and all federal reports.					
FR4.SS.03	Incorporate TPL information on the CMS-64.					
FR4.SS.04	Provide the capability to create a Quarterly Report of Abortions (CMS 64.9b) based on IME rules.					
FR4.SS.05	Provide the capability to create a quarterly report on expenditures under the Money Follows the Person program based on IME rules.					
FR4.SS.06	Provide the capability to create a quarterly report on member premium payments and refunds based on IME rules.					
FR4.SS.07	Incorporate information concerning member premium payments and refunds on the CMS-64.					
FR4.SS.08	Include the following data in the reports to support the					

FR	Federal Reporting Requirements - MMIS	A	B	C	D	E
	federal reporting function: a. All the claim records from each processing cycle. b. Online entered, non-claim-specific financial transactions, such as recoupments, mass adjustments, cash transactions. c. Provider, member and reference data from the MMIS. d. Individual claim records for all claims not paid through the MMIS.					
FR.SS.01	Provide the ability to regenerate the MSIS file and all federal reports based on changes to the federal report code.					
FR.SS.02	Process and maintain inputs and outputs including, but not limited to the following: **Inputs:** a. Data concerning payments outside the MMIS. b. Data concerning adjustments to payments made outside the MMIS. **Outputs:** a. MSIS data file. b. Reports required supporting preparation of the CMS 64, CMS 37, CMS 21 and CHIP Statistical Enrollment Report, CMS 21B, CMS 372, SF269 Federal Financial Status reports and CMS 416. c. Report on Money Follows the Person program expenditures.					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
FI1.01	Provide individual EOB notices, within 45 days of the payment of claims, to all or a sample group of the members who received services under the plan as described in §11210.					
FI1.01.01	Provide EOB notices on the web portal in multiple languages, as defined by IME.					
FI1.01.02	Provide capability to generate an EOB for every member or a selected group of members, based on requirements as defined by IME, including in multiple languages.					
FI2.01	Update claims history and online financial files with the payment identification (check number, EFT number, warrant number or other), date of payment and amount paid after the claims payment cycle.					
FI2.02	Maintain garnishments and tax levies and assignment information to be used in directing or splitting payments to the provider and garnishor.					
FI2.03	Maintain financial transactions in sufficient detail to support 1099.					
FI2.04	Account for recovery payment adjustments received from third parties that do not affect the provider's					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
	1099.					
FI2.05	Provide a full audit trail to the source of general ledger transactions generated by the MMIS or other supporting financial packages.					
FI2.05.01	Link financial data back to the source claim line or system generated payment transaction.					
FI2.05.02	Provide full accountability and control of all claims processed through the system until final disposition including full documentation and audit trails to support the claims payment process.					
FI2.05.03	Provide financial audit controls meeting Generally Accepted Accounting Principles (GAAP).					
FI2.06	Provide reports in electronic format for performing periodic bank account or fund allocation reconciliations.					
FI2.07	Maintain a history of claim recovery payments in excess of expenditures and allow distribution to the appropriate parties, including providers, members or insurers in accordance with IME policy.					
FI2.08	Maintain a history of refunds.					
FI2.09	Withhold the federal share of payments to Medicaid providers to recover Medicare overpayments.					
FI2.SS.01	Provide an accounts payable module to manage payments to providers, members and other entities.					
FI2.SS.02	Provide an AR module to manage receivables from providers, members and other entities.					
FI2.SS.03	Provide a follow-up process to ensure that required changes to account coding and financial management business rules are applied.					
FI2.SS.04	Support automated retroactive changes that are user driven (e.g., changes in account coding). Retroactive changes will not change closed totals but will retain them and reflect revised totals.					
FI2.SS.05	Provide the ability to easily navigate between accounts payable and AR.					
FI2.SS.06	Produce the 1099 file, as directed by IME, using AR data to appropriately adjust providers' earnings for recoupment.					
FI2.SS.07	Process voids and replacements for incorrect payments and create AR where appropriate.					
FI2.SS.08	Generate one payment for all claims with same NPI or Medicaid ID for atypical providers.					
FI2.SS.09	Provide the ability to record debts and process accurate and timely cash receipts from debtors.					
FI2.SS.10	Automatically create AR based on claim voids, recoupments, settlements and receipt of unsolicited refunds from providers. Stamp account code and federal report code on each AR based on the codes stamped on the claim lines or business rules, as defined by IME.					
FI2.SS.11	Provide the capability to manually create a receivable and stamp account code and federal report code, based on direction from IME.					
FI2.SS.12	Provide the ability to create a payment plan for					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
	manually and automatically created AR.					
FI2.SS.13	Provide online viewing of all transactions and provider balances.					
FI2.SS.14	Create a variety of financial reports required for monitoring. Organization of the summarization must be such that it allows tracking back to the level of the detailed claim.					
FI2.SS.16	Provide online inquiry access to the accounts payable and AR modules. Searchable data fields include, but are not limited to: a. Financial control numbers. b. Provider id and name. c. Type of receivable (created by a claim transaction or by a financial transaction). d. Collection code. e. Original balance. f. Prior balance. g. Current activity. h. Balance forward. i. Claim control number that generated the receivable (if the receivable was generated as a result of a claim action). j. Reason code. k. Cycle date. l. Schedule of future payments. m. Age of receivable in days. n. Dates Associated with each action on the receivable (e.g., date established, date of each payment). o. National Provider ID. p. Legacy ID number. q. Tax Identification Numbers. r. County Code. s. I/3 Vendor Identification Number. t. Percentage and or dollar amounts to be deducted from payments. u. Type of collections made and date. v. Both financial transactions (non-claim-specific) and adjustments (claim-specific). Search criteria (the key inquiry data elements) for access to this database will be defined by IME.					
FI3.01	Track Medicare deductibles and coinsurance paid by Medicaid for all crossover claims, by member and program type.					
FI3.02	Process and retain all data from provider credit and adjustment transactions.					
FI3.03	Produce payment information to the payment issuing system.					
FI3.04	Issue an electronic remittance advice detailing claims processing activity at the same time as the payment or payment information transfer.					
FI3.05	Ensure that the system supports sending electronic claim payment and advice transactions (ASC X12N 835) meeting the standards required by 45 CFR Part					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
	162.					
FI3.05.01	Report on the remittance advice and the ASC X12N 835 any payment amounts applied to an AR or interest debt.					
FI3.05.02	Provide controlled access to a message field for the text of the messages to be printed on the Remittance Advice (RA) for each error code. Provide the capability for online inquiry to a message File for IME and contractor staff.					
FI3.05.03	Report carrier name, address and policy information for all relevant third party liability TPL resources on the remittance advice for claims denied for TPL.					
FI3.05.04	Provide ability to populate multiple message fields on the RA.					
FI3.05.05	Provide the ability to apply and report on the RA “soft” claims edits to send warnings and alerts, but not deny or suspend the claim line.					
FI3.05.06	Produce a RA that can be downloaded as a Portable Data File (PDF) version from the web portal.					
FI3.05.07	Provide the capability to capture denial path of claims, including edits, showing all of the denial reasons on the RA.					
FI3.05.08	Meet the requirements for production of RAs as specified in the State Medicaid Manual Part 11, Federal Regulations 42 CFR 433.116 and 42 CFR 455.20.					
FI3.06	Net provider payments against credit balance or AR amounts due in the payment cycle in determining the payment due the provider.					
FI3.07.01	Provide the ability to apply claim payments to satisfy an outstanding AR balance, including payment of interest.					
FI3.07.02	Provide the ability to apply cash receipts against AR and interest, based on business rules provided by IME.					
FI3.08	Process voids and replacements for incorrect payments or returned warrants, crediting fund source accounts and creating AR or credit balances where appropriate.					
FI3.09	Support stop payment processes.					
FI3.10	Allow online access to AR or provider credit balances to authorized individuals.					
FI3.11	Allow online access to remittance advice through a web-based browser.					
FI3.12	Provide support for identification and application of recovery funds and lump-sum payments.					
FI3.13	Identify providers with credit balances and no claim activity during a state-specified number of months.					
FI3.14	Notify providers when a credit balance or AR has been established.					
FI3.14.01	Provide the ability to generate notices to the debtor when AR have an overdue balance and send an alert to the designated IME or contractor staff based on IME rules.					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
FI3.15	Display adjustment and or void in a separate section of the remittance advice.					
FI3.16	Allow for withholding of payments in cases of fraud or willful misrepresentation without first notifying the provider of its intention to withhold such payment.					
FI3.17	Support refunding of federal share of provider overpayments within one year from discovery of an overpayment for Medicaid services in accordance with Affordable Care Act.					
FI3.SS.01	Provide the ability to identify interest that is applied through settlements (e.g., liens, settlements and sanctions).					
FI3.SS.02	Manage provider IDs so remittance advices can include claims from more than one benefit plan.					
FI3.SS.03	Allow for the creation of multiple categories of AR (audit, overpayments, fraud) at the claim line level.					
FI3.SS.04	Automatically create a receivable collectable whenever a provider advance is created, unless instructed by IME.					
FI3.SS.05	Allow for collection of individual receivables to be suspended but still reported.					
FI3.SS.06	Provide the capability to create a letter to the provider notifying the provider of the creation of the AR and of appeal rights based on IME rules.					
FI3.SS.07	Provide the capability to automatically change AR status to allow offset against accounts payable and interest calculation, based on business rules established by IME.					
FI3.SS.08	Support the ability to recover receivables from another NPI and Medicaid ID with the same TIN.					
FI3.SS.09	Provide the capability to identify the state and federal fiscal year in which an AR was created and the original date of claim adjudication as applicable.					
FI3.SS.10	Provide the ability to allow uncollectable credit balances to be set as directed by IME.					
FI4.01	Provide a financial transaction application for processing non-claim specific financial transactions including payouts, AR, refund checks and returned warrants.					
FI4.01.01	Automatically create financial transactions and apply correct account and federal report coding, based on: a. Data entered by a user manually. b. Data uploaded to the system from Excel spreadsheets or other software. c. Enrollment of a member into benefit plans that require single or recurring capitation payments, premium or management fees. d. Business rules for creation of hospital disproportionate share payments. e. Other requirements of IME.					
FI4.02	Support the process of issuing a manual check, retaining all data required for fund source determination, payee identification and reason for check issuance.					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
FI4.03	Update records to reflect the processing of uncashed (stale) or cancelled (voided) Medicaid checks. Process replacements for lost or stolen warrants and updated records with new warrant information.					
FI4.03.01	Update and track information necessary to support a reconciliation of cancelled, outdated and or replaced warrants.					
FI4.04	Process payments from providers for refunds and update records as needed. Capability to adjust 1099 reporting.					
FI4.04.01	Generate a snapshot file that lists the activity in each provider's year to date earnings at the time the 1099 is created. A copy of each provider's 1099 form for the year shall be maintained for seven years.					
FI4.04.02	Process and track requests for duplicates and provider change requests for 1099 in accordance with IME business rules.					
FI4.04.03	Process the annual IRS “no match” provider file and generate a report, as defined by IME.					
FI4.04.04	Interface with NPPES and Internal Revenue Service (IRS) to validate accuracy of provider data, including NPI and Tax-ID, on the 1099.					
FI4.04.05	Provide capability for providers to securely access and print their 1099 from the web portal.					
FI4.05	Allow for history adjustments to claims processing to reflect changes in funding sources and other accounting actions that do not impact provider payment amounts or 1099 reporting.					
FI.SS.01	Provide capability to perform credit balances adjustments.					
FI.SS.02	Provide interoperability between the MMIS and I/3 state accounting system, eliminating manual financial processes.					
FI.SS.03	Provide remittance processing capabilities to account for both payment offsets and cash receipts.					
FI.SS.04	Accumulate payments for multiple benefit plans by provider and include on same remittance advice.					
FI.SS.05	Summarize payment cycle transactions by account coding.					
FI.SS.06	Create a payment processing summary file for upload to state accounting system.					
FI.SS.07	Balance all payment cycle processing, including balancing a Claims Payment Summary Report to a Remittance Advice Report.					
FI.SS.08	Provide the capability to reduce a provider payment by a percentage or hold an entire payment by provider type or other selection criteria designated by IME.					
FI.SS.09	Support the calculation of disproportionate share payments, per business rules provided by IME.					
FI.SS.10	Allow for limiting payment amounts, per IME business rules.					
FI.SS.12	Support multiple AR for a given provider to include a prioritization of satisfaction of the outstanding					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
	balances that may be overridden.					
FI.SS.13	Designate the financial status of all cash receipt transactions, including the date of record creation, updates, comments, financial coding and attach any supporting documentation.					
FI.SS.14	Update MMIS financial claims history to reflect cash receipts.					
FI.SS.15	Support drill down capability for AR and cash receipts.					
FI.SS.16	Produce reports and notices and letters in Microsoft Office compatible files, for use in spreadsheets and emailing of reports.					
FI.SS.17	Allow for export of financial management reports to Excel, based on user-defined parameters.					
FI.SS.18	Include beginning and end dates on reports, if applicable.					
FI.SS.19	Provide reports in electronic format, as defined by IME, including, but not limited to the following: a. Monthly report for return of federal funds for AR. b. Collection activity for all AR by category (Summary and Detail). c. Collection activity of AR that are federally funded. d. Accounts receivable balances by category (Summary and Detail). e. Cash Receipts report. f. Claim payments used to satisfy receivables. g. Payment cycle reports, including the Claims Payment Summary Report. h. Accounts receivable aging reports (Summary and Detail) with work queues for the different aging levels (e.g., 30-60-90 day). i. Providers' 1099 earnings report annually. j. Providers earnings reports for the IRS in accordance with federal and state regulations. k. Collection notices and letters for ARs available in multiple user-defined formats. l. Providers receiving collection notices and letters. m. Providers referred to the state or other collection agent for collection. n. Accounts receivable related to bankrupt providers. o. Accounts receivable by Account Number (parameter of last activity date within the current fiscal year). p. Deposit reports including summary and detailed deposit tickets. q. Outstanding and historical accounts payable transactions. r. Prompt Payment Report.					
FI.SS.20	Identify the type of TPL recovery on each AR.					
FI.SS.21	Provide a link for related AR correspondence.					
FI.SS.22	Provide the capability to maintain reason codes for all					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
	receipts of money (i.e., recoupment payments).					
FI.SS.23	Provide the capability to assign a financial control number to any cash transaction.					
FI.SS.24	Provide the capability to track and store federal financial participation (FFP) amounts.					
FI.SS.25	Provide the capability to maintain complete audit trails of AR processing and all transactions must be reflected in subsequent financial reporting.					
FI.SS.26	Provide the capability to automatically transfer credit balances when a provider changes ownership as determined by IME.					
FI.SS.27	Provide the capability to send payment file as directed by IME for EFT.					
FI.SS.28	Create AR for the purpose of billing entities responsible for a portion of the non-federal share of the cost of services. The AR is based on claims adjudicated in each payment cycle. The AR must identify claim line details supporting the billed amount based on IME rules.					
FI.SS.29	Provide the capability to record the disputed amount of AR for the non-federal share of a claim at the line level, record the dispute reason and resolution indicators based on IME rule and link an image of supporting documentation.					
FI.SS.30	Provide capability to adjust an AR for the non-federal share of a claim at the line level and send alerts based on IME policy and reflect credits on the next billing.					
FI.SS.31	Provide the capability to automatically change “legal settlement county” for members based on the results of resolution of disputes over the non-federal share of a claim.					
FI.SS.32	Provide the capability to limit a total provider payment in each payment cycle by an amount specified by IME loaded from an excel spreadsheet.					
FI.SS.33	Provide the capability to generate a monthly report of Medicare premium and crossover payments.					
FI.SS.34	Calculate and provide electronic record of the total dollars of assessment fees that are to be repaid to the state.					
FI.SS.35	Calculate the assessment fee as an add-on to rates paid to providers designated by IME. Automatically set up an AR to recover all or a portion of the assessment fee as directed by IME. The AR can be satisfied as an off-set to future payments or through receipt of payment from the provider as directed by IME.					
FI.SS.36	Provide the capability to produce a report of aged AR, with flags on those that have no activity within a Department-specified period of time and the AR set-up during the reporting period.					
FI.SS.37	Provide the capability to produce a report to identify claim-specific and non-claim-specific adjustments by type of transaction (payout, recoupment or refund)					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
	and provider type, on a monthly basis.					
FI.SS.38	Provide the capability to produce paper billings and electronic billing file for billing the non-federal share of specific services to a county or other entity.					
FI.SS.39	Provide the capability to identify the claims that are the responsibility of a county or other entity for billing the non-federal share of specific services.					
FI.SS.40	Provide capability to track and report on all financial transactions, by source, including TPL recoveries, fraud and abuse recoveries, provider payments, drug rebates.					
FI.SS.41	Maintain the table of I/3 state accounting system codes in the system and code the payment and credit to the appropriate program cost center.					
FI.SS1.42	Accept and process the Department of Administrative Services Offset Program file received monthly from the Department.					
FI.SS.43	Provide the capability to refund overpayments on AR.					
FI.SS.44	Provide a method to link payments from providers to the specific claim line affected.					
FI.SS.45	Provide capability to accommodate the issuance and tracking of non-provider-specific payments through the MMIS (e.g., refund of an insurance company overpayment) and adjust expenditure reporting appropriately.					
FI.SS.46	Provide capability to maintain lien and assignment information to be used in directing or splitting payments to the provider and lien holder.					
FI.SS.47	Provide the capability for recoveries to be made from provider payments at the Department user-defined percentage from 0 to 100.					
FI.SS.48	Provide the capability to produce a summary report of all payments for each payment cycle.					
FI.SS.49	Provide the capability to drill down to the claim line from any provider payment.					
FI.SS.50	Process and maintain inputs and outputs including, but not limited to: **Inputs:** a. Mass adjustment requests are entered and edited online or uploaded from EXCEL spreadsheets. b. Gross adjustments (debits and credits) are entered online or uploaded from EXCEL spreadsheets for non-claim-specific financial transactions such as fraud and abuse settlements, TPL recoveries and advance payments. c. Data concerning adjustments to payments made outside the MMIS. **Outputs:** a. All required reports. b. File of paid claims and encounter data to the Provider Cost Audit and Rate Setting contractor.					

FI	Financial Management Requirements - MMIS	A	B	C	D	E
	c. File of paid claims and encounter data to Medical Services contractor.					

Program Integrity Business Area - MMIS

This business area includes the system requirements for program integrity.

PI	Program Integrity Management Requirements - MMIS	A	B	C	D	E
PI.SS.01	Produce a report of claim detail, with multiple select and sort formats, which shall include but not be limited to: a. Provider ID and name. b. Member ID and name. c. Referring provider ID. d. Category of service. e. Service date(s). f. Diagnosis code(s), with description. g. Procedure code(s), with description. h. Therapeutic class code(s). i. Drug generic code(s), with description. j. Lock in indicator. k. Billed and paid amounts. l. Prescribing Provider					
PI.SS.02	Produce a report regarding data on ambulatory and inpatient services provided to nursing facility residents within a single report by a long-term care facility.					
PI.SS.03	Produce LTC facility summary, which lists the following for each facility: a. Facility characteristics and data. b. Number of performing providers. c. Number of members served by each performing provider. d. Dollars paid to each performing provider for services to LTC members. e. Dates of service. f. Produce LTC detail, which includes: 1. Names and IDs of members using inpatient services during an LTC facility confinement. 2. Hospital stay dates of service. 3. Amount billed per hospital stay. 4. All leave days. 5. Claims data.					
PI.SS.04	Generate a report of LTC physician detail, which identifies the number of visits to LTC facilities by performing providers, by provider number and gives details for members, including date of service and amount billed.					
PI.SS.05	Generate annual ranking by dollars for utilizing members and providers, by program, including listings of the top 100 for each category.					
PI.SS.06	Provide the lock-in contractor with a file of member					

PI	Program Integrity Management Requirements - MMIS	A	B	C	D	E
	Program Integrity claim details from the MMIS to support their review and investigation of inappropriate utilization of services in the member population.					
PI.SS.07	Produce summary and detail information report on hospital stays, including length of stay, room and board charges, ancillary charges and medical expenses prior to and immediately following the hospital stay. Produce a report, as specified by the IME, of all services received by members who are receiving a specific service or drug, are enrolled in selected programs, have a certain living arrangement or are receiving services from certain providers or provider groups.					
PI.SS.08	Provide access to the Program Integrity contractor all reports produced for the Program Integrity module.					
PI.SS.09	Process and maintain inputs and outputs including, but not limited to: **Inputs:** None **Outputs:** a. Provider data to Program Integrity contractor. b. Member data to Program Integrity contractor. c. Reference data to Program Integrity contractor. d. Claims data to Program Integrity contractor. e. Provide a monthly copy of the paid claims file to the Medicaid Fraud Control Unit (MFCU). f. Member lock-in report to Member Services contractor.					

Care Management Business Area - MMIS

This business area includes the system requirements for managed care and waiver management.

MG	Managed Care Enrollment Requirements - MMIS	A	B	C	D	E
MG1.01	Capture enrollee choice of PCCM on beneficiary record.					
MG1.02	Auto-assign enrollees to a PCCM who fail to choose a PCCM and complete provider lock-in process.					
MG1.03	Display enrollees associated with PCCM.					
MG1.04	Disenroll member from PCCM.					
MG1.05	Allow enrollee to disenroll from a PCCM without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.					
MG1.06	Automatically disenroll enrollees from a terminated PCCM provider and places the beneficiary in regular FFS status.					
MG1.06.01	If a provider is terminated from participation in the					

MG	Managed Care Enrollment Requirements - MMIS	A	B	C	D	E
	Medicaid program, automatically disenroll the provider from the PCCM program and generate report of disenrollment action.					
MG1.07	Perform mass reassignment of enrollees if contract with PCCM is terminated or beneficiary disenrolls for any reason other than ineligibility for Medicaid.					
MG1.08	Generate notices to members of enrollment or disenrollment from PCCM.					
MG1.10	Identify members excluded from enrollment, subject to mandatory enrollment or free to voluntarily enroll in PCCM.					
MG1.11	Prioritize enrollment for members to continue enrollment if the PCCM does not have the capacity to accept all those seeking enrollment under the program.					
MG1.12	Provide a default enrollment process for those members who do not choose a PCCM.					
MG1.13	Automatically re-enroll a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less.					
MG1.13.01	If the provider is not available then default to normal auto-assignment process even if disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less.					
MG1.14	Support ANSI X12N 834 transaction, as required by HIPAA.					
MG2.01	Identify PCCMs who have agreed to provide gatekeeper services, geographic location(s), number of assigned members and capacity to accept additional patients.					
MG2.02	Accept and processes updates information about the PCCM as changes are reported.					
MG2.03	Capture termination information when a PCCM provider contract is cancelled.					
MG2.03.01	Automatically disenroll PCCM from managed care program.					
MG2.04	Generate weekly or as required by IME reports to monitor adequacy of PCCM network (e.g., number and types of physicians and provider locations).					
MG2.05	Generate weekly or as required by IME reports to monitor enrolled providers to prohibit affiliations with individuals debarred by federal agencies or otherwise terminated.					
MG3.01	Calculate administrative payment per-member-per-month (PMPM) for primary care gatekeeper services.					
MG3.01.01	Calculate and issues performance incentive payment for qualifying medical homes.					
MG3.02	Support ANSI X12N 837 transactions, as required by HIPAA.					
MG3.03	Support ANSI X12N 835 transaction, as required by HIPAA.					
MG4.01	Edit and deny payment to FFS providers for services without PCCM referral and or prior authorization.					

MG	Managed Care Enrollment Requirements - MMIS	A	B	C	D	E
MG4.02	Allow payment to providers for services carved out of the PCCM benefit package (e.g., family planning, women health specialist).					
MG4.03	Allow payment for emergency medical condition without authorization from PCCM.					
MG4.04	Edit and deny payment to referral providers (pharmacy, lab, radiology, specialty physician, etc.) if service is not authorized by a PCCM gatekeeper.					
MG4.05	Allow payment to FFS providers for services rendered in pre-enrollment periods or other periods of transition.					
MG5.01	Generate as required by IME reports for monitoring enrollee access to medical services.					
MG5.01.01	Generate data extract of all paid claims and encounter for use by actuarial contract.					
MG5.01.02	Produce weekly or as required by IME a report in electronic format of all members enrolled with each PCCM. The report must identify if the member is new to the PCCM in the current month. The report must also identify all members that are no longer enrolled with a PCCM effective with the current month.					
MG5.03	Generate as required by IME reports to monitor PCCM referrals to specialty care.					
MG5.04	Produce report for each PCCM identifying the PCCM's enrollees and the total payment per month per enrollee.					
MG.SS.01	Generate a capitation payment for clients enrolled in the PACE benefit plan based on the rate for the provider per IME policy.					
MG.SS.02	Produce weekly or as required by IME a report of all members enrolled with a PACE provider.					
MG.SS.03	Edit and deny all FFS payments after enrollment in PACE.					
MG.SS.04	Provide a "PACE" indicator on client file when a client is enrolled in the PACE benefit plan.					
MG.SS.05	Prevent payment of any claim billed by a provider that is not the PACE provider, including Medicare cross-over claims, if the client is enrolled in the PACE benefit plan.					
MG.SS.06	Provide capability to adjust the PACE payment for client participation.					
MG.SS.07	Provide capability to assure the PACE program does not co-exist with any other benefit plan.					
MG.SS.08	Allow access to the member contact data through link on any screen.					
MG.SS.09	Maintain date-specific Managed Health Care enrollment data spans on the MMIS eligibility file, including: a. Enrollments begin and end dates. b. Provider ID. c. Vendor ID. d. Plan type. e. State ID.					

MG	Managed Care Enrollment Requirements - MMIS	A	B	C	D	E
	f. County of residence. g. Zip code. h. Aid type. i. Birth date. j. Medicare eligibility. k. Gender. l. Case number. m. Reason for disenrollment.					
MG.SS.10	Manage dual enrollment in Iowa benefit plans based on IME hierarchy enrollment rules.					
MG.SS.11	Process and maintain inputs and outputs including, but not limited to the following: **Inputs:** a. Eligibility updates from the Department. b. Primary care provider selection for MediPASS from the Member Services contractor. c. HMO selection from the Member Services contractor. d. Managed care provider enrollment data from Provider Services contractor. e. Encounter data from managed care plans. **Outputs:** a. Monthly files of paid claims and encounter data to actuarial contractor.					

MC	Managed Care Organization Requirements - MMIS	A	B	C	D	E
MC1.01	Capture information on contracted MCOs, including geographic locations, capitation rates and organization type.					
MC1.02	Capture information identifying contracted providers within MCO network, including Primary Care Providers (PCPs).					
MC1.03	Capture information identifying providers who have agreed to provide gatekeeper services, number of members assigned and capacity to accept additional patients.					
MC1.04	Accept and process update information as changes are reported.					
MC1.05	Capture termination information when an MCO contract is cancelled.					
MC1.06	Remove and end-date PCP status from MCO (optional if states require MCO to identify PCPs).					
MC1.07	Provide information to support assessment of adequacy of provider network. This includes identifying and collecting data on the number and types of providers and provider locations.					
MC1.08	Provide information to support review of new enrollments and to prohibit affiliations with individuals debarred by federal agencies.					
MC2.01	Calculate per-member per-month (PMPM) capitation payment based on state-defined rate factors such as					

MC	Managed Care Organization Requirements - MMIS	A	B	C	D	E
	age, gender, category of eligibility, health status, geographic location and other.					
MC2.02	Compute capitation payment for the actual number of days of eligibility in a month (i.e., enrollee may not be enrolled for a full month).					
MC2.03	Identify individuals and enrollees who have terminated enrollment, disenrolled or are deceased and excludes those individuals from the monthly MCO capitation payment.					
MC2.04	Generate regular capitation payments to MCOs, at least on a monthly basis in compliance with HIPAA-standard X12 820 Premium Payment transaction where applicable.					
MC2.05	Adjust capitation payment based on reconciliation of errors or corrections (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).					
MC2.06	Perform mass adjustment to rates according to state policy (e.g., annual adjustment, negotiated rate change, court settlement).					
MC2.07	Perform periodic reconciliations of state member records with MCO, PCP enrollment records.					
MC2.08	Verify correct transfer of capitation payment when member disenrolls from one MCO and enrolls in another plan.					
MC2.09	Support ANSI X12N 820 Premium Payment transaction as required by HIPAA.					
MC3.01	Collect and store encounter data on a periodic basis.					
MC3.02	Apply key edits to encounter data (e.g., MCO, physician, member ID numbers, diagnosis's and procedure codes). Note: The encounter record edits can be different from claims edits.					
MC3.03	Return erroneous encounter data for correction.					
MC3.05	Periodically produce reports for audits on accuracy and timeliness of encounter data, including matching encounter record to MCO paid claim and to the provider's billing.					
MC3.06	Capability to calculate the "Encounter Cost Value," or the cost of services reported on the encounter claim had they been paid on a Fee-for-Service basis.					
MC3.07	Accept and process encounter claims in formats, as mandated by HIPAA (e.g., X12N 837).					
MC4.04	Collect and sort encounter data for use in completing Medicaid Statistical Information System (MSIS) reports.					
MC4.05	Collects and sorts encounter data for use in determining capitation rates.					
MC4.09	Access encounter data to identify persons with special health care needs as specified by IME.					
MC4.10	Produce reports to identify network providers and assess enrollee access to services.					

MC	Managed Care Organization Requirements - MMIS	A	B	C	D	E
MC4.11	Produce managed care program reports by category of service, category of eligibility and by provider type.					
MC5.01	Block payment to FFS providers for services included in the MCO benefit package, with the exceptions stated per the state plan.					
MC5.02	Allow FFS payment to providers for services carved out of the MCO benefit package. (These services are usually delivered by providers external to the MCO).					
MC5.03	Allow payment to FFS providers for services rendered in pre-enrollment periods or other periods of transition.					
MC6.01	Generate monthly or as required by IME reports of capitation payment by various categories (e.g., by eligibility group, rate cell).					
MC6.02	Generate FFS claims reporting for services furnished outside of a capitation agreement (i.e., for services "carved-out" of the managed care program).					
MC7.01	Collect basic administrative information, for instance: a. The identification of an MCO. b. Contract start and end dates. c. Contract period and year. d. Capitation effective date. e. Maximum enrollment threshold. f. Enrollee count. g. Member month. h. Re-insurance threshold. i. Geographic area served. j. Other information as required by IME.					
MC8.01	Identify members who are eligible for a state's Medicaid program by qualifying under a section 1115 waiver eligibility expansion group. Distinguish the "1115 expansion eligibles" from other groups of Medicaid-eligibles.					
MC8.02	Collect and maintain the data necessary to support the budget neutrality reporting requirements as specified in the state's 1115 waiver (including the ability to identify those members who would be ineligible for Medicaid in the absence of the state's 1115 waiver).					
MC.SS.01	Process and maintain inputs and outputs including, but not limited to: **Inputs:** a. Encounter data from managed care plans. **Outputs:** a. Enrollment Rosters to managed care organizations. b. Monthly files of paid claims and encounter data to actuarial contractor.					

ME	Primary Care Case Manager (PCCM) and Medical Home and Managed Care Gatekeeper Requirements - MMIS	A	B	C	D	E
ME1.01	Capture enrollee choice of MCO or PCP and enter into member record.					
ME1.03	Assign enrollee to MCO or PCP based on factors such as member age, gender, geographic location; and MCO capitation rate, location.					
ME1.05	Display enrollees associated with MCO.					
ME1.06	Disenroll member from MCO.					
ME1.07	Disenroll member without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.					
ME1.08	Automatically disenroll and re-enroll members in new plans during periods of open enrollment or when an MCO leaves the program.					
ME1.09	Automatically disenroll member from a terminated MCO and places in regular FFS status.					
ME1.10	Generate notices to member of assignment to or disenrollment from MCO.					
ME1.11	Identify members excluded from enrollment, subject to mandatory enrollment or free to voluntarily enroll in MCO.					
ME1.12	Prioritize enrollment for members to continue enrollment if the MCO does not have the capacity to accept all those seeking enrollment under the program.					
ME1.13	Provide a default enrollment process for those members who do not choose a MCO.					
ME1.14	Automatically re-enroll a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less (optional, if state plan so specifies).					
ME1.15	Support ANSI X12N 834 transaction, as required by HIPAA.					
ME2.01	Receive and process eligibility data from state's eligibility source system.					
ME2.02	Receive MCO contract information from contract data store (e.g., address, covered services, rates).					
ME2.03	Receive and process provider eligibility data from MMIS or data repository for PCP program.					
ME2.05	Calculate or select premium payment amount and generate PMPM payment (capitation, Premium, case management fee).					
ME2.06	Support ANSI X12N 820 transaction for PMPM premium payment as required by HIPAA.					
ME2.07	Transmit enrollment and PMPM payment data to MMIS or data repository.					
ME2.08	Transmit enrollment records and PMPM payments to MCOs.					
ME3.01	Calculate and generate premium notices to members.					
ME3.02	Process premium receipts from members.					
ME3.02.01	Identify outstanding premium payments due from members and reports for debt collection accordance					

ME	Primary Care Case Manager (PCCM) and Medical Home and Managed Care Gatekeeper Requirements - MMIS	A	B	C	D	E
	with IME policy.					
ME3.03	Support inquiries regarding premium collections.					
ME3.03.01	Member premium rules must be configurable to accommodate program rules.					
ME3.03.02	Automatically extend or terminate eligibility for premium based eligibility programs in accordance with rules for each program.					
ME3.03.03	Accept data file from lock box for premium payments.					
ME3.04	Produce premium collection reports.					
ME4.01	Comply with provisions for Administrative Simplification under the HIPAA of 1996 to ensure the confidentiality, integrity and availability of ePHI: a. Provide safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between state Medicaid and Health Agencies. b. Perform regular audits. c. Support incident reporting.					
ME.SS.01	Maintain date-specific Managed Health Care enrollment data spans on the MMIS eligibility file, including: a. Enrollment begin and end dates. b. Provider ID. c. Vendor ID. d. Plan type. e. State ID. f. County of residence. g. Zip code. h. Aid type. i. Birth date. j. Medicare eligibility. k. Gender. l. Case number. m. Reason for disenrollment.					
ME.SS.02	System must be able to support a medical home infrastructure when implemented in the state of Iowa as directed by the IME.					
ME.SS.03	System must be able to enroll, disenroll, maintain, track and produce reports for Medical Home as directed by IME.					
ME.SS.04	Disenroll a member from PCCP program when enrolled in Medical home, and when appropriate, enroll a member in PCCP program if they leave the Medical home.					
ME.SS.05	Allow the capability for a member to be in a medical home and on lock-in.					

WA	Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
WA1.01	Identify by waiver unduplicated participants enrolled in 1915c waiver programs.					
WA1.01.01	Identify by waiver unduplicated participants enrolled in 1115 waiver programs.					
WA1.01.02	Identify unduplicated participants enrolled in Facility and Enhanced State Plan programs.					
WA1.01.03	Accept the waiver and Enhanced State Plan indicator from eligibility system.					
WA1.02	Generate notices or alerts to agency if number of unduplicated participants enrolled in the waiver program exceeds the number of participants approved in the waiver application.					
WA1.03	Track and report the number of unduplicated participants in the 1915c waiver program.					
WA1.03.01	Track and report the number of unduplicated participants in the 1115 waiver program.					
WA1.04	Identify the date a participant is assessed to meet the waiver LOC.					
WA1.04.01	Identify the date a participant is assessed to meet the assessment criteria for Facility and Enhanced State Plan programs.					
WA1.SS.01	Provide the ability to accept different start and end dates for different waiver and Enhanced State Plan programs and services under each waiver. Provide the ability to accept different start and end dates for Facility eligibility.					
WA1.SS.02	Provide the ability to accept adds, changes and deletes for a waiver or waiver service from a waiver program and from an individual member's service plan.					
WA1.SS.03	Provide the ability to identify and extract services approved as exceptions to certain waiver programs or service plan.					
WA1.SS.05	Provide the ability to accept real time adds, changes and deletes for Facility eligibility and Enhanced State Plan eligibility and services.					
WA2.01	Capture enrollment information, including NPI if required, on entity or individual meeting the qualifications contained in the provider agreement, including geographic locations and capitation or FFS rates.					
WA2.01.01	Provide enrollment information, including NPI if required, on providers to external source.					
WA2.02	Prevent enrollment of entities and individuals who do not meet the provider qualifications contained in the provider agreement.					
WA2.03	Update information as changes are reported.					
WA2.04	Capture termination information when a waiver, Facility and Enhanced State Plan provider voluntarily terminates or a provider agreement is cancelled.					
WA2.05	Prohibit enrollment of providers affiliated with individuals debarred by state or federal agencies, listed in abuse registries or otherwise unqualified to					

WA	Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
	provide service.					
WA2.05.01	Upload abuse registries and debarred files monthly and matches all providers against the uploaded data. Sends alert whenever there is a match.					
WA4.01	Process claims for medical services.					
WA4.02	Apply edits to prevent payments for services covered under a waiver, Facility and Enhanced State Plan programs to a Medicaid provider who does not have a provider agreement.					
WA4.03	Prevent payments for members who have become ineligible for Medicaid.					
WA4.04	Suspend payments for waiver and Enhanced State Plan services furnished to individuals who are inpatients of a hospital, nursing facility or Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and sends notice to the provider of the admission. If the state has approved personal care retainer or respite services provided in an ICF/MR building but not covered under the ICF/MR benefit, an exception may be made.					
WA4.05	Limit payment for services to those described within the member's approved plan of care. Limits payment on claims exceeding dollar or utilization limits approved in waiver or exceeding the approved individual waiver budget cap.					
WA4.06	Edit waiver, Facility and Enhanced State Plan services claims for prior authorization, if applicable.					
WA4.07	Edit waiver, Facility and Enhanced State Plan services claims for Third-Party Liability (TPL) coverage prior to payment to ensure Medicaid is the payer of last resort.					
WA4.08	Edit waiver, Facility and Enhanced State Plan services claims for member cost share of premium or enrollment fees prior to payment.					
WA5.01	Gather data and produce a variety of financial reports to facilitate cost reporting and financial monitoring of waiver programs.					
WA5.02	Gather data and produce utilization reports for monitoring cost neutrality of waiver services to a target population. The average cost of waiver services cannot be more than the cost of alternative institutional care. State may define average either in aggregate or for each participant.					
WA5.03	Access individual member claims and or encounter histories to extract data needed to produce annual report to CMS on cost neutrality and amount of services.					
WA5.04	Collect and store data and produce reports in electronic format consistent with data collection plan to assess quality and appropriateness of care furnished to participants of the waiver programs.					
WA5.04.01	Collect and store data and produce reports in electronic format to support county billing process					

WA	Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
	programs.					
WA5.04.02	Collect and store data and produce reports in electronic format to assess waiver performance standards.					
WA5.05	Monitor provider capacity and capabilities to provide waiver and Enhanced State Plan services to enrolled participants.					
WA5.SS.01	Generate reports on the structure of the benefit plans to help IME set the benefit plan rules more efficiently.					
WA5.SS.02	Provide, accept, maintain and process information with designated entities, as required by IME.					
WA.SS.01	For state supplemental program pay payee on the member file rather than provider.					
WA.SS.02	Provide capability to add a waiver program or add services to an existing waiver program through changes to the rules engine.					
WA.SS.03	Maintain date-specific Managed Health Care enrollment data spans on the MMIS eligibility file, including: a. Enrollment begin and end dates. b. Provider ID. c. Vendor ID. d. Plan type. e. State ID. f. County of residence. g. Zip code. h. Aid type. i. Birth date. j. Medicare eligibility. k. Gender. l. Case number. m. Reason for disenrollment.					
WA.SS.04	Generate electronic notice of decisions for approved service plans that the case manager may send to the providers and the members.					
WA.SS.05	Services must be authorized by units per month or units within a specified time period.					
WA.SS.06	Provide support for CCO to determine amount of funding available per member.					
WA.SS.07	Provide appropriate edits for lifetime and annual limits on services such as home and vehicle modification.					
WA.SS.08	Notify case managers when plans need to be reviewed. Below is the link to the current ISIS workflow charts located in the IME Resource Library. *http://www.ime.state.ia.us/IMEResourceLibrary.html*					
WA.SS.09	Support waiting lists for the various programs.					
WA.SS.10	Use modifiers to associate claims with the appropriate services when the provider provides different rates of services for the same service for the same authorized time period (such as meals or respite).					
WA.SS.11	Workflow between incident reporting and the care plan review.					
WA.SS.12	Provide reporting: Below is the link to the current ISIS					

WA	Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
	workflow charts located in the IME Resource Library. : *http://www.ime.state.ia.us/IMEResourceLibrary.html* a. Consumers turning 18. b. Verification that a person is on waiver (only for the rent subsidy program). c. Audit trails of service plans. d. Allow workers to see claims paid for a service plan.					
WA.SS.13	Edit the authorized service against claims paid before allowing the case worker to change the service.					
WA.SS.14	Capture requests for quality assurance (QA) changes to service plans.					
WA.SS.15	Provide workflow to support LOC eligibility determinations and continued stay reviews.					
WA.SS.16	Allow case managers to build case plans authorizing services, not to exceed maximums allowed by IME program rules.					
WA.SS.17	Provide a workflow process for authorizing exceptions to policies.					
WA.SS.18	Provide workflow process to support prior authorization of selected services.					
WA.SS.19	Process and maintain inputs and outputs including, but not limited to: **Inputs:** a. Eligibility System. **Outputs:** a. None.					

The Department is requesting a proposed solution to implement the requirements indicated below for Waiver, Facility and Enhanced State Plan Services Management as a replacement for the current ISIS system. Please refer to Section 4 Operating Environment of this RFP as well as the IME Resource Library for additional information on the current ISIS system at the following link: ***http://www.ime.state.ia.us/IMEResourceLibrary.html***

Depending on the proposed bidder's cost and solution, the Department may or may not elect to procure these services.

Optional Waiver, Facility and Enhanced State Plan Services Management Requirements – MMIS

OWA.SS	Optional Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
OWA.SS.01	Allow the Department and non-Department users secure access to the MMIS system.					
OWA.SS.02	Allow users to view and update only those items allowed by IME policy based upon the user's role.					
OWA.SS.03	Store user's information such as name, e-mail, phone number and address. Display this information for use by other users.					
OWA.SS.04	Automatically disable outdated users based on IME					

OWA.SS	Optional Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
	policy which is currently 60 days or as directed by IME.					
OWA.SS.05	Allow supervisors and certain user roles the ability to assign and reassign members and work from one user to another.					
OWA.SS.06	Provide for the ability for users identified as a team to have access to each other's work and any team work tasks.					
OWA.SS.07	Provide for the ability to search for and select a specific member by name, partial name, state ID and social security number.					
OWA.SS.08	Accept and store provider rate information to be used when authorizing services.					
OWA.SS.09	Provide ability to search for and select providers by number, name, county location and services they are certified to provide.					
OWA.SS.10	Accept daily approvals, cancels, denials and change actions from the Medicaid eligibility system(s) for waiver and facility members.					
OWA.SS.11	Assign users to members based on criteria including but not limited to role, county, program as determined by IME policy.					
OWA.SS.12	Provide workflows for identified business process, action and decision steps. Automatically start these workflows based upon changes identified by IME policy. Include tasks completed by the user roles involved in processing a members program application and ongoing care management. This includes but is not limited to tasks such as counties accepting legal settlement, changes in eligibility or services, cancellations, denials and reminders of other key tasks, such as eligibility and service plan reviews along with LOC assessments.					
OWA.SS.13	Allow users to reverse or undo responses to a workflow task if they determine they have responded incorrectly.					
OWA.SS.14	Accept client participation determined in eligibility or by adjustments. Store the member participation amount so that it can be used to reduce claims for long term care claims by these amounts.					
OWA.SS.15	Accept entry of the facility provider where a member resides when receiving hospice services. Store this information so it can be used to determine the facility provider's rate when making payment for the room and board portion on a hospice member's claims.					
OWA.SS.16	Accept entry of eligibility, service plan and services. Allow adds, changes and deletes of this information as determined by IME policy. Allow authorization and approval by assigned users and use the authorized and approved data for claims payment.					
OWA.SS.17	Include edits to validate the service plan and services					

OWA.SS	Optional Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
	based on policy. Prevent entry of authorizations that do not meet policy criteria, exceed monthly budget caps and exceed service unit or rate caps. Service dates must be on or after application date and on or after the LOC effective date. The service dates can't overlap. Providers must be enrolled in the Iowa Medicaid program for the specific service being authorized. See service plan errors in draft manuals. *http://www.ime.state.ia.us/IMEResourceLibrary.html*					
OWA.SS.18	Reject changes to service plans and authorizations where claims may have been paid unless claims corrected accordingly.					
OWA.SS.19	Store and use the authorization data. Data includes: eligibility dates, waiver type, LOC effective date, county of legal settlement when applicable, service dates, services codes, provider, rates and units of service.					
OWA.SS.20	Split plans and services when LOC is lowered and determine if services exceed the new lower level monthly cap.					
OWA.SS.21	Allow cash out of services and creation of a CCO budget and savings using rules and policies provided by the IME.					
OWA.SS.22	Collect and track items and amounts paid under CCO and Money Follows the Person (MFP).					
OWA.SS.23	Allow for changes to be made to budgets. Roll the monthly budget for CCO forward each month.					
OWA.SS.24	Provide a notice of decision showing authorized services for members and providers when applicable in electronic and printable form.					
OWA.SS.25	Allow for corrections to a member's authorized long term care facility eligibility date spans. Make adjustment to affected claims such as vendor adjustments.					
OWA.SS.26	Identify those members that are in long term care facilities for purposes of Medicare Part D co-pays.					
OWA.SS.27	Allow facility provider access to their eligible members and resident's approval, changes and termination of facility eligibility including state ID, dates, client participation amounts.					
OWA.SS.28	Allow waiver provider access to their eligible member's approval, changes and termination of services eligibility including state ID, dates, client participation amounts, service spans, units and rates.					
OWA.SS.29	Archive all changes made to a member and services. Identify the user that made those changes for purposes of an audit trail and research.					
OWA.SS.30	Provide reports determined by IME. Some examples include, member's needing a service plan, workload (member's by user), services authorized and related paid claims, providers for members assigned to a specific user, workload tasks, overdue tasks, denied					

OWA.SS	Optional Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
	claims, member's near age 18 for county point coordinators, member's with invalid plans and member's with expired LOC reviews.					
OWA.SS.31	Provide the capability to create member profile reports, as approved by the IME.					
OWA.SS.32	Services can be authorized by units by month or units within a date span or as identified by IME.					
OWA.SS.33	Edit for monthly, annual and lifetime limits on services based on IME rules and policies. Provide reports displaying accumulated use or remaining funds available.					
OWA.SS.34	Provide for electronic automated referral to and or from the long term care incident reporting system.					
OWA.SS.35	Create processes for approval and overriding edits due to exceptions to policy and appeals.					
OWA.SS.36	Allow for modifiers to identify duplicate services for the same provider, same member, same service, same time period and different rates.					
OWA.SS.37	Allow for extracts or imports of data from consumer self direction option (CCO Financial Management Service Agencies (FMSA)) with reconciliation of actual expenses to budget services.					
OWA.SS.38	Store the date that a member's complete plan of care (POC) is initially completed. Maintain separate dates and allow updates to be made for each document and assessment within the POC. Provide the capability of an alert in the workflow management process when document due dates are approaching.					
OWA.SS.39	Generate notices or alerts to the IME if number of unduplicated participants enrolled in the waiver program(s) exceeds the number of participants approved in the waiver application.					
OWA.SS.40	Produce monitoring reports to determine if services approved in the POC are provided.					
OWA.SS.41	Suspend payments for waiver services furnished to individuals who are inpatients of a hospital, nursing facility ICF/MR and sends notice to the provider of the admission. If the state has approved personal care retainer or respite services provided in an ICF/MR building but not covered under the ICF/MR benefit, an exception may be granted.					
OWA.SS.42	Limit payment for services to those described within the member's approved POC. Deny claims exceeding dollar or utilization limits approved in a waiver program or exceeding the approved individual waiver budget cap.					
OWA.SS.43	Provide the ability to automatically approve prior authorizations for waiver services up to a specific dollar amount.					
OWA.SS.44	Process waiver provider and member claims and make timely and accurate payments.					
OWA.SS.45	Provide the ability to accept different start and end					

OWA.SS	Optional Waiver, Facility and Enhanced State Plan Services Management Requirements - MMIS	A	B	C	D	E
	dates for different waiver programs for an individual member.					
OWA.SS.46	Store the date that a member's POC, LOC, Preadmission Screening and Annual Resident Review (PASARR), screening records, clinical assessment and other required documents is initially completed and allow the user to update the date of the next document re-evaluation if applicable. Provide the capability of an alert in the workflow management tool that the document is due.					
OWA.SS.47	Create the ability to bill multiple counties (including state cases) for a legal settlement per program per member.					
OWA.SS.48	Maintain and create a monthly managed waiting list and report for each of the waivers and include data as determined by the IME in electronic and printable format.					

RI	Immunization Registry (MMIS Interfaced to Registry) - MMIS	A	B	C	D	E
RI1.1	Collect and maintain claims history for vaccinations at the Member-specific level.					
RI1.2	Interface with a statewide automated immunization registry and allow regularly scheduled data exchanges. a. Populates the statewide automated registry to fully populate the registry with Medicaid children. b. Populates the statewide automated registry with Medicaid claims for children receiving immunizations.					
RI1.3	Send, at a minimum, the following information to a statewide immunization registry through the interface: a. Medicaid identifier. b. Demographic information. c. CPT billing procedure code. d. Identify rendering service provider. b. Reminder and recall notice dates.					
RI1.4	Edit data for data validity, duplicate records and perform quality checks; sends error message if appropriate.					
RI3.2	Measure immunization coverage for the Medicaid population using current Advisory Committee on Immunization Practices (ACIP) schedule and update as necessary.					
RI3.3	Select and send data weekly or as directed by IME to the registry at least on a weekly basis.					
RI3.5	Generate results of surveillance of vaccine-preventable diseases.					

RI	Immunization Registry (MMIS Interfaced to Registry) - MMIS	A	B	C	D	E
RI4.1	Simplification under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to ensure the confidentiality, integrity and availability of Electronic Protected Health Information (ePHI) in transit and at rest.					
RI4.2	Provide safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies.					

7.1.3 MMIS and POS infrastructure Requirements

MMIS and POS Infrastructure Requirements

This business area includes the infrastructure requirements for the MMIS and POS

RE	Rules Engine System Requirements – MMIS and POS	A	B	C	D	E
RE.SS1.01	The IME requires the contractor to propose a comprehensive rules engine design to support multiple health programs and service delivery and payment methods to include managed care, FFS and waiver arrangements. The design must include the capability to develop and maintain rules related to the following general categories including both a business and technical definition of the rule: a. Member rules. b. Provider rules. c. Benefit plan rules. d. Claim adjudication rules (including adjustments. e. Reference rules. f. Managed Care rules. g. Financial rules. h. Federal reporting rules. i. System parameter rules. j. Prior Authorization. k. PCCM and or medical home.					
RE.SS1.02	Provide a rules engine sufficiently scalable to meet rules growth and processing demands.					
RE.SS1.03	Provide role-based security to the rules.					
RE.SS1.04	Provide a graphical front-end to the rules engine, integrated throughout the development environment, enabling designated staff (e.g., business, policy and financial analysts) to easily connect and apply or disable, rules.					
RE.SS1.05	Allow for rules to be rapidly implemented in a real-time enterprise environment.					

RE	Rules Engine System Requirements – MMIS and POS	A	B	C	D	E
RE.SS1.06	Support flexibility with respect to customization of the rules to support processing requirements throughout the IME.					
RE.SS1.07	Support adaptability to easily accommodate timely changes in response to federal, legislative or administrative mandates.					
RE.SS1.08	Provide capability for the user to view and model rules for system exceptions online and to trace exception rule dependencies.					
RE.SS1.09	Provide a debugging process that automatically analyzes and identifies logical errors (i.e., conflict, redundancy and incompleteness) across business rules.					
RE.SS1.10	Allow for the tracking and reporting of rules usage and orchestration to provide tracing capability to display instances of rules execution during testing.					
RE.SS1.11	Produce documentation regarding all business rules in electronic format and make it accessible to the IME.					
RE.SS1.12	Provide the capability to manage implementation timing.					
RE.SS1.13	Allow for rules to be date specific, including date added, date modified, start date, end date and effective date.					
RE.SS1.14	Provide a modular structure so that the same rules engine can be used by different services or be called as a service itself.					
RE.SS1.15	Contain a process for a built-in multi-level rule review and approval process that will identify any conflicts in business rules as they are being developed.					
RE.SS1.16	Store all rules maintenance activities in an audit trail that provides a history of the rules changes. Provide capability to ensure that all rules changes are recorded and retained in a long-term audit repository saving the before and after version of the change and the date, time and identification of the individual who made the change and the effective time period of the rule.					
RE.SS1.17	Provide the capability to establish and link notes to rules to explain why the rule was modified, created or inactivated.					
RE.SS1.18	Provide a rules search capability by keyword, data element or other criteria so that staff may search for existing rules.					

AR	General Architectural Requirements – MMIS and POS	A	B	C	D	E
AR.SS.01	The contractor must provide MMIS and POS systems that meet the requirements of the Iowa Medicaid Enterprise, meet all CMS certification requirements, are aligned with the MITA standards and meet all Iowa functional and business requirements specified in this					

AR	General Architectural Requirements – MMIS and POS	A	B	C	D	E
	RFP.					
AR.SS.02	Must meet Iowa Enterprise Information Technology standards.					
AR.SS.03	Must meet Iowa and federal standards concerning web accessibility.					
AR.SS.04	Utilize n-tier architecture that minimizes the need for desktop software and is primarily browser based. The system must at a minimum support Internet Explorer and Firefox.					
AR.SS.05	Ensure all data is stored in relational databases that utilize referential integrity rules to prevent inconsistent data unless authorized by IME (for example, documents in the document management system).					
AR.SS.06	Provide system screens that are easy to read, user friendly and display all data elements necessary for a user to perform his and or her job function.					
AR.SS.07	Provide easy navigation to include but not be limited to, the following: a. Drop-down menus. b. Application-specific toolbars. c. Auto population of persistent data. d. Direct links to help, reference information, manuals and documentation. e. Short-cut and function key functionality. f. Mouse-over captions for all icons and data elements. g. Navigation menus, fields and page tabs. h. Auto skips from field to field so that the cursor moves automatically to the next field as soon as the last character in the previous field is completely filled. i. “Forward” and “Back” navigation. j. The ability to have multiple screens open and link from one screen to another without cutting and pasting data. For an example, if a user is on a member screen and wants to look at the provider data, the user should be able to link to the provider information by clicking on the provider number and then return to the original member screen, without requiring to cut-and-paste the member number to get back to the member screen.					
AR.SS.08	Provide an interface that manages field level and role-based security that allows only authorized users to see the information necessary to perform their job efficiently. Role-based security must also be available that allows a level of security to be applied to a specific job category.					
AR.SS.09	Provide system availability 24/7, other than for scheduled maintenance.					
AR.SS.10	Maintain the most current vendor supported version of the product(s), with the IME’s prior approval through					

AR	General Architectural Requirements – MMIS and POS	A	B	C	D	E
	the life of the contract at no additional cost to the IME.					
AR.SS.11	Provide Enterprise Application Integration (EAI), to include web services technology and standards to promote Iowa Medicaid Enterprise applications integration.					
AR.SS.12	Ensure full HIPAA compliance through the life of the contract at no additional cost to the IME.					
AR.SS.13	Provide an audit trail for each transaction on the screen, identifying who made the change, what change was made, date and time the change was made, why the change was made and provide a record of the data prior to the time the change was made.					
AR.SS.14	Align with MITA standards through the life of the contract at no additional cost to the IME.					
AR.SS.15	Provide functionality to interface with multiple entities outside of the Iowa Medicaid Enterprise for exchange of information, such as other eligibility determination systems, prior authorization entities, health information exchange, including provider directory information and Immunization and Death Registries.					
AR.SS.16	Provide metadata management that is accessible by the IME staff. Provide context-sensitive help from all screens.					
AR.SS.17	Maintain a data dictionary of all claims, member and provider data. The data dictionary must be available and searchable online. Required elements on the data include but not limited to: i.e., business name, field type, length, description, source, valid values.					
AR.SS.18	Metadata reports must be able to be generated to accompany all data extracts to external destinations including but not limited to i.e., OIG audit requests, PERM, MSIS and Data Warehouse.					
AR.SS.19	Metadata Management: SOA architecture commonly provides application and data integration via an abstraction layer. Given the requirements of interoperability and independence, the proper use and management of metadata is extremely important to the effective operation of the SOA; It must also allow for: a. Separation of the data and structures and convert them to a data layer within the SOA architecture. b. Development of a Common Data Model and Metadata using the MITA HL7 methodology. Achievement of the SOA loosely coupled “separation of concern” approach, by separating the data layer from the application layer to more effectively and easily manage the data without changing the application code. This will create the desired more loosely coupled SOA environment and enable the business to accelerate any system changes required in the future.					

HP	HIPAA Transaction Requirements – MMIS and POS	A	B	C	D	E
HP.SS.01	Ensure that the system remains compliant with all EDI standards adopted under HIPAA including, but not limited to the Accredited Standards Committee X12 (ASC X12) Version 005010 Technical Reports Type 3 for HIPAA Transactions and proposed adoption of the National Council for Prescription Drug Programs (NCPDP.D.O) Telecommunication Standard Implementation Guide. Current, prior and future versions of the aforementioned standards will be supported throughout the contract at no additional cost.					
HP.SS.02	Ensure that the system routinely conducts system and process testing to support efficient and reliable electronic data interchange, including: a. Tests for integrity and syntax. b. Tests for adherence to national implementation guides. c. Tests for balancing. d. Tests for situational elements in the state implementation guide. e. Tests for code set conformance. f. Tests for each specialty, line of business or provider class.					
HP.SS.03	Ensure that the system receives processes and returns the HIPAA mandated attributes that are utilized to enforce IME policy.					
HP.SS.04	Ensure that the system maintains a complete record of all HIPAA transaction attributes received, along with necessary identifiers to correctly associate incoming transaction attributes to system-generated transactions to construct outgoing transactions.					
HP.SS.05	Ensure that the system maintains data to support EDI transmission logs of all transactions (successful or failed).					

MT	MITA Technical Requirements – MMIS and POS	A	B	C	D	E
MT.SS.01	The contractor must propose, implement and operate an Iowa Medicaid Enterprise solution that meets the requirements of the RFP and includes MITA Level 3 standards.					
MT.SS.02	The contractor is required to identify any business processes that are at Level 1 or Level 2 and propose a solution to progressively move to Level 3 or higher. Level 3 requires that the business process be implemented as a set of reusable business services using the MITA defined interface within a SOA.					

MT	MITA Technical Requirements – MMIS and POS	A	B	C	D	E
MT.SS.03	The contractor's proposed system(s) must be based on an orientation of business processes, business rules and data and metadata management that allows modular componentized design approach that enhances interoperability across service modules and with external applications and data sources.					
MT.SS.04	The IME will be allowed to participate in any Change Management Request (CMR) process operated by the contractor on any client system user group.					
MT.SS.05	Service modules must be able to be defined independently, with the interface modules bridging the gap between modules. For example, the Member Module specification must be defined independent of the Provider Module. The alignment of the two specifications is defined in the interface module.					
MT.SS.06	Contractor will represent the state in multi-state discussions regarding MITA technical standards, including but not limited to the National Medicaid EDI Healthcare (NMEH), MITA and Sub-Working Group (SWG), as directed by the IME.					
MT.SS.07	Support secure **messaging** ~~ME.SSaging~~ between IME and providers through National Health Information Network (NHIN) Direct and/or the statewide HIE.					

SOA	SOA Requirements – MMIS and POS	A	B	C	D	E
SOA.01	The contractor must employ a SOA to take advantage of COTS products and allow for the reuse of system modules across business functions as services. Iowa has an existing SOA infrastructure that is fully described at: https://forge.iowa.gov/wiki/. Iowa is considering enhancing this infrastructure and the contractor is encouraged to propose a SOA infrastructure for the MMIS that could be extended to the Iowa statewide enterprise.					
SOA.02	Technology Independence: The service modules must be able to be invoked from multiple platforms and utilize standard protocols.					
SOA.03	Standards-Based Interoperability: The system must be able to support multiple industry standards, including, at a minimum: HL7 (V 3), XML, Extensible Style sheet Language Transformation (XSLT), Web Services Interoperability (WS-I), Web Service Description Language (WSDL), Simple Object Access Protocol (SOAP)1.1 or 2.0, Universal Description , Discovery and Integration (UDDI), Web Services (WS)-BPEL (Business Process Execution Language), Representational State Transfer (REST) (in place of SOAP), W-Message Transmission Optimization Mechanism (MTOM) Policy.					

SOA	SOA Requirements – MMIS and POS	A	B	C	D	E
SOA.04	Life-Cycle Independence: Each service module should be able to operate in a separate life-cycle.					
SOA.05	Invoke Interfaces: The Service interfaces must be able to be invoked locally or remotely.					
SOA.06	Communication Protocol: A Service must be able to be invoked by multiple protocols. The choice of protocol must not restrict the behavior of the service. Binding to a specific protocol must take place at run-time and deployment-time and not at the design or development time.					
SOA.07	Flexibility: The contractor must focus on the business processes that comprise the systems, with the following in mind: a. Ability to adapt applications to changing technologies. b. Easily integrate applications with other systems. c. Leverage existing investments in desired legacy applications. d. Quickly and easily create a business process from existing services.					
SOA.08	Enterprise Service Bus (ESB): The proposed solution must include an ESB for data transport, messaging, queuing and transformation. **Message Management.** This consists of reliable delivery of messages between services and built-in recovery. **Data Management**. This involves converting all messages between services to a common format and in turn, converting messages from the common format to the application. **Service Coordination.** This consists of orchestrating the execution of an end-to-end business process through all needed services on the ESB. Services can adapt to changes in environments and are supported by a standards-based set of service management capabilities. Services can be simple or complex sets of services that are interconnected by the ESB. There are many different vendor implementations of an ESB and the functions included in an ESB vary from one vendor to another. The list of functions above are key functions needed for realizing an SOA and are not intended to be all inclusive.					
SOA.09	The solution must include: a. A library of services providing the documentation referencing the services. b. Use of MITA standard interface definitions (expressed in WSDL) and messages (expressed as an XML and schema) for all services. c. Use of the MITA/HL7 methodology for defining the information model and messages.					

PL	Programming Language Requirements – MMIS and POS	A	B	C	D	
PLSS.01	The contractor should to the extent possible employ an operating environment compatible with the current Iowa ITE environment that is fully described at: https://forge.iowa.gov/wiki/.					
PLSS.02	Include in its proposal a list of the languages to be used and the applications or modules in which the languages will be used. The state will approve industry-standard languages appropriate to the task that operate without additional add-on licenses.					

SP	Security & Privacy Requirements – MMIS and POS	A	B	C	D	
SPSS.01	The system must use state of Iowa Enterprise Authentication and Authorization Service for authentication only to the extent possible.					
SPSS.02	Provide the capability to establish multilevel security settings by either group(s) or individual(s). Provide an interface that manages field level and role-based security that allows only authorized users to see the information necessary to perform their job efficiently. Role-based security must also be available that allows a level of security to be applied to a specific job category.					
SPSS.03	Provide security and privacy controls to meet all federal and state requirements including both security and confidentiality and HIPAA in the development and operation of the system.					
SPSS.04	Provide online screens for the maintenance of security management.					
SPSS.05	Maintain audit and control records of all system and database access transactions and the security model capable of preventing unauthorized use, providing appropriate security reports and alerts.					
SPSS.06	Allow authorized users access to all user history activity including logon approvals and disapprovals.					

SL	Software Licenses and Maintenance Requirements – MMIS and POS	A	B	C	D	E
SLSS.01	The contractor must list all proprietary and COTS software, as defined by State Medicaid Manual (SMM), Part 11, in attachment G.					
SLSS.02	IME's prior approval is required before upgrades, new releases and or version updates are made to all software within the system.					
SLSS.03	Prior approved upgrades, new releases and or version					

SL	Software Licenses and Maintenance Requirements – MMIS and POS	A	B	C	D	E
	updates for contractor-owned software, must be furnished to IME at no additional cost, including modifications and enhancements to the contractors proprietary versions and core product used in Other states.					
SLSS.04	Transfer of all software that supports the system.					
SLSS.05	Comply with the contractual obligations by obtaining a state License Agreement (see Attachment A to the Services Contract) granting in perpetuity to the state appropriate license to any of its proprietary products proposed as modules of the system solution or proprietary tools that are not commercially available required to maintain the system. Continued support of these proprietary products upon expiration of the contract will be provided under separate maintenance and support agreements. (See Attachment B to the Services Contract).					
SLSS.06	The contractor will be responsible for operation of the system through CMS certification and life of the contract.					

DQ	Data Quality Control Requirements – MMIS and POS	A	B	C	D	E
DQSS.01	The contractor must apply industry standards for professional principles of data management, data security, data integrity and data quality control.					
DQSS.02	A modern relational database management system must be used.					
DQSS.03	All tables must be properly normalized, de-normalized or dimensionalized for efficient operation.					
DQSS.04	Relations between tables within databases must be properly set and controlled.					
DQSS.05	Database integrity features (such as primary keys, foreign keys, unique constraints) must be used to enforce field and relationship requirements.					
DQSS.06	Control must be in place to prevent duplicate or orphan records.					
DQSS.07	Transactions must provide for error recovery (i.e., if the entire transaction does not process completely, the entire transaction is rolled back).					
DQSS.08	Communication routine must use integrity checks to assure accuracy of a file before it is processed.					
DQSS.09	HIPAA transaction processing must be tested and validated according to guidelines developed by the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) (Note: Implementation Guides are now referred to as Technical Reports Type 3 (TR3s) by ANSI X12.					

DQ	Data Quality Control Requirements – MMIS and POS	A	B	C	D	E
DQSS.10	Provide automated programming routines for standardization of street addresses, zip code validation, derivation of geo codes from addresses, derivation of legislative districts from addresses and Tax ID Number validation for providers.					

EV	Environment Requirements – MMIS and POS	A	B	C	D	E
EVSS.01	In addition to production environments, the contractor must provide additional isolated environments. These additional environments, along with test data and appropriate copies of the logic modules that make up the systems, must be established during the Development task of the DDI Phase and maintained during the Operations Phase. Version control procedures and update schedules must be used to facilitate testing, track discrepancies and facilitate regression test analysis. The contractor must provide the IME with isolated environments, described below, to conduct independent integrated testing.					
EVSS.02	The unit and system testing may be done in the contractor's development environment. Establishment of these environments is to be identified as milestones in the applicable work plan, to be approved by the Department.					
EVSS.03	User Acceptance Test (UAT) – The contractor will provide a UAT environment to be a mirror image of the production environment, including reports and financial records, which allow users to perform system testing to ensure the system meets the requirements and for the user community. Users must be able to mimic production work to ensure the system performs as expected. UAT will include scenarios that test all modules and interfaces. The contractor will provide a method to refresh the UAT environment with a full set of data from the production system, at the IME's request.					
EVSS.04	The training environment must be a mirror image of the production environment, including reports and financial records, which provide functionality necessary to allow the IME to provide hands-on knowledge transfer for users in all aspects of the MMIS operation. This environment will allow the IME to maintain unique data for use in knowledge transfer and to conduct knowledge transfer without impacting other test and production environments. The contractor will provide a method to refresh the UAT environment with a full or partial set of data from the production system, at the IME's request. Additionally, the contractor will provide a method to clone a set of					

EV	Environment Requirements – MMIS and POS	A	B	C	D	E
	records from the production environment into the Knowledge transfer Environment, so that knowledge transfer can be delivered to 20 trainees using the same data scenario. This process should be able to run at the IME's request.					
EVSS.05	Conversion Testing Environment is a mirror image of the future production environment, including reports and financial records, which will be used to load converted data resulting from the data migration process that allows business users to test the future business logic against converted data. Additionally, the contractor will perform Automated Functional Testing in this environment against the converted data (i.e., once the converted data is loaded and passes initial verification and validation, the contractor will perform a series of tests to validate that the new system produces identical (or expected results). After CMS has certified the systems for enhanced funding this environment is no longer needed.					
EVSS.06	Business Scenario Test Environment: The ITF environment must be a mirror image and replicate the full functionality of the production environment, including reports and financial records. This environment will also allow the business user, after onset of operations, to perform "what if" testing to assess the impact of a proposed business rules change resulting from policy and legislation changes. The contractor will provide a method to refresh the integrated testing facility (ITF) environment with a full set of data and rules from the production system on a schedule approved by the IME. Provide the ability to estimate what changes would need to take place in benefit plans (service limitations, aggregate dollar ceilings, provider payment rates or other combinations) to control State Medicaid expenditures to a specified growth rate from one state fiscal year to the next.					
EVSS.07	Trading Partner Testing Environment: The environment will provide an environment for testing transactions for HIPAA syntax correctness 24/7. This environment must be capable of providing response to trading partners describing the results of the format validation. Must retain an audit trail for diagnosis of results.					
EVSS.08	All non-production environments must: a. Have the capability to de-identify member data. b. Test for EDI syntax integrity. c. Include a complete online MMIS test system, including a test version of all batch and online programs and files to be used for testing releases and non-release changes. d. Provide the ability to execute impact analysis					

EV	Environment Requirements – MMIS and POS	A	B	C	D	E
	testing of any proposed change. e. Provide the ability to maintain regression test cases using an automated testing tool approved by IME to support regression testing. f. Provide the ability to save and reuse test cases without the need to re-enter the data. g. Allow testing of separate business areas concurrently and allow concurrent use of any environment by the IME, contractor and IV&V and QA Services staff. h. Provide for testing of all CMR before implementation. Allow users to create and edit provider, member and health plan records for testing.					
EVSS.09	Provide an automated configuration management process to control the promotion of rules changes and any associated application programming code changes, COTS software releases system parameter changes and data structure changes from a proposed or development version to a test version to a production version status while retaining automated audit history of the changes.					
EVSS.10	Provide an automated means to revert the test environment to all the rules in effect at any previous point in history (of rules engine control) for use in situations to either change the production system back to an earlier version or for use in establishing an isolated environment for an audit or problem diagnosis needing to re-create a previous version of the production environment.					
EVSS.11	Provide a repository of non-technical project artifacts, including requirements, use cases, storyboards, supplemental specifications, test cases and test scripts, which is regularly maintained. This repository will allow users to view and modify an artifact, as needed, to support requirements gathering or testing. This repository must have search capability and all of the requirements should be cross-referenced to maintain the requirements traceability throughout all artifacts.					

7.1.4 MMIS Infrastructure Requirements

MMIS Infrastructure Requirements

This business area includes the infrastructure requirements for the MMIS

WP	Web Portal Requirements – MMIS	A	B	C	D	E
WPSS1.01	Provide a web portal that is browser-independent and that will operate for most functions, regardless of browser brand, as long as the browser has broad usage (at least 500,000 users nationally at one time)					

WP	Web Portal Requirements – MMIS	A	B	C	D	E
	and the version is recent in publication (within the last four years). Web-based claims submission, correction and void and replace may require use of the state-standard version of Internet Explorer™.					
WPSS1.02	The web portal and other system modules, as required by IME, must be available 24 hours per day, 7 days per week (24/7) except for IME approved maintenance time.					
WPSS1.03	Provide the capability to accept all claim types, corrections and voids and replacement claims through direct data entry on the web portal.					
WPSS1.04	Provide the capability to link the web portal to any other applications, as defined by IME.					
WPSS1.05	Provide smart links on the web portal for IME, provider and member users that provide navigation to tasks that need to be completed by that specific customer.					
WPSS1.06	Allow IME to identify items for monitoring. Items may be automated operations on the web portal or manual actions.					
WPSS1.07	Provide a web portal navigation that all users can easily understand. The portal must be secure, but not complicated to use and not require multiple sign-in steps.					
WPSS1.08	Allow providers, members, trading partners, IME and IME's designees to register online for access to the secure areas of the portal based on security rules defined by IME.					
WPSS1.09	Provide a user interface that complies with recognized usability standards (e.g., the American Disabilities Act, Older Americans Act, The Rehabilitation Act Section 508 Subpart B Section 1194.21).					
WPSS1.10	Provide the capability for an online tutorial functionality.					
WPSS1.11	Provide capability for web portal information to be searchable by keywords.					
WPSS1.12	Provide contractor or IME staff contact information and offer interactive online support. This will allow the contractor or IME staff the capability to respond to online provider questions.					
WPSS1.13	Allow for easy navigation between screens through help menus. Instructions must be provided to point the web portal users to the appropriate area of inquiry or handbook containing the desired information.					
WPSS1.14	Comply with IME usability and content standards (i.e., style guide) and provide a layout that has user-configurable resolution, fonts and color choices.					
WPSS1.15	Provide and display web content in multiple languages as directed by IME.					
WPSS1.16	Provide basic general information about the Medicaid Program that would be of interest to potential providers and members and other collaborating agencies.					
WPSS1.17	Provide the capability to provide HIPAA response transactions via the web portal.					
WPSS1.18	Provide audit trail and history of all transactions conducted on the web portal.					

WP	Web Portal Requirements – MMIS	A	B	C	D	E
WPSS1.19	Provide ability for general public to report suspected fraud and abuse via web portal.					
WPSS1.20	Provide a privacy policy page that allows Medicaid members who wish to submit complaints regarding the misuse of their private health care and Medicaid identification information.					
WPSS1.21	Provide the ability to post announcements and alerts (general and member and or provider specific) that are displayed at user sign-on. Users should be required to acknowledge the announcement, so that it is not repeatedly displayed at subsequent sign-on.					
WPSS1.22	Maintain archives of posted announcements and non-provider specific alerts, including the date and Message.					
WPSS1.23	Maintain HIPAA compliance and support the access, privacy and security requirements.					
WPSS1.24	Provide multiple level role-based securities as designated by IME.					
WPSS1.25	Provide low bandwidth versions of IME-specified pages for easy access by providers with mobile, wireless web access.					
WPSS1.26	Post Frequently Asked Questions (FAQs) online organized by topic or key word search and update periodically as determined by IME.					
WPSS1.27	Automatically log off users after a set amount of time expires as defined by IME. A warning Message must be displayed prior to session timeout.					
WPSS1.28	Provide the capability to 'blast' alerts and or communication to the provider community via email address to include selection criteria by provider type, status, location.					
WPSS1.29	Provide the functionality to display informational Messages in descending date order (most recent to oldest).					
WPSS1.30	Allow users to view and print provider manuals, instructions, bulletins, program descriptions, eligibility criteria and forms for current and prior versions as directed by IME.					
WPSS1.31	Provide interactive functionality to allow members to do the following, but not limited to: a. Search for providers. b. Benefit plan inquiry. c. Eligibility inquiry (current and history). d. Explanation of benefits. e. Select primary care providers for managed care.					
WPSS1.32	Provide capability to allow members to request replacement ID cards.					
WPSS1.33	Support the ability to receive and respond to secure messaging and HIPAA compliant transactions from providers.					
WPSS1.34	Provide the ability to upload remote documents used by LTC providers' caseworker, such as, but not limited to, the Pre-Admission Screening Application (prior					

WP	Web Portal Requirements – MMIS	A	B	C	D	E
	authorizations).					
WPSS1.35	Allow a Medicaid provider to enroll by any of the following methods: a. Electronically on the web portal. b. By downloading printable application forms from the web portal.					
WPSS1.36	Support ability to utilize electronic and/or digital signatures in compliance with IME, state and federal policies.					
WPSS1.37	Provide a trigger mechanism to identify web applications for which required paper documents have not been received and auto-generate a resolution letter to the applicant.					
WPSS1.38	Log, track and transmit supporting documentation entered into the web portal to the provider module of the MMIS or other modules such as prior authorization, as needed or directed by IME.					
WPSS1.39	Allow an administrative user account within the provider practice that can then activate, deactivate and assign varying levels of access to additional practice staff.					
WPSS1.40	Provide web functionality to allow providers to verify their current information and update as needed.					
WPSS1.41	Allow a provider to check the status of their Medicaid provider enrollment application, regardless of the method used to submit the application.					
WPSS1.42	Provide for the easy creation of surveys, by IME or contractor staff, on the web portal, in format or style to be determined by IME.					
WPSS1.43	Provide for ease of deployment of surveys and acceptance of responses as authorized by IME: a. Allow for email responses. b. Provide secure “Once-only” responses. c. Provide security for the survey and responses.					
WPSS1.44	Provide survey results and feedback to IME: a. Tabulate the results of each survey and present the results in chart or graph format. b. Provide access to response data as a file that may be imported to Excel or other applications. c. Allow for responses to be viewed using pie charts, bar graphs and tabular reports. d. Support reporting features that will allow for response data to be tabulated by total number of completed surveys and number completed by county, district or other parameters in the survey.					
WPSS1.45	Provide authorized users web access to forms for direct data entry as directed by IME – some examples are: a. Change of address form for members. b. Change of address form for providers. c. Provider enrollment application. d. Email correspondence. e. Claims submission – all claim types.					

WP	Web Portal Requirements – MMIS	A	B	C	D	E
	f. Prior authorization, prior authorization addendums, prior authorization updates. g. TPL entry or update. h. Fraud and abuse reporting. i. Discharge and disenrollment information. j. Hospital and therapeutic leave bed hold days. k. Fraud and abuse reporting. l. Complaints.					
WPSS1.46	Provide authorized users access to retrieve information, documents and files on the web portal as directed by IME. Examples include, but are not limited to: a. Eligibility verification. b. Claims status. c. Claims history. d. Payment status. e. Program announcements. f. Bulletin and notices. g. Knowledge transfer schedules. h. Provider network information. i. Discharge and disenrollment information. j. Prior authorization status.					
WPSS1.47	Provide and support a transaction module of the portal that allows, at minimum: a. Authorized trading partners to submit EDI files for immediate processing and retrieval of the corresponding response acknowledgement. b. Authorized trading partners to retrieve RAs and claims histories. c. Providers to initiate enrollment using an online application process. d. Providers and other entities to enroll as EDI trading partners using an online application process. e. Providers to view claim status information, payment history, member eligibility and benefit information. f. Providers to submit requests for prior authorization, addendums or updates to prior authorization, as well as updates to member insurance coverage and view existing prior authorization information by prior authorization number, provider number or member Medicaid ID. g. Provider access to interactive fee schedule functionality to allow providers to look-up procedure rates. h. Provider access to a complete fee schedule that is downloadable in Excel or PDF format.					
WPSS1.48	Provide capability to accept electronic claims and attachments, including direct data entry in real –time or uploaded batches of claims, via the web portal.					
WPSS1.49	Process direct data entry claims real-time via the web portal and reject claims that fail front-end edits.					

WP	Web Portal Requirements – MMIS	A	B	C	D	E
WPSS1.50	Include EPSDT information on the web portal and allow members to submit EPSDT questions: a. Provide program awareness and general information. b. Provide copies of all notices. Route questions by email according to the workflow rules approved by IME.					
WPSS1.51	Allow providers to submit member insurance coverage information via the web and attach to the correct member record.					
WPSS1.52	Enable the web portal to accurately display TPL information, including carrier information, providers and other authorized users.					
WPSS1.53	Allow authorized providers to directly data enter and submit prior authorization requests, prior authorization addendums and updates to prior authorizations on the web portal.					
WPSS1.54	The prior authorization request function must support all requests as required by IME (e.g.,) and must accept all necessary codes (e.g., revenue codes for outpatient visits), as directed by IME.					
WPSS1.55	Notify initiator of prior authorization decision immediately when appropriate or by another method if decision is delayed.					
WPSS1.56	Provide the ability for authorized entities (e.g., case managers) to do online prior authorization, prior authorization addendums and updates to prior authorizations through the web portal.					
WPSS1.57	Support receipt and storage of attachments (e.g., medical records, radiographs and digital orthodontic files) submitted in support of the prior authorization request, including addendums and updates to prior authorizations.					
WPSS1.58	Provide a place for providers to enter whether they are accepting new Medicaid patients, whether they are accepting Medicare patients and other designations as directed by IME.					
WPSS1.59	Provide provider specific online report retrieval capabilities including printing of the provider's 1099.					
WPSS1.60	Process and maintain inputs including, but not limited to: a. Updates to content. b. Alert information.					
WPSS1.61	Provide an authentication routine to allow active and inactive providers the ability to change their provider record through direct data entry via the web portal based on selected criteria approved by IME.					
WPSS1.62	Provide support for online registration for provider knowledge transfer seminars.					
WPSS1.63	The web portal must be interactive and allow authorized providers to direct data enter and submit the prior authorization requests to the MMIS. The web portal must support receipt and storage of attachments (e.g., medical records) submitted in support of the prior					

WP	Web Portal Requirements – MMIS	A	B	C	D	E
	authorization request.					
WPSS1.64	Provide the capability for providers to check the status of their prior authorization request(s) online via the web portal, using prior authorization ID or member ID.					
WPSS1.65	The web portal should have the following functionality: a. View explanation of benefits. b. View eligibility coverage. c. Submit address or contact information update, i.e., address, phone, e-mail. d. Provide audit trail of who has seen PHI. e. EPSDT, Disease management and other health care alerts for health maintenance. f. Information regarding electronic health records and HIE. g. Lock-in. h. Prior authorization approvals, including HCBS and LTC services. i. Select medical home and PCCM. j. View PDL. k. Find a provider. l. Secure messaging to IME member services. m. Enrollment. n. Re-enrollment. o. Enter presumptive eligibility. p. HCBS incident reporting. q. Show electronic remittance advices. r. Provider knowledge transfer registration. s. Application for electronic health records incentive payments. t. Upload documents i.e., supporting documents for applications, LOC, including the original assessment and the member's signature. u. Claims submission. v. View of prior authorizations (including services authorized for home and community based services). w. On boarding and testing for EDI. x. Search of provider communications. y. Secure ME.SSaging to IME staff. z. Eligibility verification. aa. Claims status verification. bb. Submission of prior authorization requests. cc. Provider surveys. dd. Security must be role based with distributed security management so providers can manage access for their staff, i.e., password resets.					
WPSS1.66	Provide workflow and attestation for meaningful use of electronic health records.					
WPSS1.67	Provide the ability to send text Messages to member cell phones specific to e-health reminders, i.e., prenatal reminders, well child check up alerts, disease management reminders.					
WPSS1.68	Provide search capability based on wild cards or any					

WP	Web Portal Requirements – MMIS	A	B	C	D	E
	combination of fields. For web portals, provide site-wide search capabilities for all documents within the web portal.					
WPSS1.69	Allow providers to identify members who enroll in their health home. Part of the enrollment should include the health risk scoring.					

WM	Workflow Requirements - MMIS	A	B	C	D	E
WMSS.01	Provide capability to accept an electronic document real time from an external system and make the document available to that external system real time.					
WMSS.02	Provide the ability to split or modify electronic documents for the purpose of indexing while maintaining the original document.					
WMSS.03	Ensure that authorized workflow participants have direct access to perform all their designated roles within the workflow.					
WMSS.04	Provide capability to document a narrative of every provider and member telephone contact and to index the narrative to both provider and member identifier as appropriate.					
WMSS.05	Document and maintain definition and modeling of workflow processes and their constituent activities.					
WMSS.06	Provide configurable work distribution rules, using configuration tables.					
WMSS.07	Include a user-friendly graphical user interface GUI for process definition, execution, monitoring and management.					
WMSS.08	Accept documents through various input methods, including, but not limited to: a. Web Portal. b. E-mail. c. FAX. d. Internal creation from Personal Computers (PCs). e. Imaging. f. System generated. g. Mailroom. h. Web service.					
WMSS.09	Support a role-based interface for process definition that leads the user through the steps of defining the workflow associated with a business process, including processes that are managed by IME staff only; and that captures all the information needed by the workflow engine, to execute that process to include, but not be limited to: a. Start and completion conditions. b. Activities and rules for navigation between processes. c. Tasks to be undertaken by IME staff involved in the process.					

WM	Workflow Requirements - MMIS	A	B	C	D	E
	d. Authorized approvers, including capture of the identity of the approver. e. References to applications which may need to be invoked. f. Definition of other workflow-relevant data. g. An audit trail of the history of changes that have been made to the workflow definition over time so that the workflow definition for any previous point in time can be determined.					
WMSS.10	Provide integrated online workflow management capability to track all Iowa Medicaid Enterprise activities.					
WMSS.11	Store data in a central repository.					
WMSS.12	Include a high-speed imaging solution capable of imaging documents and automatically routing documents.					
WMSS.13	Capable of simplex and duplex scanning on a user-defined basis, by document type.					
WMSS.14	Support advanced Optical Character Recognition (OCR), Intelligent Character Recognition (ICR) and Optical Mark Recognition (OMR) capabilities of 90% accuracy rate or higher and the ability to regulate the error percentage between 90 and 100 percent by document type.					
WMSS.15	The scanning software must be programmable to accommodate user-defined field edits, such as the exclusion or inclusion of special characters (e.g., exclusion of the decimal point in diagnosis codes, inclusion of decimal point in currency).					
WMSS.16	The scanning software must have virtual rescan capabilities that will auto correct a skewed document within 20 degrees and automatically adjust document resolution at a minimum of 300 dpi.					
WMSS.17	Provide the capability to convert data contained in images into MMIS data through OCR.					
WMSS.18	Provide the capability to automatically orient forms to landscape or portrait presentation.					
WMSS.19	Provide the ability to access the database to extract data to pre-populate index fields and or values on forms (e.g., the system would capture the provider identifier and then, using that number, extract the provider's name, address and other information from the provider database).					
WMSS.20	Track the status of all activities from receipt through final disposition.					
WMSS.21	Provide the ability to send and receive faxed and secure encrypted e-form documents, process the data and image directly into and out of the system including the ability to automatically send confirmation of transmission to the sender.					
WMSS.22	Link scanned images to workflow records to provide a view of all related material (e.g., images, letters, interactions and tracking number).					
WMSS.23	Provide the ability to differentiate between forms and					

WM	Workflow Requirements - MMIS	A	B	C	D	E
	attachments and allow the attachment to be grouped with the form to create a single document with individually numbered pages.					
WMSS.24	At a minimum, log the following statistics with regard to the character correction process: a. Raw recognition rate. b. Characters questioned. c. Characters corrected. d. Beginning operator time. e. Ending operator time. f. Operator ID.					
WMSS.25	Provide the ability to access stored, system-generated member and provider notices, through the use of an index.					
WMSS.26	Contain a collaborative document management environment that will allow electronic files (e.g., Word documents, Excel spreadsheets) to be shared, collaborated upon, electronically signed, managed and controlled (such as informational letters or other items).					
WMSS.27	Provide for generation of an indicator to identify to whom the work should be distributed.					
WMSS.28	Provide the ability to determine if a designated field on a specific form contains required data (i.e., field is not left blank).					
WMSS.29	Provide the ability to recognize and automatically delete blank pages without storing them in the system.					
WMSS.30	Send data from scanned, imaged and released documents to the MMIS in real-time.					
WMSS.31	Provide the real time viewing of imaged documents and all pages within the document, by using a paging function.					
WMSS.32	Provide the ability to assign unique document identification numbers, determined by the user, with the ability to prompt the user when a duplicate document identification number is assigned; allowing the user to decide whether to use the previously assigned document identification number or assign a new number.					
WMSS.33	Provide the capability of linking resubmitted paper claims or supporting documentation to original scanned (pending) claim, including the ability to recognize a duplicate claim; and generate a notice to the defined user that an identical claim has been previously processed.					
WMSS.34	Provide the ability to auto set field characters to upper case, lower case or ignore case as defined by the user.					
WMSS.35	Provide the capability of recording user identification or user sign-on and workstation identification, to each document processed, accessed or updated on the system.					
WMSS.36	Provide the capability to attach notes, annotations, emails and other documents, to an original scanned					

WM	Workflow Requirements - MMIS	A	B	C	D	E
	document at any time, without rescanning, by direct system access (users) and end users.					
WMSS.37	Provide the capability to automatically schedule and distribute work by type of work and individual staff members or other algorithms defined by IME.					
WMSS.38	Provide for online retrieval and access to documents and files at a minimum of 10 years rolling. Certain documents will be retained online forever (i.e., lifetime procedures, mental health services as defined by IME).					
WMSS.39	Maintain image retrieval response times at an average of fifteen seconds.					
WMSS.40	Provide the capability to reject items in the system for incompleteness during upfront processing and generate a letter with address insertion and a hard copy of the image for mailing to the submitter. This function must be capable of maintaining data to generate ad hoc reports with statistical information, such as how many claims are returned to a specific address or within a user specified time period.					
WMSS.41	Provide the capability to scan radiographs and diagnostic images.					
WMSS.42	Provide the ability to recognize and read bar coded information for the purpose of extracting data from a barcode to pre-populate index values and update tracking database as determined by IME.					
WMSS.43	Allow the user to manually remove, rescan and replace a scanned image or document(s) from a previously scanned group of documents.					
WMSS.44	Provide the capability to group documents together during scanning, based on document type or a predefined number of documents set by the user.					
WMSS.45	Provide automated queues to access and distribute work to staff with the ability for authorized supervisors to override the automatic distribution and distribute work manually.					
WMSS.46	Index fields on forms must be user-definable and recognize numeric, alphanumeric, date, currency and special characters as designated by IME.					
WMSS.47	Provide the ability to validate data captured from specific fields on forms electronically read by industry standards, ICR, OMR and OCR.					
WMSS.48	Ability to process claims attachments. The system needs to be able to link the attachment to the claim and allow the attachment to be viewed online.					
WMSS.49	Provide the capability to date-stamp all activity in the record and to identify the person who performed the activity.					
WMSS.50	Provide ability to utilize user-defined templates that support various workflow processes.					
WMSS.51	Provide capability to set user-defined system and personal alerts, such as ticklers and reminders. Functionality must be user configurable and allow the user to easily add additional types of alerts, without					

WM	Workflow Requirements - MMIS	A	B	C	D	E
	requiring technical assistance. Functionality should include: a. Ability to generate alerts that assist in monitoring time-sensitive activities (i.e., completion of reports, interface execution, business process completion such as auto assignment). b. Ability to generate alerts due to changes in policy, system functionality, status and the generation/distribution/return of correspondence. c. Ability to generate alerts based on the characteristics of providers, members, claims, case types and other entities or processes.					
WMSS.52	Provide the capability to attach notes to documents and workflow responses, to include, but not be limited to: a. Date and time stamp note created. b. Identity of user entering the note. c. Unlimited note entry space. d. Type or category assignment to notes. e. Security access to notes by authorized users.					
WMSS.53	Provide the capability to assign and re-assign records to an area, unit or individual.					
WMSS.54	Integrate with imaging and data entry solution and provide the user links to view images pertaining to the desired workflow tasks and creation of workflow tasks via the imaging system.					
WMSS.55	Provide the ability to integrate voice and electronic transactions into a single workflow, with integrated queues that allow work blending and load balancing. The system should have capability to produce status reports and processing statistics.					
WMSS.56	Provide the capability to prioritize records within type.					
WMSS.57	Provide the ability to employ logic to edit claim data and suspend a claim(s) for manual review, by routing the claim to a work queue, mailbox and or inbox.					
WMSS.58	Provide the capability to set follow-up dates on records and provide for an automatic tickler capability to notify staff when follow-up is required or timeliness standards on records are about to expire.					
WMSS.59	Support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.					
WMSS.60	Provide workflow management reports to identify inventories of items in each stage of a process, new items and completed items.					
WMSS.61	Provide the ability for a user to view all their workload.					
WMSS.62	Provide the ability for a user to reserve a work item for their exclusive use.					
WMSS.63	Provide the ability for a user to view all their reserved work items.					
WMSS.64	Provide a Workflow Management Module that ensures data security.					

WM	Workflow Requirements - MMIS	A	B	C	D	E
WMSS.65	Provide reports that identify adherence to performance standards for each work flow.					
WMSS.66	Provide supporting supervisory operations for the management of workflow, including, but not limited to: a. Assignments and re-assignments and priorities. b. Status querying and monitoring of individual documents and other work steps or products. c. Work allocation and load balancing. d. Approval for work assignments and work deliverables via a tiered approach. e. Ability to take necessary action or provide notification when corrective action is needed, including the ability to modify or abort a workflow process. f. Monitoring of key information regarding a process in execution, including, but not limited to: 1. Estimated time to completion. 2. Staff assigned to various process activities. 3. Any error conditions. g. Overall monitoring of workflow indicators and statistics by sub-process, organization or individual staff members, including, but not limited to: 1. Work in queue by priority. 2. Throughput. 3. Individual and organizational productivity. 4. Current activity by individual staff member.					
WMSS.67	Provide Application Program Interface (API) to support Interface real-time with all modules of the Iowa Medicaid Enterprise.					
WMSS.68	Provide a query capability for the workflow process management system database with appropriate security access.					

ED	Electronic Data Management System Requirements - MMIS	A	B	C	D	E
EDSS.01	Include, at a minimum, the following document management capabilities: a. Retrieve images through the use of any OCR/ICR field search. b. Retrieve by report name. c. Retrieve by report number. d. Retrieve by change management request. e. Retrieve by date. f. Retrieve images by ICN/TCN. g. Retrieve images by provider number.					

ED	Electronic Data Management System Requirements - MMIS	A	B	C	D	E
	h. Retrieve images by member ID number.					
EDSS.02	Provide the capability to store electronic and imaged paper documents and systems generated reports and make them available online through a single user interface, to promote a total view of current and historical information.					
EDSS.03	Support drag-and-drop functionality to be used when creating or editing a document.					
EDSS.04	Provide the ability to print or fax one or more selected images from image search.					
EDSS.05	Include at a minimum the following document management capabilities: a. Concurrent retrieval functions to publications and other stored documents. b. Automated inventory control for all forms, letters, publications and other IME-designated documents. c. Storage of documents and files. d. Ability to generate documents in both hard copy and electronic format, including forms and letters.					
EDSS.06	Provide conversion of all documents to a format as defined by IME.					
EDSS.07	Support cataloging and indexing of all imaged documents.					
EDSS.08	Include, at a minimum, the following scanning management capabilities: a. Scan both single and double sided documents. b. Scan complete or scraped documents. c. Scan color, black and white and grayscale images. d. Support special characters. e. Support a wide range of compression methods.					
EDSS.09	Provide the capability to manipulate images, to include: a. Rotation. b. Inversion. c. Zoom. d. Brightness and contrast. e. Crop, cut and copy a portion of the image.					
EDSS.10	Allow manual data entry from scanned documents if they cannot be read and transmit electronically from an image to IME Enterprise.					

ED	Automatic Letter Generation Requirements - MMIS	A	B	C	D	E
EDSS.11	Provide the capability to create letter templates and forms, including, but not limited to:					

ED	Automatic Letter Generation Requirements - MMIS	A	B	C	D	E
	a. Provider certification materials. b. Provider recertification letters. c. General correspondence and notices for providers and members. d. Financial letters. e. COB letters. f. Service authorization letters. g. Service denials. h. Premium notices as required by IME. i. Special payments. j. Notice of Decision letters. k. Return to provider letters.					
EDSS.12	Allow for specific information on the letter templates, such as: a. Name and address. b. Date. c. Salutation. d. Free form text block. e. Signature block. f. Electronic signature capability. g. Revision date. h. Phone number. i. Department letterhead.					
EDSS.13	Store letter templates and forms within the system, with the following attributes assigned to each letter template, including, at a minimum: a. Letter template and form name. b. IME letter template and form number. c. Letter template and form unit owner (e.g., provider services). d. Contact position and location for updates. e. Last revision date (archived letter and form must be available). f. Letterhead type used (not applicable to forms). g. Whether IME administrator signature is contained on the letter template (not applicable to forms). h. Whether the letter requires a hand-written signature. i. Canned language and standardized paragraphs. j. Allow for multiple versions of the template including a revision log.					
EDSS.14	Provide a method of automatically generating letters to providers, members and other stakeholders. The automated letter generator must: a. Provide the functionality to send letters by mail, email or fax including mass emails. b. Provide the ability to trigger letters automatically based on processing such as provider enrollment. c. Initiate system-generated letters to members and providers based on status in the workflow					

ED	Automatic Letter Generation Requirements - MMIS	A	B	C	D	E
	management queue (e.g., the system would generate second notices to providers who have not returned the required documentation). d. Allow user to generate a single letter immediately. e. Allow user to designate address to be used. f. Support the generation of letters for mass mailings. g. Allow users to insert unlimited free form text. h. Allow imposition of security rules to control who may issue each kind of letter and to designate and enforce a chain of review for certain letters.					
EDSS.15	Allow for the retrieval and reproduction of all generated letters, including the address to which the letter was sent and the date the original letter was generated.					
EDSS.16	Provide the ability to link a letter image to its appropriate data element (i.e., member, provider, claim, other).					
EDSS.17	Provide the ability to print letter templates to networked, individual or high volume centralized production printers.					
EDSS.18	Provide the capability to print letters on an IME-approved schedule for direct mailing or route letters to a user for a signature before mailing.					

7.1.5 **Current** MMIS External Interfaces

Current **MMIS External Interfaces**

Indicated below is a list of current external interfaces as **April 29, 2011** that the **current** Core MMIS contractor is required to maintain. This list does not include interfaces with other IME contractor applications or external interfaces which the Core MMIS contractor is also required to implement. The new CORE MMIS contractor will be required to identify and validate all interfaces and determine which interfaces will continue to be applicable as well as identify new interfaces. All interfaces are located in the IME Resource Library at: *http://www.ime.state.ia.us/IMEResourceLibrary.html* and should be reviewed by the bidder for any updates.

External Interfaces

(Does not Include Interfaces with Other IME Contractor applications)

Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
3M						
Out	1.02	3M		DRG Grouper	Tape	
	1.01	3M	CORE MMIS	APC Grouper	Tape	Manual
ACS						
In	37.01	CORE MMIS	ACS	Debit Card Process - Account Maintenance File	TBD	
Out	37.02	ACS	CORE MMIS	Debit Card Process - Account Maintenance Status File	TBD	
	37.03	ACS	CORE MMIS	Debit Card Process - Account Maintenance Summary File	TBD	
	37.04	ACS	CORE MMIS	Debit Card Process - Account Maintenance Reject File	TBD	
	37.05	ACS	CORE MMIS	Debit Card Process - ACH Deposit Summary File	TBD	
Advantis						
In	17.11	HMS	Advantis	Non-Pharmacy Claim Adjustments (Post Launch)		
	17.06	HMS	Advantis	TPL Data Match Update File (Enhancement)		
	4.15	Check Write System	Advantis	Bank Reconciliation File		
Out	17.04	Advantis	HMS	Paid Claims Extract File -Month End	Connect Direct	NDM-CORE MMIS
	4.15	Advantis	Wells Fargo	Bank Reconciliation File		
	17.09	Advantis	HMS	Provider Extract File	Connect Direct	NDM-CORE MMIS
	17.07	Advantis	HMS	Carrier File Extract Data File	Connect Direct	NDM-CORE MMIS
	17.05	Advantis	HMS	Eligibility Master File (also called "Recipient Master File")	Connect Direct	NDM-CORE MMIS

	17.11	Advantis	CORE MMIS	Non-Pharmacy Claim Adjustments (Post Launch)	Connect Direct	NDM-CORE MMIS
	17.06	Advantis	CORE MMIS	TPL Data Match Update File (Enhancement)	Connect Direct	NDM-CORE MMIS
AEA						
In	2.01	CORE MMIS	AEA	Special Education Eligibility -IMS AEA Extract	SFTP	IME SFTP
Out	51.00	AEA	Data Warehouse	Medicaid Recovery A/R	FTP	
Check Write System						
In	4.05	CORE MMIS	Check Write System	Remittance Advice -Flat File	Connect Direct	NDM-CORE MMIS
	4.10	CORE MMIS	Check Write System	Remittance Advice Check Balance Report	Connect Direct	NDM-CORE MMIS
	4.09	CORE MMIS	Check Write System	Remittance Advice Mailing Summary Report	Connect Direct	NDM-CORE MMIS
	4.08	CORE MMIS	Check Write System	Remittance Advice Check Register File	Connect Direct	NDM-CORE MMIS
	4.07	CORE MMIS	Check Write System	Remittance Advice Box Labels File	Connect Direct	NDM-CORE MMIS
	4.06	CORE MMIS	Check Write System	Remittance Advice -Box File	Connect Direct	NDM-CORE MMIS
	4.14	CORE MMIS	Check Write System	Bank Reconciliation File	Connect Direct	NDM-CORE MMIS
	4.13	CORE MMIS	Check Write System	RCF Check Balance Report	Connect Direct	NDM-CORE MMIS
	4.01	CORE MMIS	Check Write System	RCF Letter File	Connect Direct	
	4.11	CORE MMIS	Check Write System	RCF Check Register	Connect Direct	NDM-CORE MMIS
	4.04	CORE MMIS	Check Write System	Remittance Advice -Envelope File	Connect Direct	NDM-CORE MMIS
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
In	4.12	CORE MMIS	Check Write System	RCF Mailing Summary Report	Connect Direct	NDM-CORE MMIS
Out	4.15	Check Write System	Advantis	Bank Reconciliation File		
	4.03	Check Write System	CORE MMIS	Control File	Empty Trigger File	
CMS						
In	6.01	Drug Rebate Management	CMS	64.9R Report Data		
	46.00	Part A&B BuyIn	CMS	Medicare A&B Eligibility - Monthly	Connect Direct	
	7.07	Title XIX Eligibility	CMS	Medicare Enrollment Finder File (EDB)	Connect Direct	
	7.04	Title XIX Eligibility	CMS	Medicare Part D - Prescription Drug	Connect Direct	

	6.07	CORE MMIS	CMS	Other Encounter Data - Quarterly	FTP	IME FTP Server
	6.03	CORE MMISPOS	CMS	Rebate File		
	6.06	CORE MMIS	CMS	Inpatient Encounter Data - Quarterly	FTP	IME FTP Server
Out	7.06	CMS	Title XIX Eligibility	Medicare Enrollment (EDB)	Connect Direct	
	7.05	CMS	Title XIX Eligibility	Medicare Part D - Prescription Drug		
	40.00	CMS	Part A&B Buyin	Medicare A&B Premium Billing - Monthly	Connect Direct	
	6.04	CMS	CORE MMISPOS	Drug Rebate File Update		
	6.02	CMS	Drug Rebate Management	Quarterly Drug Rebate Data		
	6.05	CMS	CORE MMISPOS	Drug Rebate Labeler Update		
County Billing System						
In	8.01	CORE MMIS	County Billing System	Combined County Bill -Accounts Receivable File	Connect Direct	NDM-CORE MMIS
Dakota Imaging System						
Out	9.01	Dakota Imaging System	CORE MMIS	Claim Data Upload	FTP	IME DI
	9.02	Dakota Imaging System	OnBase	Image Transfer		
Data Warehouse						
In	57.00	HCBS	Data Warehouse	Medicaid Recovery A/R	FTP	
	58.00	IDPH	Data Warehouse	Date of Death File	FTP	
	59.00	Maximus	Data Warehouse	Hawki Daily Decision File	FTP	
	59.01	Maximus	Data Warehouse	Hawki Enrollments	FTP	
	59.03	Maximus	Data Warehouse	Hawki Survey	FTP	
	55.00	Delta Dental	Data Warehouse	Hawki Encounters	FTP	
	50.03	Program Integrity	Data Warehouse	Medicaid Recovery A/R	FTP	
	59.02	Maximus	Data Warehouse	Hawki Perm Data	FTP	
	62.00	Revenue Collections	Data Warehouse	Medicaid Recovery A/R	FTP	
	63.00	United Health Care	Data Warehouse	Hawki Encounters	FTP	
	64.00	Wellmark	Data Warehouse	Hawki Encounters	FTP	
	61.00	PCA	Data Warehouse	Medicaid Recovery A/R	FTP	
	12.03	CORE MMIS	Data Warehouse	Provider Extract	Connect Direct	NDM-CORE MMIS
	60.00	MFCU	Data Warehouse	Medicaid Recovery A/R	FTP	
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
In	53.00	BSCS	Data Warehouse	Medicaid Recovery A/R	FTP	
	12.01	CORE MMIS	Data Warehouse	HMO Encounter Data	FTP	IME FTP
	12.02	CORE MMIS	Data Warehouse	APC Grouper Tapes	Tape	
	12.04	CORE MMIS	Data Warehouse	Prior Approval Extract	Connect Direct	NDM-CORE

MMIS						
	12.05	CORE MMIS	Data Warehouse	CORE MMIS Eligibility Extract	Connect Direct	NDM-CORE
MMIS						
	12.06	CORE MMIS	Data Warehouse	Full Adjudicated Claims Records Info	Connect Direct	NDM-CORE
MMIS						
	20.13	IDPH	Data Warehouse	Vital Statistics (Post Launch)		
	35.03	GHS	Data Warehouse	Medispan	FTP	
	51.00	AEA	Data Warehouse	Medicaid Recovery A/R	FTP	
	52.00	BBA	Data Warehouse	Medicaid Recovery A/R	FTP	
	12.14	CORE MMIS	Data Warehouse	Procedure, Diagnosis & Drug	Connect Direct	NDM-CORE
MMIS						
Out	50.02	Data Warehouse	Program Integrity (Ingenix)	Claims Data	FTP	
	54.00	Data Warehouse	APS	Claims Data	FTP	
	54.03	Data Warehouse	Title XIX Eligibility	Hawki Daily Decision File	FTP	
	54.02	Data Warehouse	Title XIX Eligibility	Date of Death No Match	FTP	
	54.01	Data Warehouse	APS	Provider Data	FTP	
	51.02	Data Warehouse	IFMC	Hawki Survey Data	FTP	
	51.00	Data Warehouse	IFMC	Hawki Encounters	FTP	
	50.01	Data Warehouse	Program Integrity (Ingenix)	Provider Data	FTP	
	51.01	Data Warehouse	IFMC	Hawki Enrollments	FTP	
Drug Rebate Management						
In	11.01	Pharmacy Data Warehouse	Drug Rebate Management	Rebate Claims		
	11.02	Pharmacy Data Warehouse	Drug Rebate Management	Drug Rebate Labeler Data		
	6.02	CMS	Drug Rebate Management	Quarterly Drug Rebate Data		
Out	6.01	Drug Rebate Management	CMS	64.9R Report Data		
HIPP						
In	15.01	CORE MMIS	HIPP	Paid Claims Extract	Connect Direct	NDM-CORE
MMIS						
Out	15.04	HIPP	CORE MMIS	HIPP Resource File	Connect Direct	NDM-CORE
MMIS						
	15.02	HIPP	CORE MMIS	HIPP Claims (MARS Reporting)	Connect Direct	NDM-Other
	15.03	HIPP	CORE MMIS	Title XIX Eligible File for HIPP Cost Effectiveness Process	Connect Direct	NDM-Other
HMO (Coventry)						
Out	16.02	HMO (Coventry)	CORE MMIS	Other Encounter data	N/A	
HMO (Iowa Health Solutions)						
Out	16.04	HMO (Iowa Health Solutions)	CORE MMIS	Other Encounter data	N/A	
	16.03	HMO (Iowa Health Solutions)	CORE MMIS	Inpatient Encounter data	N/A	

HMO (Magellan)

Interface	Visio Ref:	Source:	Destination:	Interface Name:	Type:	Server:
In	33.30	Title XIX Eligibility	HMO (Magellan)	Iowa Plan Eligible (Monthly & Daily)	FTP	IME FTP
Out	16.06	HMO (Magellan)	CORE MMIS	Inpatient Encounter data	SFTP	IME SFTP
	16.07	HMO (Magellan)	CORE MMIS	Other Encounter data	SFTP	IME SFTP

HMS

In		Medicare Buy-in System	HMS	Buy-in A-B Master File	Connect Direct	
		Medicare Buy-in System	HMS	Medicare Premium	Connect Direct	
	20.12	IDPH	HMS	Vital Statistics		
	17.07	Advantis	HMS	Carrier File Extract Data File	Connect Direct	NDM-CORE MMIS
	17.05	Advantis	HMS	Eligibility Master File (also called "Recipient Master File")	Connect Direct	NDM-CORE MMIS
	17.04	Advantis	HMS	Paid Claims Extract File -Month End	Connect Direct	NDM-CORE MMIS
	17.09	Advantis	HMS	Provider Extract File	Connect Direct	NDM-CORE MMIS
		Medicare Buy-in System	HMS	Billing - Monthly File	Connect Direct	
Out	17.06	HMS	Advantis	TPL Data Match Update File (Enhancement)		
	17.10	HMS	Pharmacy POS	Pharmacy Claim Adjustments		
	17.11	HMS	Advantis	Non-Pharmacy Claim Adjustments (Post Launch)		

HMSI (Thru Advantis)

In	17.09	CORE MMIS	HMSI (Thru Advantis)	Provider Extract File	Connect Direct	NDM-CORE MMIS
	17.07	CORE MMIS	HMSI (Thru Advantis)	Carrier File Extract Data	Connect Direct	NDM-CORE MMIS
	17.04	CORE MMIS	HMSI (Thru Advantis)	Paid Claims Extract File -Month End	Connect Direct	NDM-CORE MMIS
	17.05	CORE MMIS	HMSI (Thru Advantis)	Eligibility Master File (also called "Recipient Master File")	Connect Direct	NDM-CORE MMIS

IABC System

In		Title XIX Eligibility	IABC System	Iowa Care Autoclose file	SM	
	18.01	CORE MMIS	IABC System	Medically NeedyTransmission File	Connect Direct	NDM-CORE MMIS
Out	18.06	IABC System	TXIX Eligibility	Facility & Waiver Eligibility	SM	
	18.05	IABC System	Title XIX Eligibility	Member Medical Eligibility -Monthly	SM	
	18.02	IABC System	CORE MMIS	Medically Needy Transmission File	Connect Direct	NDM-Other
	18.03	IABC System	CORE MMIS	Medically Needy Worker File	Connect Direct	NDM-Other

	18.04	IABC System	Title XIX Eligibility	Member Medical Eligibility -Daily	SM	
ICAR						
In	19.01	CORE MMIS	ICAR	Child Support TPL Extract	Connect Direct	NDM-CORE MMIS
Out	19.02	ICAR	CORE MMIS	ICAR TPL Update	Connect Direct	NDM-CORE MMIS
IDPH						
In	20.08	CORE MMIS	IDPH	Claims, Yearly Birth Data	Connect Direct	NDM-CORE MMIS
	20.09	CORE MMIS	IDPH	Encounter, Yearly Birth Data	Connect Direct	NDM-CORE MMIS
	20.05	CORE MMIS	IDPH	EPSDT Claims Extract	Connect Direct	NDM-CORE MMIS
	20.04	CORE MMIS	IDPH	EPSDT Screening Informing Extract	Connect Direct	NDM-CORE MMIS
	20.03	CORE MMIS	IDPH	EPSDT Informing Extract	Connect Direct	NDM-CORE MMIS
	20.02	Title XIX Eligibility	IDPH	TXIX Child Eligibility-Monthly	SM	
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
Out	20.13	IDPH	Data Warehouse	Vital Statistics (Post Launch)		
	58.00	IDPH	Data Warehouse	Date of Death File	FTP	
	20.12	IDPH	HMS	Vital Statistics		
IMCARS						
Out	22.01	IMCARS	CORE MMIS	Provider Charge Information	FTP	Manual
	22.02	IMCARS	CORE MMIS	Provider DRG & APG Data	FTP	Manual
	22.03	IMCARS	CORE MMIS	Provider, Procedure Type & Procedure Code Charges	FTP	Manual
	22.04	IMCARS	CORE MMIS	DRG Code Weights	FTP	Manual
	22.05	IMCARS	CORE MMIS	APG Code Weights	FTP	Manual
IME Server						
In	36.02	CORE MMIS	IME Server	Provider Address File	FTP	IME FTP
Iowa SQL Data Base(Myers &Stauffer)						
In	23.04	CORE MMIS	Iowa SQL Data Base(Myers	Provider Extract	FTP	IME FTP COLD
	23.02	CORE MMIS	Iowa SQL Data Base(Myers	Outpatient Claims Extract	FTP	IME FTP COLD
	23.01	CORE MMIS	Iowa SQL Data Base(Myers	Inpatient Claims Extract	FTP	IME FTP COLD
IRS						

In	24.01	CORE MMIS	IRS	Provider 1099 Tapes	FTP	Web Portal
	24.02	CORE MMIS	IRS	Corrected 1099s	FTP	Web Portal
	24.03	CORE MMIS	IRS	1099 Verification File	FTP	Web Portal

ISIS

In	25.03	Title XIX Eligibility	ISIS	Provider Master File	SM	
	48.04	TXIX Eligibility	ISIS	Facility & Waiver Eligibility	FTP	
	48.05	TXIX Eligibility	ISIS	Nursing Home Terminations	FTP	
Out	44.00	ISIS	TXIX Eligibility	County of Legal Residence	FTP	
	44.04	ISIS	TXIX Eligibility	PACE Eligibility	FTP	
	44.03	ISIS	TXIX Eligibility	Money Follows Person Eligibility	FTP	
	44.01	ISIS	TXIX Eligibility	Enhanced Services	Connect Direct	
	25.02	ISIS	Title XIX Eligibility	Facility Waiver Member Eligibility Chgs	FTP	
	25.01	ISIS	Title XIX Eligibility	Waiver Services Prior Auths	FTP	
	44.02	ISIS	TXIX Eligibility	Member Institution Indicator	FTP	

Mathematica

In	26.01	CORE MMIS	Mathematica	MSIS RX Claims File	FTP	IME FTP Server
	26.02	CORE MMIS	Mathematica	MSIS Inpatient Claims Extract	FTP	IME FTP Server
	26.03	CORE MMIS	Mathematica	MSIS LTC Claims Extract	FTP	IME FTP Server
	26.04	CORE MMIS	Mathematica	MSIS Other Claims Extract	FTP	IME FTP Server
	26.05	CORE MMIS	Mathematica	MSIS Recipient Extract	FTP	IME FTP Server

MEDISPAN

Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
Out	35.02	MEDISPAN	Pharmacy Data Warehouse	MEDISPAN Drug File		
	35.01	MEDISPAN	Pharmacy POS	DTMS Pro-DUR		

Milliman USA

In	28.01	CORE MMIS	Milliman USA	Actuarial Encounter Data	SFTP	IME SFTP

CORE MMIS

In	16.07	HMO (Magellan)	CORE MMIS	Other Encounter data	SFTP	IME SFTP
	30.01	Pharmacy Data Warehouse	CORE MMIS	Drug Reference File	SFTP	IME SFTP
	22.05	IMCARS	CORE MMIS	APG Code Weights	FTP	Manual
	22.04	IMCARS	CORE MMIS	DRG Code Weights	FTP	Manual
	22.03	IMCARS	CORE MMIS	Provider, Procedure Type & Procedure Code Charges	FTP	Manual

	22.02	IMCARS	CORE MMIS	Provider DRG & APG Data	FTP	Manual
	22.01	IMCARS	CORE MMIS	Provider Charge Information	FTP	Manual
	19.02	ICAR	CORE MMIS	ICAR TPL Update	Connect Direct	NDM-CORE MMIS
	18.03	IABC System	CORE MMIS	Medically Needy Worker File	Connect Direct	NDM-Other
	18.02	IABC System	CORE MMIS	Medically Needy Transmission File	Connect Direct	NDM-Other
	1.01	3M	CORE MMIS	APC Grouper	Tape	Manual
	17.11	Advantis	CORE MMIS	Non-Pharmacy Claim Adjustments (Post Launch)	Connect Direct	NDM-CORE MMIS
	16.06	HMO (Magellan)	CORE MMIS	Inpatient Encounter data	SFTP	IME SFTP
	16.04	HMO (Iowa Health Solutions)	CORE MMIS	Other Encounter data	N/A	
	16.03	HMO (Iowa Health Solutions)	CORE MMIS	Inpatient Encounter data	N/A	
	16.02	HMO (Coventry)	CORE MMIS	Other Encounter data	N/A	
	15.04	HIPP	CORE MMIS	HIPP Resource File	Connect Direct	NDM-CORE MMIS
	15.03	HIPP	CORE MMIS	Title XIX Eligible File for HIPP Cost Effectiveness Process	Connect Direct	NDM-Other
	15.02	HIPP	CORE MMIS	HIPP Claims (MARS Reporting)	Connect Direct	NDM-Other
	1.02	3M	CORE MMIS	DRG Grouper	Tape	
	4.03	Check Write System	CORE MMIS	Control File	Empty Trigger File	
	17.06	Advantis	CORE MMIS	TPL Data Match Update File (Enhancement)	Connect Direct	NDM-CORE MMIS
	32.01	Solucient	CORE MMIS	ICD-9-CM File Update	Manual Review	
	30.02	Pharmacy Data Warehouse	CORE MMIS	POS Claims (& Adjustments)	SFTP	IME SFTP
	9.01	Dakota Imaging System	CORE MMIS	Claim Data Upload	FTP	IME DI
	37.02	ACS	CORE MMIS	Debit Card Process - Account Maintenance Status File	TBD	
	37.03	ACS	CORE MMIS	Debit Card Process - Account Maintenance Summary File	TBD	
	37.04	ACS	CORE MMIS	Debit Card Process - Account Maintenance Reject File	TBD	
	37.05	ACS	CORE MMIS	Debit Card Process - ACH Deposit Summary File	TBD	
	39.02	CORE MMIS	CORE MMIS	Member Extract for TMS - NEMT Broker		
Out	34.11	CORE MMIS	University of Iowa	Quarterly Encounter Data	FTP	UOI FTP Server
	34.02	CORE MMIS	University of Iowa	Pharmacy Claims Extract -Public Policy	FTP	UOI FTP Server
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
Out	34.03	CORE MMIS	University of Iowa	Medical Claims Extract -Case Mgmt	FTP	UOI FTP Server
	34.04	CORE MMIS	University of Iowa	Medical Claims Extract, Public Policy	FTP	UOI FTP Server
	34.05	CORE MMIS	University of Iowa	Institutional Claims Extract -Case Mgmt	FTP	UOI FTP

Server						
	34.06	CORE MMIS	University of Iowa	Institutional Claims Extract -Public Policy	FTP	UOI FTP
Server						
	34.10	CORE MMIS	University of Iowa	Quarterly Recipient Eligibility -Public Policy	FTP	UOI FTP
Server						
	34.08	CORE MMIS	University of Iowa	Provider Master File -Public Policy	FTP	UOI FTP
Server						
	31.05	CORE MMIS	RBA	Title XIX Report of Expenditure -Eligibility	Onbase	
	34.07	CORE MMIS	University of Iowa	Provider Master File -Case Mgmt	FTP	UOI FTP
Server						
	34.01	CORE MMIS	University of Iowa	Pharmacy Claims Extract -Case Mgmt	FTP	UOI FTP
Server						
	31.08	CORE MMIS	RBA	ICF/MR Vendor Payment by County	Onbase	
	34.09	CORE MMIS	University of Iowa	Quarterly Recipient Eligibility -TCM	FTP	UOI FTP
Server						
	31.06	CORE MMIS	RBA	Medicaid Summary by County -Medically Needy	Onbase	
	4.12	CORE MMIS	Check Write System	RCF Mailing Summary Report	Connect Direct	NDM-CORE
MMIS						
	31.04	CORE MMIS	RBA	Title XIX Report of Expenditure -Services	Onbase	
	31.30	CORE MMIS	RBA	Elderly Waiver Summary By County	Onbase	
	31.02	CORE MMIS	RBA	Title XIX Monthly Report -YTD	Onbase	
	31.01	CORE MMIS	RBA	Title XIX Monthly Report -Monthly	Onbase	
	31.07	CORE MMIS	RBA	Medicaid Summary by County -Medicaid	Onbase	
	4.06	CORE MMIS	Check Write System	Remittance Advice -Box File	Connect Direct	NDM-CORE
MMIS						
	39	CORE MMIS	TMS-NEMT	TMS-NEMT Broker Files	FTP	IME FTP
	39.02	CORE MMIS	CORE MMIS	Member Extract for TMS - NEMT Broker		
	38.00	CORE MMIS	Wells Fargo	ACH Deposit File	TBD	
	37.01	CORE MMIS	ACS	Debit Card Process - Account Maintenance File	TBD	
	8.01	CORE MMIS	County Billing System	Combined County Bill -Accounts Receivable File	Connect Direct	NDM-CORE
MMIS						
	6.07	CORE MMIS	CMS	Other Encounter Data - Quarterly	FTP	IME FTP
Server						
	6.06	CORE MMIS	CMS	Inpatient Encounter Data - Quarterly	FTP	IME FTP
Server						
	4.09	CORE MMIS	Check Write System	Remittance Advice Mailing Summary Report	Connect Direct	NDM-CORE
MMIS						
	4.10	CORE MMIS	Check Write System	Remittance Advice Check Balance Report	Connect Direct	NDM-CORE
MMIS						
	4.07	CORE MMIS	Check Write System	Remittance Advice Box Labels File	Connect Direct	NDM-CORE

MMIS						
	36.02	CORE MMIS	IME Server	Provider Address File	FTP	IME FTP
	4.05	CORE MMIS	Check Write System	Remittance Advice -Flat File	Connect Direct	NDM-CORE
MMIS						
	4.04	CORE MMIS	Check Write System	Remittance Advice -Envelope File	Connect Direct	NDM-CORE
MMIS						
	4.14	CORE MMIS	Check Write System	Bank Reconciliation File	Connect Direct	NDM-CORE
MMIS						
	4.13	CORE MMIS	Check Write System	RCF Check Balance Report	Connect Direct	NDM-CORE
MMIS						
	29.02	CORE MMIS	OnBase	CORE MMIS Report Files	FTP	IME FTP
COLD						
	4.11	CORE MMIS	Check Write System	RCF Check Register	Connect Direct	NDM-CORE
MMIS						
	30.07	CORE MMIS	Pharmacy Data Warehouse	CORE MMIS Providers File	SFTP	IME SFTP
	4.01	CORE MMIS	Check Write System	RCF Letter File	Connect Direct	
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
Out	4.08	CORE MMIS	Check Write System	Remittance Advice Check Register File	Connect Direct	NDM-CORE
MMIS						
	13.06	CORE MMIS	EDI Clearinghouse	835 Remittance Advice Transaction	FTP	Noridian FTP
	30.03	CORE MMIS	Pharmacy Data Warehouse	Adjustment Claims for Medically Needy	SFTP	IME SFTP
	2.01	CORE MMIS	AEA	Special Education Eligibility -IMS AEA Extract	SFTP	IME SFTP
	19.01	CORE MMIS	ICAR	Child Support TPL Extract	Connect Direct	NDM-CORE
MMIS						
	18.01	CORE MMIS	IABC System	Medically NeedyTransmission File	Connect Direct	NDM-CORE
MMIS						
	17.09	CORE MMIS	HMSI (Thru Advantis)	Provider Extract File	Connect Direct	NDM-CORE
MMIS						
	17.07	CORE MMIS	HMSI (Thru Advantis)	Carrier File Extract Data	Connect Direct	NDM-CORE
MMIS						
	17.05	CORE MMIS	HMSI (Thru Advantis)	Eligibility Master File (also called "Recipient Master File")	Connect Direct	NDM-CORE
MMIS						
	17.04	CORE MMIS	HMSI (Thru Advantis)	Paid Claims Extract File -Month End	Connect Direct	NDM-CORE
MMIS						
	20.04	CORE MMIS	IDPH	EPSDT Screening Informing Extract	Connect Direct	NDM-CORE
MMIS						
	13.07	CORE MMIS	EDI Clearinghouse	820 Payment Processed Transactions	FTP	Noridian FTP
	20.05	CORE MMIS	IDPH	EPSDT Claims Extract	Connect Direct	NDM-CORE
MMIS						
	13.05	CORE MMIS	EDI Clearinghouse	278 Prior Authorization Response Transactions (Future)	TBD	

	12.06	CORE MMIS	Data Warehouse	Full Adjudicated Claims Records Info	Connect Direct	NDM-CORE MMIS
	12.05	CORE MMIS	Data Warehouse	CORE MMIS Eligibility Extract	Connect Direct	NDM-CORE MMIS
	12.04	CORE MMIS	Data Warehouse	Prior Approval Extract	Connect Direct	NDM-CORE MMIS
	12.03	CORE MMIS	Data Warehouse	Provider Extract	Connect Direct	NDM-CORE MMIS
	12.02	CORE MMIS	Data Warehouse	APC Grouper Tapes	Tape	
	12.14	CORE MMIS	Data Warehouse	Procedure, Diagnosis & Drug	Connect Direct	NDM-CORE MMIS
	12.01	CORE MMIS	Data Warehouse	HMO Encounter Data	FTP	IME FTP
	15.01	CORE MMIS	HIPP	Paid Claims Extract	Connect Direct	NDM-CORE MMIS
	26.01	CORE MMIS	Mathematica	MSIS RX Claims File	FTP	IME FTP Server
	30.05	CORE MMIS	Pharmacy Data Warehouse	Pharmacy Claims Paid	SFTP	IME SFTP
	30.04	CORE MMIS	Pharmacy Data Warehouse	Recipient Eligibility	SFTP	IME SFTP
	30.20	CORE MMIS	Pharmacy Data Warehouse	Medical Claims File	FTP	ITE SFTP Server
	29.01	CORE MMIS	OnBase	Workview Data Integration		
	28.01	CORE MMIS	Milliman USA	Actuarial Encounter Data	SFTP	IME SFTP
	26.05	CORE MMIS	Mathematica	MSIS Recipient Extract	FTP	IME FTP Server
	26.04	CORE MMIS	Mathematica	MSIS Other Claims Extract	FTP	IME FTP Server
	20.03	CORE MMIS	IDPH	EPSDT Informing Extract	Connect Direct	NDM-CORE MMIS
	26.02	CORE MMIS	Mathematica	MSIS Inpatient Claims Extract	FTP	IME FTP Server
	30.06	CORE MMIS	Pharmacy Data Warehouse	CORE MMIS NABP/PROV Cross-Reference File	SFTP	IME SFTP
	24.03	CORE MMIS	IRS	1099 Verification File	FTP	Web Portal
	24.02	CORE MMIS	IRS	Corrected 1099s	FTP	Web Portal
	24.01	CORE MMIS	IRS	Provider 1099 Tapes	FTP	Web Portal
	23.04	CORE MMIS	Iowa SQL Data Base(Myers	Provider Extract	FTP	IME FTP COLD
	23.02	CORE MMIS	Iowa SQL Data Base(Myers	Outpatient Claims Extract	FTP	IME FTP COLD
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
Out	23.01	CORE MMIS	Iowa SQL Data Base(Myers	Inpatient Claims Extract	FTP	IME FTP

COLD						
	20.09	CORE MMIS	IDPH	Encounter, Yearly Birth Data	Connect Direct	NDM-CORE
MMIS						
	20.08	CORE MMIS	IDPH	Claims, Yearly Birth Data	Connect Direct	NDM-CORE
MMIS						
	26.03	CORE MMIS	Mathematica	MSIS LTC Claims Extract	FTP	IME FTP
Server						
CORE MMISPOS						
In	6.04	CMS	CORE MMISPOS	Drug Rebate File Update		
	6.05	CMS	CORE MMISPOS	Drug Rebate Labeler Update		
Out	6.03	CORE MMISPOS	CMS	Rebate File		
OnBase						
In	29.01	CORE MMIS	OnBase	Workview Data Integration		
	29.02	CORE MMIS	OnBase	CORE MMIS Report Files	FTP	IME FTP
COLD						
	9.02	Dakota Imaging System	OnBase	Image Transfer		
PADSS						
In	30.08	Pharmacy Data Warehouse	PADSS	Providers File		
	30.09	Pharmacy Data Warehouse	PADSS	Recipient Eligibility		
	30.11	Pharmacy Data Warehouse	PADSS	Drug File		
	30.10	Pharmacy Data Warehouse	PADSS	POS Claims		
Out	30.16	PADSS	Pharmacy POS	Approved PA Requests		
	30.14	PADSS	Pharmacy Data Warehouse	Process Reporting Data		
Pharmacy Data Warehouse						
In	30.20	CORE MMIS	Pharmacy Data Warehouse	Medical Claims File	FTP	ITE SFTP
Server						
	30.05	CORE MMIS	Pharmacy Data Warehouse	Pharmacy Claims Paid	SFTP	IME SFTP
	35.02	MEDISPAN	Pharmacy Data Warehouse	MEDISPAN Drug File		
	30.07	CORE MMIS	Pharmacy Data Warehouse	CORE MMIS Providers File	SFTP	IME SFTP
	30.06	CORE MMIS	Pharmacy Data Warehouse	CORE MMIS NABP/PROV Cross-Reference File	SFTP	IME SFTP
	30.03	CORE MMIS	Pharmacy Data Warehouse	Adjustment Claims for Medically Needy	SFTP	IME SFTP
	30.14	PADSS	Pharmacy Data Warehouse	Process Reporting Data		
	30.12	Pharmacy POS	Pharmacy Data Warehouse	POS Claims		
	30.04	CORE MMIS	Pharmacy Data Warehouse	Recipient Eligibility	SFTP	IME SFTP
Out	30.19	Pharmacy Data Warehouse	Pharmacy POS	Physician Lock-ins		
	11.01	Pharmacy Data Warehouse	Drug Rebate Management	Rebate Claims		
	30.09	Pharmacy Data Warehouse	PADSS	Recipient Eligibility		

	30.08	Pharmacy Data Warehouse	PADSS	Providers File		
	30.24	Pharmacy Data Warehouse	Pharmacy POS	SMAC Rates File		
	30.23	Pharmacy Data Warehouse	Pharmacy POS	Adjustment Claims -MN		
	30.22	Pharmacy Data Warehouse	Pharmacy POS	Pharmacy Lock-Ins		
	30.21	Pharmacy Data Warehouse	Pharmacy POS	Pharmacies File		
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
Out	30.02	Pharmacy Data Warehouse	CORE MMIS	POS Claims (& Adjustments)	SFTP	IME SFTP
	30.18	Pharmacy Data Warehouse	Pharmacy POS	Other Providers (Prescribers) File Results		
	30.17	Pharmacy Data Warehouse	Pharmacy POS	Providers (NABP) Crosswalk File		
	30.15	Pharmacy Data Warehouse	Pharmacy POS	Recipient Eligibility		
	30.13	Pharmacy Data Warehouse	Pharmacy POS	Full Medispan Drug File		
	30.11	Pharmacy Data Warehouse	PADSS	Drug File		
	30.10	Pharmacy Data Warehouse	PADSS	POS Claims		
	11.02	Pharmacy Data Warehouse	Drug Rebate Management	Drug Rebate Labeler Data		
	30.01	Pharmacy Data Warehouse	CORE MMIS	Drug Reference File	SFTP	IME SFTP
Pharmacy POS						
In	30.19	Pharmacy Data Warehouse	Pharmacy POS	Physician Lock-ins		
	30.22	Pharmacy Data Warehouse	Pharmacy POS	Pharmacy Lock-Ins		
	30.23	Pharmacy Data Warehouse	Pharmacy POS	Adjustment Claims -MN		
	35.01	MEDISPAN	Pharmacy POS	DTMS Pro-DUR		
	30.21	Pharmacy Data Warehouse	Pharmacy POS	Pharmacies File		
	30.17	Pharmacy Data Warehouse	Pharmacy POS	Providers (NABP) Crosswalk File		
	30.16	PADSS	Pharmacy POS	Approved PA Requests		
	30.15	Pharmacy Data Warehouse	Pharmacy POS	Recipient Eligibility		
	30.13	Pharmacy Data Warehouse	Pharmacy POS	Full Medispan Drug File		
	17.10	HMS	Pharmacy POS	Pharmacy Claim Adjustments		
	30.24	Pharmacy Data Warehouse	Pharmacy POS	SMAC Rates File		
	30.18	Pharmacy Data Warehouse	Pharmacy POS	Other Providers (Prescribers) File Results		
Out	30.12	Pharmacy POS	Pharmacy Data Warehouse	POS Claims		
RBA						
In	31.02	CORE MMIS	RBA	Title XIX Monthly Report -YTD	Onbase	
	31.08	CORE MMIS	RBA	ICF/MR Vendor Payment by County	Onbase	
	31.07	CORE MMIS	RBA	Medicaid Summary by County -Medicaid	Onbase	
	31.06	CORE MMIS	RBA	Medicaid Summary by County -Medically Needy	Onbase	
	31.05	CORE MMIS	RBA	Title XIX Report of Expenditure -Eligibility	Onbase	
	31.30	CORE MMIS	RBA	Elderly Waiver Summary By County	Onbase	

	31.01	CORE MMIS	RBA	Title XIX Monthly Report -Monthly	Onbase	
	31.04	CORE MMIS	RBA	Title XIX Report of Expenditure -Services	Onbase	

Solucient

Out	32.01	Solucient	CORE MMIS	ICD-9-CM File Update	Manual Review	

Title XIX Eligibility

In	7.05	CMS	Title XIX Eligibility	Medicare Part D - Prescription Drug		
		Medicare Buy-in System	Title XIX Eligibility	Buy-in A-B Transactions	SM	
Interface	*Visio Ref:*	*Source:*	*Destination:*	*Interface Name:*	*Type:*	*Server:*
In	54.02	Data Warehouse	Title XIX Eligibility	Date of Death No Match	FTP	
	7.06	CMS	Title XIX Eligibility	Medicare Enrollment (EDB)	Connect Direct	
	25.02	ISIS	Title XIX Eligibility	Facility Waiver Member Eligibility Chgs	FTP	
	25.01	ISIS	Title XIX Eligibility	Waiver Services Prior Auths	FTP	
	18.05	IABC System	Title XIX Eligibility	Member Medical Eligibility -Monthly	SM	
	18.04	IABC System	Title XIX Eligibility	Member Medical Eligibility -Daily	SM	
	54.03	Data Warehouse	Title XIX Eligibility	Hawki Daily Decision File	FTP	
	7.03	COBC Contractor	Title XIX Eligibility	Medicare Crossover- Response	FTP	
Out	7.07	Title XIX Eligibility	CMS	Medicare Enrollment Finder File (EDB)	Connect Direct	
		Title XIX Eligibility	IABC System	Iowa Care Autoclose file	SM	
	7.04	Title XIX Eligibility	CMS	Medicare Part D - Prescription Drug	Connect Direct	
	7.02	Title XIX Eligibility	COBC Contractor	Medicare Crossover-COBA ELIG	Connect Direct	
	33.30	Title XIX Eligibility	HMO (Magellan)	Iowa Plan Eligible (Monthly & Daily)	FTP	IME FTP
	33.29	Title XIX Eligibility	Magellan	Iowa Plan Eligible-Daily	FTP	
	25.03	Title XIX Eligibility	ISIS	Provider Master File	SM	
	20.02	Title XIX Eligibility	IDPH	TXIX Child Eligibility-Monthly	SM	
	33.32	Title XIX Eligibility	Maximus	TXIX Elig & Referral daily - hawk-i (5 files)	FTP	

University of Iowa

In	34.02	CORE MMIS	University of Iowa	Pharmacy Claims Extract -Public Policy	FTP	UOI FTP Server
	34.09	CORE MMIS	University of Iowa	Quarterly Recipient Eligibility -TCM	FTP	UOI FTP Server
	34.08	CORE MMIS	University of Iowa	Provider Master File -Public Policy	FTP	UOI FTP Server
	34.07	CORE MMIS	University of Iowa	Provider Master File -Case Mgmt	FTP	UOI FTP Server
	34.06	CORE MMIS	University of Iowa	Institutional Claims Extract -Public Policy	FTP	UOI FTP Server
	34.05	CORE MMIS	University of Iowa	Institutional Claims Extract -Case Mgmt	FTP	UOI FTP Server

	34.01	CORE MMIS	University of Iowa	Pharmacy Claims Extract -Case Mgmt	FTP	UOI FTP Server
	34.03	CORE MMIS	University of Iowa	Medical Claims Extract -Case Mgmt	FTP	UOI FTP Server
	34.11	CORE MMIS	University of Iowa	Quarterly Encounter Data	FTP	UOI FTP Server
	34.10	CORE MMIS	University of Iowa	Quarterly Recipient Eligibility -Public Policy	FTP	UOI FTP Server
	34.04	CORE MMIS	University of Iowa	Medical Claims Extract, Public Policy	FTP	UOI FTP Server

Wells Fargo

In	4.15	Advantis	Wells Fargo	Bank Reconciliation File	
	38.00	CORE MMIS	Wells Fargo	ACH Deposit File	TBD
Out	49.00	Wells Fargo	TXIX Eligibility	Iowa Care Premium Payments	

7.1.6 Pharmacy Point-of-Sale (POS)

Pharmacy Point-of-Sale (POS) System Requirements

This business area includes the system requirements for the Pharmacy Point-of-Sale including drug rebate management and drug utilization review.

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
POS1.01	Provide real-time access to member eligibility.					
POS1.01.01	Perform reconciliation of the member eligibility in the MMIS and POS on a daily basis with 100% accuracy, approved by IME and must reflect the current eligibility in the MMIS. The member is shared on the MMIS as POS files or real-time reconciliation of the record.					
POS1.02	Provide real-time access to providers' eligibility, including the pharmacy and prescriber NPI and authorization IDs for electronic submission of claims.					
POS1.02.01	Provide capability to limit a provider, especially a specialty provider, to specific prescriptions.					
POS1.03	Provide real-time access to the state's drug and formulary file and maintain an up to date copy for POS use.					
POS1.03.01	Accommodate weekly updates of NDC file.					
POS1.03.02	Maintain current and historical coverage status and pricing information on legend drugs and Over The Counter (OTC) items.					
POS1.03.03	Provide the drug formulary in a manner that allows provider electronic health record e-prescribing to reference the PDL and formulary while the prescription is being written. This may be through the Iowa HIE or through sure scripts or a combination of the two.					
POS1.04	Provide real-time access to benefit business rules.					
POS1.05	Provide real-time access to drug file and pharmacy claims history.					
POS1.05.01	Provide the capability for online updating of the drug file in real-time.					
POS1.05.02	Produce a state-specific eligibility verification transaction response using the NCPDP standard transaction format to return detailed eligibility Messages. Store a record of each such response in the system. Refer to the vendor drug system requirements documentation for details on the state-specific response.					
POS1.05.03	Provide capability to generate a monthly report of POS network activity, including network availability statistics and network response time.					
POS1.06	Ensure that all claims are assigned a unique identification number upon entering the system.					
POS1.07	Interfaces with the MMIS or other payment systems to maintain records of time of claims payment in order for the payment systems to pay claims within 30 days after receipt by the POS system of an error free claim.					
POS1.SS.0	Requires IME approval of the vendor for the drug					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
1	pricing function.					
POS1.SS.02	Provide for batch updating of the drug file with information received from the drug pricing vendor.					
POS1.SS.03	Provide inquiry capabilities to all data currently in the system.					
POS1.SS.04	Support real-time spenddown including reversal of prescription amounts applied against the spenddown amount if the prescription is not filled.					
POS2.01	Perform online real-time capture and adjudication of pharmacy claims submitted by providers via POS devices or a switch vendor. Accept POS transmissions from all data switch companies that currently submit transmissions for state-approved programs and comply with the procedures and protocols specified in the Switch Service Bureau Interface Standards.					
POS2.01.01	Allow voids and replacements to be submitted in electronic format.					
POS2.01.02	Allow real time reversals – in the event the member chooses not to get the prescription due to spenddown or co-pay. The reversal must adjust spenddown amount in real time.					
POS2.02	Return to the pharmacy providers the status of the claim and any errors or alerts associated with the processing, such as: a. Edit failures. b. Prospective Drug Utilization Review (ProDUR) alerts. c. Member or coverage restrictions. d. Prior authorization missing. e. Required coordination of benefits. f. Refill too soon. g. Requires generic substitution. h. Deny experimental drugs. i. Requires unit dose (or not). j. Package size not approved. k. Drug Efficacy Study Implementation (DESI) is not covered.					
POS2.03	Verify the member is eligible on the date of service and not otherwise restricted (e.g., enrolled in MCO or a lock-in program).					
POS2.03.01	Process all claims based on the date of birth on the eligibility file (IME to define edits and audits).					
POS2.04	Verify the pharmacy provider is eligible on the date of service.					
POS2.04.01	Capture the prescriber's NPI number on all drug claims and provide the ability to edit against the NPI for that provider including verification that prescriber is not on the CMS excluded provider list.					
POS2.05	Verify all fields defined as numeric contain only numeric data.					
POS2.06	Verify all fields defined as alphabetic contain only alphabetic data.					
POS2.07	Verify that all dates are valid and reasonable.					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
POS2.07.01	Perform an edit to ensure that the prescription refill date is within IME defined parameters.					
POS2.07.02	Provide and maintain the online real-time functionality to support the Pharmacy POS Help Desk in assisting providers with claims processing and policy issues, software issues and claims submittal problems.					
POS2.08	Verify all data items, which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.					
POS2.09	Verify all coded data items consist of valid codes, including NDC for drugs.					
POS2.09.01	Verify that the date of service is prior to the NDC termination dates and the NDC is not designated with a DESI flag.					
POS2.10	Verify any data item that contains self-checking digits (e.g., member ID number) pass the specified check-digit test.					
POS2.11	Verify required data items are present and retained including all data needed for state or federal reporting requirements. (See SMM 11375.)					
POS2.12	Verify the date of service is within the allowable time frame for payment.					
POS2.13.01	Accept billing for compound drugs (those with multiple NDC codes) real time.					
POS2.13.02	Price compound drugs using methodology established by IME.					
POS2.14	Verify the claim is not a duplicate of a previously paid claim.					
POS2.14.01	Apply limits on utilization per day (e.g., quantity limits).					
POS2.14.02	Provide the system flexibility to modify, enhance or develop pricing methodologies, as mandated by federal and state laws, rules, regulations, guidelines or litigation settlements. Obtain prior state approval for any such changes and implement them within state approved timelines.					
POS2.14.03	Provide the capability to prevent payment on drug claims if there is an adjudicated professional, dental or institutional claim with the same drug and same member, within a time frame defined by IME.					
POS2.15	Pays according to the state plan at the lesser of approved pharmacy reimbursement methods: a. Average Wholesale Price (AWP) minus % + Dispensing Fee. b. Federal Maximum Allowable Cost (MAC) or (CMS Upper Limit + Dispensing Fee). c. Usual and Customary Charges to the General Public. d. State MAC (State MAC) + Dispensing Fee).					
POS2.15.01	Provide the capability to transfer on-screen calculator that will populate various drug pricing fields using the formula specified by the state, indicating the final method of payment used.					
POS2.15.02	Provide an application which supports the maintenance of multiple types of MAC. In addition to					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
	the drugs listed on the Centers for Medicare & Medicaid Services Federal Upper Limit (CMS FUL), also known as the Federal Maximum Allowable Cost (FMAC), the state designates other products as MAC (e.g. State MAC products (SMAC)). Supply the capability to apply MAC pricing at various levels: by drug, strength, dosage form and or package size.					
POS2.16	Process electronic adjustments of paid claims submitted through the Pharmacy POS system.					
POS2.17	Utilize data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.					
POS2.18	Check claims against state-defined service limitations.					
POS2.19	Deduct member co-payment amounts as appropriate when pricing claims.					
POS2.20	Deduct TPL amounts as appropriate when pricing claims.					
POS2.21	Verify the claim is for services covered by the state plan.					
POS2.22	Verify all data necessary for legal requirements are retained.					
POS2.23.01	Maintain three (3) years of adjudicated pharmacy claims history on line (based on adjudication date).					
POS2.23.02	Maintain an audit trail of all data transactions performed by Pharmacy POS Help Desk staff.					
POS2.23.03	Provide the capability to accommodate existing and future NCPDP standards (including D.0 enhancements).					
POS2.23.04	Provide the capability to receive all NCPDP data fields, as defined by IME approved payer sheet. Must have capability for future inclusion or exclusion of NCPDP data fields as directed by IME.					
POS2.23.05	Provide custom messaging, as required by IME, to enhance NCPDP D.0 Messages used.					
POS2.23.06	Provide the capability to allow authorized users to make manual adjustments to the drug maintenance file for IME to respond quickly to changes in coverage. This helps IME avoid delays in implementing policy due to the updating processes of the vendor's drug information database file.					
POS2.23.07	Provide the capability to load and process claims under multiple formularies.					
POS2.01	Provide the capability to stamp the account code(s) and a federal report code on each claim line.					
POS3.01	Interface with the pharmacy prior authorization database.					
POS3.01.01	Provider inquiry capability on the NDC file so that providers may determine if an NDC is covered, requires prior authorization or is non-covered.					
POS3.02.01	Provide the capability to override edit checks based on the existence of a pharmacy prior authorization on file or on the existence of override indicator.					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
POS3.03	Interface with electronic authorization of health care service transactions required by 45 CFR Part 162, as follows: a. Retail pharmacy drug referral certification and authorization.					
POS3.04	Perform edits to ensure that a prior authorization is present when required.					
POS3.05	Notify submitter when required prior authorization is missing.					
POS4.01	Provide an automated, integrated online real-time ProDUR system that is flexible and allows user update of ProDur edits without programmer intervention.					
POS4.01.01	Provide capability to customize ProDUR criteria that are received from IME, but ensure that any modified criteria are not overwritten by subsequent updates from the drug pricing file vendor.					
POS4.02	Provide a prospective and concurrent review of prescription practices at the pharmacy and member level.					
POS4.03	Compare the claim against member history and benefit rules to determine if the new claim complies with state standards for: a. Therapeutic appropriateness. b. Over utilization. c. Under utilization. d. Appropriate use of generic products. e. Therapeutic duplication. f. Drug-disease contraindications. g. Drug-pregnancy contraindications. h. Drug-drug interactions. i. Incorrect drug dosage or duration of drug treatment. j. Clinical abuse or misuse. k. Consistent with patient age. l. Consistent with patient gender. m. Consistent with refill policy.					
POS4.04	Generate alerts (Messages) to pharmacy providers as required by IME policy.					
POS4.05	Allow the pharmacy the ability to override an alert.					
POS4.06	Maintain user controlled parameters for all standards and Messages.					
POS5.01	Deny claims for members with appropriate third party coverage including Medicare, enrollment in MCO. In this case, provide insurance information in the POS Message along with notice of denial of payment.					
POS5.02	Identify claims appropriate for pay and chase function. If the drug is designated as “pay and chase,” then process and pay (if it meets all other criteria) and report the claim for follow-up activities.					
POS5.03	Identify claims requiring third party payment.					
POS5.03.01	Provide the system functionality to identify, track and report on claims for which the state is the secondary payor. Such functionality must also include the ability to identify, track and report on the primary payor's					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
	payment history.					
POS6.01	Flag claims for drug rebate processing.					
POS6.02	Prepare extracts of pharmacy claims history required by the drug manufacturer rebate process. Claims must include all NDC and other data needed to support the rebate process, including but not limited to the following: a. Period of time covered. b. NDC number. c. Total units paid. d. Product names. e. Number of prescriptions paid. f. Rebate amount per unit based on the CMS approved formula.					
POS6.02.01	Ensure that all drug rebate tables and databases are available for query and reporting by the users.					
POS6.02.02	Maintain drug rebate invoice and correspondence history as designated by state and federal requirements.					
POS6.02.03	Provide the capability to calculate, bill and collect rebates for durable medical equipment (DME) and supplies.					
POS6.02.04	Provide the capability to exclude certain providers and or certain claims from the drug rebate extract based on IME criteria.					
POS6.02.05	Provide utilization reports concerning rebate activity from the drug rebate system.					
POS6.03	Maintain a database of pharmacy claims history (or access to the claims history) for purposes of retrospective drug utilization review (DUR), prescriber and pharmacy provider profiling, management reporting and other decision support functions.					
POS6.03.01	Provide the capability to develop member profiles with comparisons to peer groups (e.g., diagnosis, procedures, age, gender and other demographic criteria).					
POS6.03.02	Provide the capability to develop provider profiles that offer comparisons to peers.					
POS6.03.03	Provide the capability to produce reports that identify providers with high use of pharmacy DUR edit override codes.					
POS6.03.04	Provide the capability to support analysis of member utilization patterns by drug category, individual drug, geographic parameter and member demographics.					
POS6.03.05	Provide the capability to support analysis of prescription patterns by physician, by drug category, individual drug, geographic parameter and member demographics.					
POS6.03.06	Provide the capability to track prescribing patterns for previously identified high-cost or high-utilization cases.					
POS6.03.07	Provide the capability to user to define an unlimited number of edits and business rules for POS claim rejection that can be tied to standard National Council for Prescription Drug Program Drug Utilization Review					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
	(NCPDP DUR) reject codes for claim denial and or ProDUR.					
POS6.03.08	Provide capability to integrate physician administered drugs from medical claims into the POS for the purpose of ProDUR and RetroDUR processing.					
POS6.03.09	Provide flexibility to design or manipulate RetroDUR report elements for incorporation into a standard report or ad hoc report requested by IME.					
POS6.03.10	Provide provisions for ad hoc reporting, as determined by IME.					
POS6.03.11	Produce the necessary RetroDUR information to support IME in completing the CMS Annual Drug Utilization Review (DUR) report, as described in Section 1927(g)(3)(D) of the Social Security Act, the state annual drug utilization review (DUR) report, as required by Iowa code 249A.24 or any changes defined by CMS or the state in the future to allow IME to remain compliant with federal and state reporting requirements.					
POS6.04	Provide data to support the state in case of a drug manufacturer dispute over the rebate invoice.					
POS6.04.01	Maintain historical drug rebate rates for prior quarters, from 1991 forward.					
POS6.04.02	Provide capability to perform screen prints to be transmitted to other software or email to aid in trouble shooting or showing examples of issues found in the system.					
POS6.04.03	Provide capability for electronic invoicing to manufacturers and the capability for electronic dispute resolution, in which manufacturers and labelers can only see their own claim-level detail for rebates.					
POS6.04.04	Provide the capability to accept and process claims transmitted from the MMIS for the purpose of drug rebate.					
POS6.04.05	Provide the capability to collect supplemental rebates, with separate invoicing and accounting as well as the capability, to manage and collect all rebates for the Iowa Medicaid Program.					
POS6.05	Accommodate receipt of current quarter drug rebate payment details through other electronic forms, as defined by IME.					
POS6.06	Allow manual adjustment to rebate invoice amounts in the event of disputes from manufacturers and similar scenarios.					
POS6.07	Provide capability to produce a quarterly report to the Department on the drug rebate information required for the CMS 64 report.					
POS6.08	Capture and retain mailing date for all invoices.					
POS6.09	Accommodate account balance updates for applying Treasury bill (T-Bill) rates to overdue balances, for AR subject to interest charges.					
POS6.10	Provide capability to generate reports that identify potential decimal quantity errors or unit of measure errors.					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
POS6.11	Generate an audit trail of transactions related to the drug rebate invoices and provide the capability to display original and all revised invoice records.					
POS6.12	Generate an online audit trail of all updates to ProDUR criteria.					
POS6.13	Provide an AR module in the drug rebate system to be approved by IME. The AR module provide a reporting module, to include, but not be limited to: a. An AR report (must match the CMS-64 balance). b. Claim Audits. c. CMS and reconciliation of state invoice (ROSI) discrepancies. d. CMS and drug file discrepancies. e. CMS and mismatches. f. Labeler differences. g. Contact anomalies. h. Drug (invoice) audits. i. Under threshold invoices. j. Suspended checks. k. ROSI and Prior Quarter Adjustment. Statement (PQAS) inconsistencies.					
POS6.14	Provide a drug rebate detailed reporting module, to include, but not be limited to: a. NDC details. b. NDC history. c. Manufacturer summary. d. ROSI and PQAS. e. Unallocated balance. f. Adjusted claims. g. Check and allocation comparisons. h. HCPCS code claims paid. i. Interest override. j. Dispute recapitulation.					
POS6.15	Provide a drug rebate summary reporting module, to include, but not be limited to: a. Payment Summary. b. Rebate Summary (payment received, invoiced amount & disputed amount by quarter). c. Quarterly Payments. d. Dispute code report. e. Dispute activity. f. Invoice register. g. Invoices for quarter not paid. h. CMS-64 (must match AR (A/R) report ending balance) Top 10 balances. i. Drug type summary.					
POS6.16	Provide capability to assign NDC to a different labeler (in the event of a sale or transfer of an NDC from one pharmaceutical manufacturer to another).					
POS6.17	Provide capability to produce a report on “zero dollar” unit rebate amounts.					
POS6.18	Provide the capability to accept PQAS electronically.					
POS6.19	Provide the capability to apply credit balances from					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
	previous quarters to amounts due from the current quarter prior to the invoicing process.					
POS6.20	Provide the capability to conduct data analyses, as required by IME.					
POS6.21	Provide the capability to run drug rebate invoice cycles on an ad hoc basis at the program-specific level.					
POS6.22	Record drug rebate payments at the NDC, federal report code and account code level.					
POS6.23	Allow drug manufacturer access to invoices and supporting drug rebate data via the web portal.					

POS	Pharmacy Point-of-Sale Requirements	A	B	C	D	E
POS6.24	The following are the primary inputs to the POS claims processing function: **Inputs:** a. Pharmacy claims from providers. b. Pharmacy claim adjustments and reversals from providers. c. Provider, member and TPL data from the MMIS. d. NDC coverage data request from providers. e. Member eligibility data requests from providers. f. Prior authorization approvals from the Pharmacy Medical Services contractor. g. Medical claims from CORE MMIS for rebate processing. **Outputs:** The major outputs of the POS claims processing function, which will be provided to the IME online or in hardcopy format at the IME's request, are listed below are listed below: a. Provide adjudicated claims and payment data to the Core MMIS contractor for the check-write cycle as determined by the IME. b. Provide a monthly claim submission statistical report to the IME that identifies the number of claims and adjustment requests submitted and a breakdown of the results of processing by claims status (i.e. paid, denied,) with total dollars for paid and adjusted claims. c. Provide a monthly report of help desk activity, including the number of calls received by type of inquiry, number of incoming calls, hold time statistics and number of calls answered by a live operator. And number calls left in voicemail and number of abandoned calls. d. Provide a monthly file of pharmacy claims to the Pharmacy Medical Services Unit to support retro-DUR activities performed by the DUR commission; this includes the file of covered outpatient physician administered drugs where NDCs have been collected pursuant to the Deficit Reduction Act. e. Produce comprehensive reports, including custom or ad hoc reports and deliver to the IME within timeframes, with content and in media and format approved by the IME. f. Drug Rebate Invoices to the manufacturers. g. Drug Rebate reporting to CMS and the State.					

8 MMIS AND POS OPERATIONAL REQUIREMENTS, CERTIFICATION AND TURNOVER PHASES

The sections below include the following topics:

8:1: Core MMIS Operational Requirements

8.1.1: Minimum Numbers of Categorized Staff

8.1.2: Internal Quality Assurance

8.1.3: Change Management Process

8.1.4: System Remediation

8.1.5: Mail and Courier Service

8.1.6: Member Management

8.1.7: Medically Needy

8.1.8: Provider Management

8.1.9: Claims Receipt Entry and Control

8.1.10: Claims Adjudication

8.1.11: Encounter Function

8.1.12: Reference Data Management

8.1.13: Prior Authorization Management

8.1.14: Third-Party Liability Management

8.1.15: Program Management Reporting

8.1.16: Federal Reporting Management

8.1.17: Financial Management

8.1.18: Program Integrity Management

8.1.19: Managed Care

8.1.20: Waiver, Facility and Enhanced State Plan Services Management

8.1.21: Optional Waiver, Facility and Enhanced State Plan Services Management

8.1.22: Interactive Voice Response System (IVRS) Management

8.1.23: Web Services

8.1.24: Workflow Management

8.1.25: Rules Engine

8.2: POS Operational Requirements

8.2.1: Internal Quality Control

8.2.2: Change Management

8.2.3: System Remediation

8.2.4: POS Activities

8.2.5: POS Provider Help Desk

8.2.6: Reference Function

8.2.7: Prospective Drug Utilization Review (ProDUR)

8.2.8: Drug Rebates

8.2.9: Rules Engine

8.3: Certification Phase

8.4: Turnover Phase

8.1 Core MMIS Operational Requirements

The Operations Phase is the daily performance of all required activities by the new contractor. Bidders will need to describe required coordination and safeguards to assure a successful operation.

The contractor must create and maintain ongoing knowledge transfer schedules for Professional Services contractors and the Department staff. The contractor must provide knowledge transfer throughout the operations phase for new staff and staff who change positions. Knowledge transfer must be provided at the IME facility or at a facility approved by the Department. The knowledge transfer will be conducted Monday through Friday, excluding the Department holidays, between the hours of 8:00 a.m. and 4:00 p.m. Central Time. The contractor is responsible for furnishing the trainees with all necessary knowledge transfer materials.

It is the responsibility of the Core MMIS contractor to provide technical assistance for MMIS related issues; such as availability of the system, system access and user notifications as system changes are implemented.

The Department's intent is to have the Iowa Medicaid Enterprise, including the MMIS and POS fully operational on October 1, 2014 or a later date set by the Department. Fully operational is defined as having the MMIS and the POS established and operational with five years of claim data online; processing correctly all claim types, claims adjustments and other financial transactions; maintaining all system files; producing all required reports; meeting all system specifications; supporting all required interfaces, paying all provider types and performing all other contractor responsibilities specified in the RFP.

Compliance with October 1, 2014 is critical to the Department's interest. Therefore all contractors are potentially subject to damages to the extent their failure to meet the operations start date prevented the IME from becoming operational on the specified start date. The contractors' capability to meet this date will be determined by the Department following the conclusion of the MMIS Implementation.

8.1.1 Minimum Numbers of Categorized Staff

The contractor must supply the staff described in this section. The contractor must maintain the number and qualifications of this staff for the operations phase.

a. Systems Management Staff - Sufficient staff to perform rules engine and benefit plan maintenance and as required to maintain all other system modules. Qualifications require a Bachelor's Degree and two years experience in the application to which the individual is assigned. Experience can be substituted for the Bachelor's Degree on a year-for-year basis.

b. Claims Supervisor – Supervises categorized staff assigned to management of claims business activities. Qualifications require a Bachelor's Degree and five years experience in medical claims processing. Experience can be substituted for the Bachelor's Degree on a year-for-year basis.

c. Three Quality Assurance (QA) Support Personnel Assist in QA activities. Qualifications require a High School diploma and three years Medicaid or health care quality assurance support experience.

8.1.2 Internal Quality Assurance

The contractor is responsible for monitoring its operations to ensure compliance with Department specified performance requirements. A foundation element of the contractor quality assurance function will be to provide continuous workflow improvement in the overall system and contractor operations. The contractor will work with the Department to identify quality improvement measures that will have a positive impact on the overall program. The quality assurance function includes providing automated reports of operational activities, quality control sampling of specific transactions and ongoing workflow analysis to determine improvements needed to ensure the contractor not only meets the performance requirements for its operational area, but also identifies and implements improvements to its operations on an ongoing basis.

8.1.2.1 State Responsibilities

The Department is responsible for the following contractor internal quality assurance functions:

a. Consult with the contractor on quality improvement measures and determination of areas to be reviewed.

b. Monitor the contractor's performance of all contractor responsibilities.

c. Review and approve proposed corrective action(s) taken by the contractor.

d. Monitor corrective actions taken by the contractor.

8.1.2.2 Contractor Responsibilities

The contractor(s) is responsible for the following internal quality assurance functions:

a. Work with the Department to implement a quality plan that is based on proactive improvements rather than retroactive responses.

b. Develop and submit to the Department for approval, a Quality Assurance Plan establishing quality assurance procedures.

c. Designate a quality assurance coordinator who is responsible for monitoring the accuracy of the contractor's work and providing liaison between the contractor and the Department regarding contractor performance.

d. Submit quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to the Department.

e. Provide quality control and assurance reports, accessible online by the Department and contractor management staff, including tracking and reporting of quality control activities and tracking of corrective action plans.

f. For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.

g. Implement a Department-approved corrective action plan within the timeframe negotiated with the Department.

h. Provide documentation to the Department demonstrating that the corrective action is complete and meets the Department requirements.

i. Perform continuous workflow analysis to improve performance of contractor functions and report the results of the analysis to the Department.

j. Provide the Department with a description of any changes to the workflow for approval prior to implementation.

8.1.2.3 Performance Standards

The performance standards the contractor's internal quality assurance functions are provided below:

a. Identify deficiencies and provide to the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.

b. Meet ninety-eight percent of the corrective action commitments within the agreed upon timeframe.

8.1.3 Change Management Process

It is the Department's intention that all maintenance and enhancements be accomplished by the contractor staff required in this RFP. This staff will be responsible for maintenance, system changes, as well as changes in the rules engine and maintenance of the benefit plans. The change management process will be staffed with sufficient resources to satisfy the service level agreements and the contractor must provide sufficient staff at no additional cost to the Department.

During the Operations Phase any system modification or operations improvement activity will be considered a project. The contractor will comply with all aspects of the approved Change Management Plan for any project undertaken during the Operations Phase required in this RFP, as deemed appropriate by the Department, for the size of the project and comply with the development standards in this RFP for any system modification projects. A Change Management Request (CMR) will be used to identify all changes for system maintenance and enhancements.

8.1.3.1 Contractor Responsibilities

Maintenance will include but not be limited to:

a. Repair defects.

b. Perform routine maintenance on reference files.

c. Complete or repair functionality that never worked.

d. Make additions and modifications to rules engine.

e. Make additions and modifications to benefit plans.

f. Add users to security levels of access.

Enhancements and modifications will include but not be limited to:

a. Make enhancements to system functionality.

b. Make modifications to the Department enterprise modules.

1. Provide an online tracking tool for the Department and contractor to use to track and generate reports on the progress of all CMRs. The online tracking tool will be integrated with the Workflow Management System and provide the following capabilities:

    i. Allow online entry of new CMR requests.

    ii. Image and include all attachments pertinent to each CMR.

    iii. Provide flexible online reporting and status inquiry into the Change Management System.

    iv. Provide automatic notification to affected parties when a CMR status changes.

    v. Maintain and provide access to all changes made by the Department or the contractor to each CMR, identifying the change made, the person making the change and the date and time of the change.

    vi. Show status report coding changes, attach test results and record all notes from the Department and contractor staff related to each CMR.

2. The system must produce Change Control Reports that are downloadable to other formats such as Excel. Information to be captured shall include at a minimum the following:

    i. Change Management Request number.

    ii. Priority number.

    iii. Modification description.

    iv. Modification related notes or comments.

    v. Request date.

    vi. Requester.

    vii. Modification start dates.

    viii. Assigned resource(s).

    ix. Estimated completion date.

    x. Estimated hours.

    xi. Hours worked to date.

    xii. Documentation impact and status.

    xiii. Testing status.

    xiv. Department approval of the modification.

    xv. Implementation date

    xvi. Indicate if implementation date is mandated by legislation or rules.

3. Be responsive to all requests from the Department for system modification, whether categorized as maintenance, defect, enhancement or modification.
4. Complete the CMR on or before the requested completion date.
5. Provide clear and complete responses to all CMRs including:
    i. Definition of the problem.
    ii. Proposed solution.
    iii. Proposed approach to implement the solution.
    iv. Proposed schedule for completion.
    v. Constraints and assumptions.
    vi. Financial impact.
    vii. Stakeholder impact (e.g., provider, members, Department).
    viii. Estimated effort detailed by:
        a. Labor in hours.
        b. Hours per task.
        c. Hours per full-time equivalent (FTE).
        d. Equipment.
        e. General and administrative support in hours.
        f. Ongoing support requirements.
        g. Provider knowledge transfer.
        h. Documentation.
6. Maintain documented and proven code promotion procedures for promoting changes from the initiation of unit testing, through the final implementation to production.
7. Maintain documented version control procedures that include the performance of regression tests whenever a code change or new software version is installed, including maintaining an established baseline of test cases, to be executed before and after each update, to identify differences.
8. Maintain adequate staffing levels to ensure CMRs are completed within the specified timeframe determined by the Department.
9. Ensure that all CMRs are addressed within timeframe determined by the Department.
10. Provide before and after copies of documentation changes that affect the CMR.

8.1.3.2 Performance Standards

a. Within 10 business days of receipt of a CMR for an enhancement or modification, provide a written response in a Statement of Understanding (SOU) demonstrating understanding of the request and a schedule for completion or a more thorough assessment of the impact of the change on operations and contract cost per contract year as designated by the Department.
b. Provide updates to all documentation within 10 business days after the Department approves the enhancement or modification for production.

c. If the contractor finds an issue or defect, the contractor must notify the Department within 24 hours. Failure to do so will result in sanctions being assessed. The contractor will be responsible for the research, coding and testing of the issue or defect. Prior to implementing any changes in production, the contractor must present the test results to the Department for approval. This work must be done without impacting scheduled Department requests.

d. Randomly survey the submitters of CMRs to verify that the user was satisfied with the timeliness, communication, accuracy and result of the CMR process ninety-five percent of the time.

8.1.4 System Remediation

The contractor is required to deliver certifiable MMIS and POS components for the proposed price. The contractor must expeditiously correct any item that CMS will not certify on a schedule to be approved by CMS and the Department. The contractor must correct all items not certified at no additional charge to the Department.

8.1.5 Mail and Courier Service

The Core MMIS contractor will maintain the mail handling function for all paper forms and correspondence and is accountable for each claim from the time it is received. The Core MMIS contractor will provide courier service to pick up mail and deliver reports or other items to external entities as required. The mailroom which is located in Des Moines, Iowa, at the IME facility, receives all incoming mail, logs the claim, screens all claim documents and attachments and returns to the provider those claims that fail the screening criteria specified by the Department. Documents that are complete are sorted and batched by type.

8.1.5.1 State Responsibilities

a. The Department will pay all postage and external entity mailing costs for IME operational costs.

b. The Department will identify the most cost effective way to print and mail.

c. The Department will be responsible for identifying large-volume mailings.

8.1.5.2 Contractor Responsibilities

a. All outgoing mail will go through the IME mailroom including regular daily mail and small-volume mailings.

b. The contractor generating the mailing will be responsible for providing a print-ready copy of the documents to the printer the Department selects (such as the state print shop or a commercial print shop).

c. Develop and maintain screening instructions for each claim type. Screen all hard copy claims upon receipt. This includes:

   1. Date-stamp the claims.
   2. Sort and batch the claims.
   3. Screen the claims.
   4. Assign claim control numbers.

5. Scan and image the claims.

d. Imaged claims must be immediately available for processing and viewing.

8.1.5.3 Performance Standards

a. Return claims lacking a procedure and diagnosis code to the provider, unless an exception is made by the Department within one business day.

b. Do not enter a claim in MMIS (with the exception of Medicare crossover claims) unless it contains the member ID number, provider ID number and signature of the provider or his authorized representative. Do not accept a facsimile stamp unless it is initialed by the provider or his/her authorized representative. Return claims not meeting these criteria to the provider within one business day.

c. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

d. One hundred percent of claims and all other documents will be scanned and available within the system within a 24 hour period of receipt excluding state holidays and weekends.

8.1.6 Member Management

The purpose of the Member Management module is to accept and maintain an accurate, current and historical source of eligibility and demographic information on individuals eligible for medical assistance in Iowa and for supporting analysis of the data contained within the member database. The maintenance of member data is required to support Iowa eligibility verification, claims processing and reporting functions. The member management module is also responsible for maintaining indicators for member lock-in. The member management function maintains an accurate and current identification of members eligible for both Medicaid and Medicare.

The Member Management module supports the business operations of the Core MMIS contractor related to Member Management which include:

a. Member Management Module: process eligibility file replacements and daily file update records received from the Department and maintain the MMIS member eligibility file for use in claims processing, eligibility verification and Program Integrity activities and reporting.

b. Eligibility Verification: provide member eligibility verification services through the interactive voice response system (IVRS) which is referred to as the Eligibility Verification System (ELVS), standard HIPAA transactions and web-based inquiries for eligibility information.

c. Eligibility verification should be a service that can be called by other services.

8.1.6.1 Activities

The activities of the MMIS Member Management function are:

a. Maintain the identification of all individuals eligible for Medicaid benefits.

b. Build and maintain a computer file of member data to be used for claims processing, administrative reporting, surveillance and utilization review functions.

c. Keep the MMIS member eligibility file current through updates of eligibility information from the eligibility system.

d. Maintain positive control including confidentiality of data over the member eligibility data required to process claims and meet state and federal reporting requirements.

e. Maintain the unique identification of all eligible's for medical benefits under Medicaid or other Iowa assistance programs as determined by the Department.

f. Distribute eligibility data to other processing agencies as required.

g. Assign members to benefit plans.

h. Manage the state Medicare buy-in process.

i. Contractor must manage the systems to support Managed Care and Medical Home Enrollment.

8.1.6.2 State Responsibilities

The capture and maintenance of member data is primarily the responsibility of the Department. The Department determines eligibility for Medicaid and other entitlement programs through the eligibility system. The Department produces daily update files and a master file containing member eligibility data, which are transmitted to the MMIS and the Department is responsible for the following member functions:

a. Determine eligibility.

b. Produce and deliver to the Core MMIS contractor daily electronic transmissions and eligibility files for update to the member eligibility file.

c. Identify individuals eligible for managed care enrollment.

d. Assign identification numbers to individual eligible.

e. Determine *hawk-i* eligibility through a contract with a third party administrator.

f. Provide presumptive eligibility system and data.

g. Determine and clarify eligibility policy.

h. Provide medically needy eligibility data to the Core MMIS contractor including conditional eligibility information, the certification period, spenddown amounts and responsible relative.

i. Identify individuals that are responsible for a premium payment.

j. Issue and mail member medical ID cards.

k. Update member eligibility file with SDX and Beneficiary and Earnings Data Exchange (BENDEX) file transactions.

l. Issue notification of eligibility and client participation to facility providers.

m. Resolve eligibility errors that require further research such as potential duplicates.

n. Verify and maintain member address within the eligibility system.

8.1.6.3 Contractor Responsibilities

The member functions of the Core MMIS contractor are to:

a. Accept and maintain an accurate, current and historical source of eligibility and demographic information on individuals eligible for Iowa medical assistance. The maintenance of member data is required to support the claims processing and reporting functions and to support the Iowa requirements for eligibility verifications.

b. Process updates to member eligibility data transferred by the Department and process a month-end replacement file for all medical assistance on a monthly, daily, or real time bases or as directed by the Department.

c. Provide online update and inquiry capability to member eligibility files and other MMIS files through the state-operated computer network.

d. Allow accessibility to the member file for the member services contractor who is responsible for manning the member call center. Support research inquiries including contacting providers for additional information and assisting providers to resolve claims processing problems. Send results of the research to the Department for issuance of a notice to the member.

e. Identify individuals eligible under the Medicaid program and who are responsible for payment of premiums to receive Medicaid. Pay claims for MEPD individuals when the premium requirement is met.

f. Provide the Member Services contractor with access to enter member lock-in data.

g. Do not pay claims from non-designated providers for lock-in members unless the emergency or referral and consultation criteria are met.

h. Accept and load presumptive eligibility records from the Department and add to the member file.

i. Ensure that the most current updated member eligibility file is used for each claims processing cycle.

j. Perform quarterly reconciliation of eligibility file records with the Department.

k. Maintain and operate a process to access archived eligibility data.

l. Maintain all member data elements as specified by the Department.

m. Update the POS and member eligibility verification applications real time or as directed by the Department.

n. Send a file to Medicare contractors identifying individuals as dual eligible (Medicaid and Medicare) to indicate that a crossover claim should be generated.

o. Educate contractors and the Department users in the creation and modification of benefit plans and in the use of the rules engine to assign members to the benefit plans and to set the hierarchy of benefit plans.

   Report specifically on:
   1. Changes to benefit plan structure or addition of benefit plans.
   2. Performance of the benefit plan administration module.
   3. Other items as determined by the Department.

p. Establish new benefit plans as directed by the Department.

q. Edit the data transferred for completeness and accuracy according to edit criteria established by the Department. Provide confirmation of data received.

r. Maintain a minimum of 60 months of eligibility history including benefit plans, lock-in, managed care enrollment and waiver and long term care programs.

s. Send a file to Medicare contractors identifying individuals as dual eligible (Medicaid and Medicare) to indicate that a crossover claim should be generated.

8.1.6.4 Performance Standards

The performance standards for the member functions are provided below:

a. Update the member eligibility database with electronically received data and provide the Department with update and error reports within 24 hours of receipt of daily updates. Update within two hours of receipt of data for batch-processing environment. Resolve eligibility transactions that fail the update process within 24 hours of error detection.

b. Refer to the state all eligibility transactions that fail the update process and cannot be resolved by contractor staff pursuant to edit rules or state approved standards within one business day of attempted error resolution.

c. Perform online updates for hardcopy update transactions to member data, except presumptive eligibility records, within one business day of receipt.

d. Add records for presumptively eligible individuals to the member eligibility file the same day as the eligibility determination.

e. Maintain a ninety-eight percent keying accuracy rate for online updates.

f. Identify and correct keying errors in online updates within one business day of identifying the error.

g. Produce and send notices to members based on adverse actions for denied ambulance and rehabilitation claims and denied and modified prior authorizations within three business days of decision on the claim.

h. Provide a weekly report to the Department of all NOD to members that were sent to members based on adverse actions for denied ambulance and rehabilitation claims and denied and modified prior authorizations within five business days of the NOD.

i. Issue NOD to members within 24 hours of the determination of the denial of ambulance claims and rehabilitation therapy services claims for occupational therapy, physical therapy and speech therapy.

j. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

k. Produce state-defined reports within the Department required timeframe.

8.1.7 Medically Needy

The medically needy program provides medical assistance to individuals who meet the categorical but not the financial criteria for Medicaid eligibility. Medically needy eligibles may be responsible for a portion of their medical expenses. This is referred to as "spenddown." The Department determines the spenddown obligation for these members. Once individuals become eligible by meeting their spenddown obligation, Medicaid pays the claims that were not used for spenddown for the certification period.

The medically needy module serves as an “accumulator” of claims that apply toward the spenddown amount. The module displays the medically needy spenddown amount, the amount of claims that have accumulated towards the spenddown amount, information for each certification period, the date spenddown is met and information about claims used to meet spenddown. The Department can access the medically needy screens online.

The medically needy function of the MMIS consists of processing claims for members eligible for the medically needy program tracking medical expenses to be applied to the spenddown and providing reports of spenddown activity.

8.1.7.1 Activities

The activities of the MMIS medically needy function are:

a. Track expenditures for members enrolled in the medically needy program.

b. Ensure that all appropriate expenditures are applied to the spenddown amount before claims are processed and paid by Medicaid.

8.1.7.2 State Responsibilities

The Department is responsible for the following medically needy functions:

a. Calculating the amount of the spenddown needed and entering a medically needy fund code indicator in the eligibility system. The fund code is sent to the MMIS.

b. Providing medically needy eligibility data to the Core MMIS contractor including conditional eligibility information, the certification period, spenddown amounts and responsible relative indicator.

8.1.7.3 Contractor Responsibilities

The Core MMIS contractor has the following responsibilities for the medically needy program:

a. Notify the medically needy program manager and other parties designated by the Department of any problems with the medically needy module within 12 hours of discovering the problem.

b. Set up certification periods with spenddown amounts according to information passed from the eligibility system for medically needy cases.

c. Enter claims in the medically needy module (in MMIS) to meet spenddown. Once spenddown is met send updated fund code to the eligibility system indicating that the person has met the spenddown for the period and is now Medicaid eligible.

d. Prioritize medical expenses that have been submitted according to the Iowa Administrative Code and Code of Federal Regulations.

e. Claims received for a non-covered Medicaid service are entered into the system and are applied toward the spenddown accumulation amount. If a claim for a non-covered service is received after spenddown has been met, the amount of the non-covered service is counted toward the spenddown instead of a claim that had been used to meet spenddown.

f. Apply verified medical expenses against the unmet spenddown obligation and reject expenses that cannot be applied to spenddown.

g. Once spenddown is met send the file to issue medical eligibility cards to the Online Card Replacement Application (OCRA) system.

h. Generate spenddown notification documents.

i. After spenddown is met ensure that eligibility verification applications are updated.

j. Respond to questions from the Department staff and IME contractors.

k. Receive and process the medically needy add-ons and changes that are sent from the eligibility system.

l. Prevent claims from paying until the member has met the spenddown amount. Allow claims for relatives to be used for spenddown per Iowa rules. Ensure claims not used for spenddown are paid.

m. Reject medical expenses that do not meet Iowa's criteria to be applied to spenddown.

n. Document and implement corrective action plans when requested by the Department.

8.1.7.4 Performance Standards

The performance standards for the medically needy program functions are provided below.

a. All claims will be applied to the medically needy spenddown accounts according to the following timelines:

    1. Within 24 hours of adjudication cycle for all Medicaid covered claims.

    2. Within 48 hours of adjudication cycle for all Non-Medicaid covered claims.

b. Identify at least ninety-five percent of the appropriate claims for the medically needy spenddown account for approved medically needy clients.

c. Create and or update operational procedure manuals within 10 business days of the implementation procedure or change by the Department.

d. Produce state-defined reports within the required timeframe as defined by the Department.

8.1.8 Provider Management

The provider management module function of the Core MMIS contractor consists of maintaining provider data, providing online access to update the provider database and providing reports related to providers. The Department has awarded a separate contract for provider enrollment, knowledge transfer, and education and provider relations. The specific requirements for the MMIS provider function are provided below.

8.1.8.1 Activities

The activities of the MMIS provider module function are:

a. Maintain comprehensive current and historical information about providers eligible to participate in the Iowa Medicaid program.

b. Maintain through the establishment of a single provider master file in an acceptable format, provider demographic, certification, rate and financial information to support accurate and timely claims processing, enhanced management reporting and utilization review activities and reporting.

c. Produce provider data and special data such as lab certification information.

d. Maintain comprehensive provider-related information necessary to enroll, audit and pay participating providers in the Iowa Medicaid program.

e. Include in the provider master file all active and inactive providers in order to support claims processing, management reporting, surveillance and utilization review and managed care operations of the program. Provider applications and information changes are interactively processed in the PMF using online screens.

8.1.8.2 State Responsibilities

The state responsibilities for the MMIS provider function are:

a. Establish policy regarding provider eligibility, service coverage, reimbursement and related issues.

b. Approve data to be carried on the Provider Master File.

c. Monitor the contractor's performance of its provider function responsibility.

8.1.8.3 Contractor Responsibilities

To support the Department operations, the Core MMIS contractor maintains a timely, accurate, automated, date-sensitive data repository of enrolled providers including current and historical status, eligibility to render services for specific programs, specific categories of service or specific procedures or services, rates of reimbursement, licensure and certification data and provider affiliations with group practices, managed care organizations, multiple business sites, billing services and other entities.

The following are the requirements of the MMIS Provider function:

a. Maintain Provider data on providers in an acceptable format.

b. Assume responsibility for the maintenance, security and operation of all computer programs and data files identified as part of the MMIS provider function.

c. Provide the provider file audit report daily or as directed by the Department.

d. Produce annual 1099s on federally approved forms and mail to providers. Produce the 1099s in electronic format if requested by the Department.

e. Produce and deliver to the Department all reports created by the provider data maintenance function at the specified frequency, medium and delivery destination.

f. Produce provider-mailing labels as directed by the Department.

g. Produce and mail notifications to providers due for re-certification or licensure based on the Department requirements.

h. Update all necessary information to track, consolidate and report 1099 information prior to issuance of the 1099.

i. Provide a complete provider file to the Department daily.

j. Provide a complete provider file to the POS system daily.

k. Accept retroactive rate changes to the provider file.

l. Support periodic provider reenrollment.

m. Provide flexible secure access to the Department staff and contractors as directed by the Department to add, modify or view provider data.

n. Update the provider file with Occupational Licensing updates daily or as directed by the Department.

o. Maintain reference data related to valid provider attributes example provider type, taxonomy codes and specialty codes.

p. Support provider data synchronization with the Health Information Network provider directory.

q. Support member identification with the Health Information Network Master Patient Index.

8.1.8.4 Performance Standards

The performance standards for the provider data management functions are provided below:

a. If the state develops an automated interface for licensing and or certification data, the Core MMIS contractor must meet these standards for update of this licensing and certification data.

   1. Validate the licensing update process within two business days of application of the update transmission.

   2. Resolve licensing transactions that fail the update process within two business days of error detection.

   3. Refer to the Provider Services contractor all licensing transactions that fail the update process and cannot be resolved by contractor staff pursuant to edit update rules or state-approved procedures within two business days of attempted error resolution.

b. Produce and mail provider 1099s by January 31st of each calendar year.

c. Produce and make provider mailing labels available for printing in the state data center within one business day of request.

d. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

e. Produce state-defined reports within the required timeframe as determined by the Department.

8.1.9 Claims Receipt Entry and Control

The claims receipt, entry and control module function ensures that all claims and related input to the MMIS are captured at the earliest possible time in an accurate manner. This function monitors the movement and distribution of claims once they are entered into the system to ensure an accurate trail from receipt of claims through final disposition. The function includes both manual and automated processes for claim control.

The claims entry and control module function of the MMIS must accept claims and other transactions via hard copy and electronic media. Electronic media claims are accepted in the form of magnetic tape, direct data entry through the web portal or electronic submission. The Core MMIS is responsible for the operations of the translator and will obtain written agreements from new providers wishing to submit claims via electronic media and provides the information to the Core MMIS contractor upon approval of the enrollment as an EDI provider.

The Core MMIS contractor maintains the mail handling function for all paper forms and correspondence and is accountable for each claim from the time it is received. The Core MMIS contractor will provide courier service to pick up mail and deliver reports or other items to external entities as required. The mailroom, which is located in Des Moines, Iowa, the Department facility receives all incoming mail, logs the claim, screens all claim documents and attachments and returns to the provider those claims that fail the screening criteria specified by the Department. Documents that are complete are sorted and batched by type.

All hardcopy forms and correspondence will be scanned, imaged and stamped with a sequential transaction control number (TCN) that uniquely identifies that document throughout the remainder of its processing. The documents are routed to the appropriate unit for handling after imaging. A batch control activation record is entered for each new batch for hardcopy claim documents. The online batch control process is designed to establish control of claims receipts as soon as they enter the mailroom to ensure that claims are not lost or delayed in processing. The batch control file allows Core MMIS contractor staff to monitor a batch of claims in the system as soon as the claims are batched.

Claim adjustments are processed as online real-time transactions. All claims are subject to the same edits and audits regardless of the billing media or method of entry into the claims module.

8.1.9.1 Activities

The activities of the MMIS claims receipt entry and control module and EDI module function are:

a. Receiving and maintaining control over electronic claims transaction.

b. Receipt and imaging of paper claims.

8.1.9.2 State Responsibilities

a. Monitor the performance of the Core MMIS contractor in regard to all aspects of claims receipt.

b. Determine and document methods and policies regarding claims receipt.

c. Design claim forms unique to the Iowa Medicaid program and make revisions to claim forms as directed by the Department.

d. Approve the format and data requirements for electronic media claims submission.

8.1.9.3 Contractor Responsibilities

The following are the requirements of the claims receipt, entry, control and EDI module functions:

a. Provide staff for courier service to pick up mail twice a day and make courier runs to various organizations external to the IME.

b. Develop and maintain screening instructions for each claim type. Screen all hard copy claims upon receipt. This includes:

    1. Date-stamp the claims.

    2. Sort and batch the claims.

    3. Screen the claims.

    4. Assign claim control numbers.

    5. Scan and image the claims.

c. Do not enter a paper claim in the MMIS unless it contains the Department defined data elements. Return claims not meeting these criteria to the provider.

d. Process all claims through the front-end claims editing functionality.

e. Screen all claims to ensure they are submitted on the correct claim form and the paper claim form is an original.

f. Log all claims returned to the provider to verify initial receipt.

g. Provide data entry through both batch and online mode.

h. Establish a quality control plan and internal procedures to ensure that all input to the system is captured timely and that all inputs to the claim input function are free from data entry errors.

i. Produce claim control and audit trail reports during any stage of the claims processing cycle, adjustment and financial transaction data as requested which consists of:

   1. Inventory management analysis by claim type, processing location and age.
   2. Input control listings.
   3. Records of unprocessable claims.
   4. Inquiry screens, including pertinent header and detail claim data and status.
   5. Claims entry statistics.
   6. Data entry operator statistics, including volume, speed, errors and accuracy.

j. Maintain an electronic image of all claims, attachments, adjustment requests and other documents. Retain all original claims and attachments until the quality of the imaged copies has been verified by the Core MMIS contractor and for no less than 90 days from transaction control number date.

k. Produce electronic copies of claims, claim attachments and adjustments and provide secure storage with ability to retrieve copies for state users upon request.

l. Identify and perform online correction to claims suspended because of data entry errors.

m. Develop quality control procedures for imaging operations to ensure that imaged copies are legible. Submit written quality control plan to the Department for review.

n. Provide to the Department claim inventory reports that will document the number of claims in each of the claims suspense area each day.

o. Assume responsibility for marketing of the EDI concept to providers. Obtain written agreements from new providers wishing to submit claims via electronic media and ensure existing EDI agreements remain in effect.

p. Ensure that EDI transmittals contain control totals and that all submitted records are loaded on the file.

q. Accept claims from eligible, enrolled Medicaid providers only. Accept submission of claims from providers, of the appropriate claim type and format for the submitting provider.

r. Notify the provider after receipt of the transmission, of those claims accepted for further processing, of those claims rejected and the nature of the errors.

s. Test providers' readiness for EDI participation and allow only those providers passing testing standards to submit EDI claims.

t. Provide and adequately staff an Electronic Data Interchange (EDI) Helpdesk call center exclusively for the Iowa Medicaid business that works closely with providers, system vendors, billing agents and clearinghouses to support EDI transactions (ANSI X12 healthcare transactions. The EDI Helpdesk shall be open from 8:00 a.m. to 5:00 p.m. Central Time (CT) for providers.

u. Coordinate the activities of the EDI helpdesk with the Provider Services contractor to perform site visits, in the cases where phone support is not sufficient to resolve or educate the providers.

v. Offer assistance and technical support to providers, trading partners and submitters who submit electronic transactions for the Medicaid Program. This assistance includes but is not limited to:

   1. Assist providers in determining the best method of electronic transaction submission.
   2. Enroll providers for electronic transaction submission.
   3. Provide transmission assistance to billing agents, clearinghouses and software vendors.
   4. Test submission software with the Department trading partners.
   5. Identify and troubleshoot technical problems related to EDI transactions.
   6. Provide confirmation of electronic transaction submission.
   7. Provide assistance to support direct data entry of claims and other transactions through the web portal.

8.1.9.4 Performance Standards

a. Data enter ninety-eight percent of all hard copy claims and adjustment and or void requests within five business days of receipt.

b. Log, image and assign a unique control number to every claim, attachment and adjustment and or void, prior authorization and other documents submitted by providers all of which must be viewable in the MMIS within one business day of receipt.

c. Return hard copy and clean claims that fail the prescreening process within one business day of receipt.

d. Maintain at least a ninety-six percent keying accuracy rate for data entered documents.

e. Produce facsimiles of electronic claims within one business day of receipt.

f. Maintain a ninety-nine percent accuracy rate for electronic claims receipt and transmission.

g. Produce and provide to the Department all daily, weekly and monthly claims entry statistics reports within one business day of production of the reports.

h. Provide access to imaged claims, attachments and adjustments and or voids, prior authorizations and other documents to all users immediately upon completion of the imaging. Response time for accessing imaged documents at the desktop must not exceed ten seconds.

i. Return an electronic receipt and or notification for claims submitted electronically within four business hours of receipt.

j. All EDI claims, including Medicare crossover claims, must be processed in the next daily cycle after receipt from provider.

k. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

l. Produce state-defined reports within the required timeframe as determined by the Department.

m. Maintain a service level (SL) percentage of at least 80 percent for incoming EDI calls as calculated by the following formula:

   SL= ((T – (A+B)/T)*100)

   Where T = all calls that enter the queue

   A= calls that are answered after 30 seconds

   B= calls that are abandoned after 30 seconds

n. Ninety-five percent of all provider clean claims are able to clear EDI editing and continue to be uploaded and processed in the system.

8.1.10 Claims Adjudication

The claims pricing and adjudication module function ensures that claims are processed in accordance with all established Iowa policies. This functional area includes claim edit and audit processing, claim pricing and claim suspense resolution processing.

Claims and transactions that will be entered into the MMIS from the claims entry function include claims that are recycled after correction and claims released to editing after a certain number of cycles based on defined edit criteria, online entry of claim corrections to the fields in error, online forcing or overriding of certain edits provider, member and reference data related to the suspended claims.

*Bidder Note: The use of the term “pay” in this section refers to the adjudication of a claim to payment status. The payment instruments and processes used to pay claims (i.e., EFT transactions) will be produced by the MMIS, the file is then sent to the Department’s financial institution.

8.1.10.1 Activities

The primary activities of the claims processing function and the claims module are shown below:

a. Maintain control over all transactions during their entire processing cycle. Monitor, track and maintain positive control over the location of claims, adjustments and financial transactions from receipt to final disposition.

b. Provide accurate and complete registers and audit trails of all processing activities.

c. Maintain inventory controls and audit trails for all claims and other transactions entered into the system to ensure processing to completion.

d. Control attachments required for claims adjudication including but not limited to:

   1. Third-party liability and Medicare Explanation of Benefits.

   2. Sterilization, abortion and hysterectomy consent forms.

   3. Prior authorization treatment plans and emergency room reports.

e. Capture all inputs timely and accurately.

f. Ensure that every valid claim for a covered service provided by an enrolled provider to any eligible member is processed and adjudicated.

g. Process all claims entered into the MMIS to the point of payment or denial.

h. Support program management and utilization review by editing claims against the prior authorization file to ensure that payment is made only for treatments or services which are medically necessary, appropriate and cost-effective.

i. Edit all claims for eligible member, eligible provider, eligible service and correct reimbursement schedule.

8.1.10.2 State Responsibilities

The Core MMIS contractor performs claims processing activities for the majority of the claims operations. However, the state assumes responsibility for the following claims operations:

a. The Department performs the following functions in support of the claims module:

   1. Monitor the performance of the Core MMIS contractor in regard to all aspects of claims processing.
   2. Determine methods and policies regarding provider reimbursement.
   3. Determine coverage policy and limitations.
   4. Determine which coding systems will be used in the MMIS for procedures, diagnoses and drugs.
   5. Approve all system edits, audits and changes to their dispositions.
   6. Perform Medicaid quality control functions in accordance with federal and state laws and regulations, with assistance from the Core MMIS contractor.
   7. Ensure that data for claims paid outside of the MMIS are provided to the Core MMIS contractor for inclusion on the MSIS reports.
   8. Approve the request for EFT for the scheduled provider payment cycle.
   9. Provide state owned vehicle for courier services.

8.1.10.3 Contractor Responsibilities

The following are the requirements of the Claims Adjudication module functions:

a. Process and adjudicate all claims and claim adjustments in accordance with the Department program policy.

b. Run a payment cycle weekly or as directed by the Department.

c. Process credits and adjustments to provider payments.

d. Process non-emergency medical transportation capitation payments and receive and store encounter data.

e. Adjudicate claims based on the rate effective on the date of service unless otherwise directed by the Department.

f. Research and develop special payment circumstances including determining the proper payment amount for the service.

g. Provide claim histories and copies of claims to the Department upon request.

h. Account for all claims entered into the MMIS system and identify the individual disposition status.

i. Process any claims or partial claims that were not used to meet the medically needy spenddown amount.

j. Accept and process all Medicare Part A and B crossover claims pursuant to the Department standards.

k. Maintain a minimum of 60 months of adjudicated (paid and denied) claims history and all claims for lifetime procedures on a current, active, online claims history file for use in audit processing, online inquiry and update and make available printed claims including the entire claim record. Maintain the remainder of converted adjudicated claims history off-line in a format that is easily retrievable.

l. Support multiple methodologies for pricing claims as established by the Department.

m. Accurately calculate the payment amount for each service according to the rules and limitations applicable to each claim type and provider type.

n. Identify the allowable reimbursement for claims according to the date-specific pricing data and reimbursement methodologies contained on applicable provider or reference files for the date-of-service on the claim.

o. Recommend for the Department approval specific edit parameters.

p. Configure the fee schedules, per diems, DRG rates, APC rates and other rates and rules established by the Department.

q. Deduct patient liability amounts according to the Department guidelines.

r. Deduct TPL amounts as appropriate when pricing claims.

s. Deduct member spenddown amounts as appropriate when pricing claims.

t. Price claims according to the policies of the program the member is enrolled in at the time of service and edit for concurrent program enrollments.

u. Offset service plan payments for HCBS waivers (e.g., claims by provider) by any existing monthly client participation amount.

v. Provide adequate qualified staff to resolve suspended claims.

w. Suspend for review, claims from providers designated for prepayment review, claims containing procedure codes or diagnosis codes designated for prepayment review and other claims due to edits in the system.

x. Recycle any claim type prior to denial, at the request of the Department. Deny claims after the Department specified number of days.

y. Conduct online real-time claims suspense resolution capabilities for all claim types.

z. Receive approval from the Department before establishing any new claim adjudication rules or changing the disposition status of existing claim adjudication rules in the system.

aa. Maintain an online resolution manual detailing the steps used in reviewing and resolving each error code. Update the resolutions manual as changes are made to claims processing procedures.

bb. Identify potential and existing third-party liability (including Medicare) and avoid paying the claim if it is for a covered service under a third party resource for applicable claim types.

cc. Maintain the rules engine.

dd. Perform overrides of claim edits and audits in accordance with the Department approved guidelines.

ee. Apply established edits to claims pursuant to the Department criteria. Add, change or delete edits as directed by the Department. Suspend claims for manual review and pricing if the claim cannot be automatically priced.

ff. Override timely filing requirements if the failure to meet the timely filing requirements is due to retroactive member eligibility determination, delays in filing with other third parties or because the claim is a resubmitted claim. Exceptions may be granted by the Department for other reasons such as court ordered payment, member or provider appeal, after the claim has been denied and the provider has made an inquiry.

8.1.10.4 Performance Standards

a. Ninety percent of all clean claims must be adjudicated for payment or denial within 20 calendar days of receipt.

b. Ninety-nine percent of all clean claims must be adjudicated for payment or denial within 60 calendar days of receipt.

c. One hundred percent of all claims must be adjudicated for payment or denial within 120 calendar days of receipt.

d. One hundred percent of all clean provider-initiated adjustment requests must be adjudicated within 10 business days of receipt.

e. Imaged claims must be immediately available for processing and viewing.

f. Claims processed in error must be reprocessed within 10 business days of identification of the error or upon a schedule approved by the state.

g. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

h. Produce state-defined reports within the required timeframe as determined by the Department.

i. Maintain a current online resolution manual detailing the steps used in reviewing and resolving each error code. Ensure manual is current as changes are made to claims processing procedures.

8.1.11 Encounter Function

All Medicaid managed care organizations and the transportation broker conducting business in the State of Iowa are required to submit medical and transportation broker encounter data to the Core MMIS contractor. Encounters are submitted by the participating HMOs, the Iowa Plan contractor (currently Magellan Behavioral Health Care), PACE and the transportation broker to report services provided to members. The data is used in evaluating service utilization and member access to care. No payment is made for submitted encounters.

The Core MMIS contractor rejects the entire month’s encounter record if the file exceeds the Department error tolerance level. The HMO and the Iowa Plan third party administrator (TPA) and the transportation broker are responsible for timely resolution of errors reported by the Core MMIS contractor and re-submitting the file in error.

The encounter data is maintained on a separate MMIS encounter history database for federal reporting, quality assessment and actuarial analysis.

8.1.11.1 Activities

The primary activities of the encounter module are to:

a. Receive, process and load encounter data into the repository. Produce and send encounter error reports to the health plans and the transportation broker and assist in reconciling the errors.

b. Organize and provide data to analyze member access to health and transportation services and quality of health and transportation care providers.

c. Ensure accuracy and adequacy of encounter data received from managed care entities and the transportation broker.

d. Produce encounter data files and reports including transportation broker.

8.1.11.2 State Responsibilities

The Department is responsible for the following encounter activities:

a. Establish policy and make administrative decisions concerning the encounter submission process.

b. Determine data content and format for encounter submissions.

c. Submit appropriate information as deemed necessary to be merged with MMIS history file for reporting encounter data.

d. The Department contracts with the University of Iowa Public Policy Center to analyze managed care data and provide reports on Healthcare Effectiveness Data and Information Set (HEDIS) outcome measurements. The third party administrator for *hawk-i* (contractor) sends the encounter data to the University of Iowa; contractor provides the *hawk-i* encounter data to the Core MMIS contractor.

e. Monitor contractor performance.

8.1.11.3 Contractor Responsibilities

The Core MMIS contractor performs virtually all activities associated with the processing of Medicaid claims and managed care and transportation brokerage encounter data. Processing of the encounter data from the HMOs, the Iowa Plan and the transportation broker includes receiving and validating the encounter data, generating and sending error reports to the plans and broker and assisting in reconciling the errors. The Core MMIS contractor is responsible for the following related to encounter processing:

a. Accepting the encounter data from the HMOs, the Iowa Plan contractor and the transportation broker.

b. Accept and log attestation from each HMO, the Iowa Plan and the transportation broker for encounter data submission as required by 42 CFR 438.606.

c. Processing edits against the encounter file to ensure the data is technically correct.

d. Generating error reports to each plan.

e. Assisting the plans:

1. Create and send to the HMOs, the Iowa Plan and the transportation broker detailed reports on the results of the edit processing, providing the HMOs, Iowa Plan and the transportation broker with the necessary information to identify the invalid data on their monthly encounter file and prepare it for resubmission.
2. Incorporate managed care encounter data received from the managed care organizations into the MMIS reporting system.
3. Maintain five years of encounter data history for all clean encounter data.
4. Based on the procedure code on the encounter claim on accepted input files count EPSDT screenings and retain for inclusion on the CMS-416. Include these EPSDT counts on the HMO Encounter EPSDT Counts Report.

f. Produce and send encounter data files to the Department contractors as required by the Department.

g. Accept, test and integrate into the MSIS files managed care encounter data submitted by MCOs and transportation broker.

h. Download encounter data extract updates to the data warehouse for reporting monthly.

i. Send HMO encounter data to CMS in the MSIS format on a quarterly basis.

j. Accept and process encounter data in different formats.

8.1.11.4 Performance Standards

The Core MMIS contractor performs virtually all activities associated with the processing of Medicaid claims and managed care and transportation brokerage encounter data which includes processing of the encounter data from the HMOs, the Iowa Plan and the transportation.

The performance standards for the encounter functions are provided below:

a. Process and report disposition of encounter file edit review to the submitting managed care organization within three business days of receipt.

b. Provide encounter data files, in acceptable format, to the Department recognized contractors within five business days of end of designated reporting period.

c. Report findings from audits of HMO, Iowa Plan and the transportation broker, encounters to the Department within five business days from the end of the reporting quarter.

d. Hardcopy claims must be imaged within one business day of receipt.

e. Imaged claims must be immediately available for processing and viewing.

f. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

g. Produce state-defined reports within the required timeframe as determined by the Department.

8.1.12 Reference Data Management

The Reference Data module contains rates and pricing information, which is used to determine allowable payments to providers, control edits and audits and support other MMIS functions. Reference tables are used in the prior authorization and claims adjudication processes.

8.1.12.1 Activities

The primary activities of the MMIS reference module and reference data functions are to:

a. Provide coding and pricing verification during claims processing for all approved claim types, assistance programs and reimbursement methodologies including capitated programs.

b. Maintain flexibility in reference parameters and file capacity to make the MMIS capable of easily accommodating changes in the Medicaid program. Support the claims processing function by providing information used in the adjudication and pricing of claims.

c. Support the data requirements of other MMIS applications such as claims processing, information access and decision support, utilization review and quality assurance, POS and prospective and retrospective DUR.

d. Provide a master file of valid procedure, diagnosis, revenue and drug codes for use in the verification and pricing of Medicaid claims.

e. Provide a means of reporting any information from the files.

f. Provide and maintain customary charge data for provider's Medicaid customary charges.

g. Provide and maintain prevailing charge data for Medicaid charges.

h. Place benefit limits and maintains relationship edits on procedure, drug, diagnosis, DRG and APC codes. Use service limit codes and indicators on the procedure and diagnosis records to control benefit utilization.

8.1.12.2 State Responsibilities

The Department sets policy for the type of reimbursement system for Medicaid services and develops the rate methodology with assistance from outside contractors. These rate calculations include fee schedules, per diem rates, interim rates, premium rates, capitation rates and institutional rates.

Payment rates such as physician and laboratory fee schedules, per diem rates, drug reimbursement formulas and interim rates, are calculated by the Department or obtained from outside sources, like Medicare and maintained in table-based files in the reference module.

The Department maintains the following reference file functions:

a. Monitor file content and report detected errors to the Core MMIS contractor for correction.

b. Determine and interpret policy and administrative decisions relating to the reference data maintenance function.

c. Direct certain updates to the reference data files.

d. Establish allowed rates or fees.

8.1.12.3 Contractor Responsibilities

The Core MMIS contractor is responsible for maintaining the different pricing files and reimbursement methodologies contained in the reference database. The Core MMIS contractor updates files based on the Department policy and federal requirements for the use of coding schemes in the MMIS. The Core MMIS contractor is responsible for maintaining all reference files in the reference module.

a. Maintain Revenue codes:

1. Maintain a revenue code data set for use in processing claims.
2. Accommodate pricing action codes and effective end dates for each revenue code.
3. Provide English descriptions of each revenue code in the revenue data set.

b. Maintain current and historical reference data for all procedure codes and modifiers that include at a minimum the following elements:

1. Date-specific pricing segments including a pricing action code for each segment showing effective dates and end dates.
2. The Department specified restrictions on conditions to be met for a claim to be paid such as provider types, member age and gender restrictions, place of service, appropriate modifiers, aid category and assistance program.
3. Pricing information such as maximum amount, fee schedule amounts and relative value scale (RVS) indicators with unlimited segments showing effective dates and end dates.
4. Prior authorization codes with unlimited segments showing effective and end dates.
5. English descriptions of procedure codes.
6. "Global" indicators for codes that include reimbursement for pre- and post- procedure visits and services.
7. Other information such as accident-related indicators for possible TPL, federal cost-sharing indicators and prior authorization required.

c. Maintain procedure information that sets adjudication limitations and medical policy restrictions for automatic pricing of medical procedures according to the effective date.

d. Identify when prior authorization and pre-procedure review approval is required.

e. Restrict the use of procedure codes to those providers qualified to perform them.

f. Accommodate variable pricing methodologies for identical procedure codes based on provider specific data.

g. Maintain the previous and current diagnosis data set of medical diagnosis codes utilizing the International Classification of Diseases, Clinical Modification (ICD-CM) version required by HIPAA and Diagnostic and Statistical Manual (DSM) coding systems, which can maintain relational edits for each diagnosis code including:

1. Age.
2. Gender.
3. Place of service.
4. Prior authorization codes with effective and end dates.
5. Inpatient length of stay criteria.
6. English description of the diagnosis code.
7. Effective date.
8. End date.

h. Maintain a master file of valid procedure, diagnosis, drug and revenue codes with appropriate pricing information for use in claims processing.

i. Perform batch and online updates to all reference files in the MMIS subject to the Department approval via the workflow process. Notify the Department electronically with results of file updates.

j. Maintain online access to all reference files with inquiry by the appropriate code.

k. Maintain the procedure, diagnosis, drug, DRG, APC, revenue code, medical criteria and other files. Provide access based on variable, user-defined select and sort criteria with all pertinent record contents.

l. Make mass updates to the allowed fee or rate effective on a certain date.

m. Maintain the per diem rates for hospitals with Medicaid-certified physical rehabilitation units as specified by the Department. Update the rates as required by the Department.

n. Provide online inquiry and update capability for all files.

o. Produce audit trail reports in the media required by the Department showing before and after image of changed data, the ID of the person making the change and the change date.

p. Edit all update transactions either batch or online for data validity and reasonableness as specified by the Department. Report all errors from batch updates to the Department.

q. Accommodate multiple reimbursement methodologies including but not limited to DRG, APC, fee schedules and per diem.

r. Maintain pricing files based on:

    1. Customary.
    2. Fee schedule.
    3. Per diem rates.
    4. DRGs.
    5. APCs.
    6. Capitation rates for managed care plans.
    7. Administrative fees for primary care management, medical home and others as designated by the Department.
    8. Maximum allowance cost (MAC), estimated acquisition cost (EAC), average wholesale price (AWP), Medicaid average wholesale price (AWP), Veterans Health Care Act 5193 and Federal Upper Limits (FUL) pricing for drugs.
    9. Multiple rates for long term care providers.
    10. Encounter rates for federally qualified health centers and rural health centers.

s. Maintain and update the DRG-based prospective payment file for inpatient hospital services and update the base rates periodically as authorized by the Department. Apply an economic index to the base rates as authorized by the Department.

t. Maintain and update DRG and APC data sets which contain at a minimum by peer group, facility and effective date, unlimited occurrences of:

    1. Price by code.
    2. High and low cost outlier thresholds.
    3. High and low length-of-stay outlier thresholds.

4. Mean length-of-stay.

u. Maintain the fee schedules in the reference file and update on an annual basis or as authorized by the Department including applying an economic index to the fee schedule rates.

v. Reimburse the following providers on the basis of a fee schedule, ambulance providers, ambulatory surgical centers, audiologists, chiropractors, community mental health centers, dentists, durable medical equipment and medical supply dealers, independent laboratories, maternal health clinics, hospital-based outpatient programs, nurse midwives, orthopedic shoe dealers, physical therapists, physicians, podiatrists, psychologists and screening centers.

w. Reimburse optometrists, opticians and hearing aid dealers on the basis of a fee schedule for professional services plus the cost of materials at a fixed fee or at product acquisition costs.

x. Reimburse managed care providers, contractors and the non-emergency transportation broker on a monthly capitation basis based on rates provided by the Department.

y. Maintain edit and audit criteria in the rules engine providing a user-controlled method of implementing service frequency and quantity limitations, service conflicts for selected procedures and diagnoses and online update capability.

z. Maintain a user-controlled claim edit and audit disposition data set with disposition information for each edit used in claims processing including disposition (pay, suspend, deny) by submission medium within claim type, description of errors EOB codes, suspend location and online update capability.

8.1.12.4 Performance Standards

a. Produce state-defined reports within the required timeframe as determined by the Department.

b. Update the CLIA laboratory designations within one business day of receipt of file.

c. Perform online updates to reference data within one business day of receipt and the Department authorization or on a schedule as approved by the Department.

d. Process procedure, diagnosis and other electronic file updates to the reference databases within two business days of receipt and approval or upon a schedule approved by the Department.

e. Provide update error reports and audit trails to the Department within one business day of completion of the update.

f. Update, edit adjudication documentation within three business days of the request from the Department.

g. Update error text file documentation within three business days of the Department approval of the requested change.

h. Maintain a ninety-nine percent accuracy rate for all reference file updates.

i. Notify the Department and correct errors within one business day of error detection.

j. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Department.

k. Produce state-defined reports within the required timeframe as determined by the Department.

8.1.13 Prior Authorization Management

The prior authorization management module responsibilities for medical and dental services are shared between the Department, the Medical Services contractor and the Core MMIS contractor.

8.1.13.1 State Responsibilities

a. Develop policy and rules concerning prior authorization.

8.1.13.2 Contractor Responsibilities

a. Operate a prior authorization system to load authorizations and track utilization of authorized services.

b. Maintain edit disposition to deny claims for services that require prior authorization (PA) if no PA is identified or active.

c. Receive and forward electronic PA requests received from providers to the appropriate prior authorization contractor as directed by the Department.

d. Scan, image and forward paper PA requests received from providers to the appropriate prior authorization contractor as directed by the Department.

8.1.13.3 Performance Standards

a. Complete all prior authorization interface updates from prior authorization entities within one business day of receipt of file if there are no critical errors.

b. Forward all prior authorization requests to the appropriate prior authorization entities within one business day.

c. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Department.

d. Produce state-defined reports within the required timeframe as determined by the Department.

8.1.14 Third-Party Liability Management

The purpose of the Third- Party Liability (TPL) module is to manage the private health insurance and other third party resources of Iowa's Medicaid members and ensures that Medicaid is the payor of last resort. The module processes and maintains all data associated with cost avoidance and recovering funds from third parties. Iowa Medicaid uses both a cost recovery process usually referred to as "pay and chase" and a cost avoidance process in managing its TPL activities. The information maintained by the module includes member TPL resource data, insurance carrier data and post payment recovery tracking data. The claims processing function uses the TPL coverage type during claims adjudication.

8.1.14.1 State Responsibilities

a. Establish policies for TPL, estate recovery and Medical Assistance Income Trusts (MAIT).

b. Provide oversight to all contractors.

c. Review and approve written communication with members on whose behalf Iowa Medicaid will be paying the employee share of health insurance.

d. Provide general policy for verbal and written communication with employers for the purposes of setting up premium payment.

e. Define documentation necessary to substantiate the need for premium reimbursement such as a check stub.

f. Define documentation necessary to substantiate the need for premium payment such as an invoice from an insurance carrier or employer.

g. Define report specifications and online screens to be provided by the contractor that will allow the state to monitor status of Health Insurance Premium Payment (HIPP) cases.

h. Produce and send member notices when needed for each type of action (i.e., accretion and deletion activity for various groups).

i. Work with members and employers to enroll members in employer's health services programs and calculate the premium payment.

j. Receive and process member check stubs for verification of HIPP premium amount.

k. Define the groups of members to be considered for HIPP. Cost effectiveness data and formulas will differ depending on the program.

l. Assist with contractor access to employer address information.

m. Send forms to employers to gather information about insurance available to the member including:

    1. What family members can be covered (e.g., employee, spouse, children, stepchildren).
    2. When coverage can begin.
    3. Whether dental and or prescription drug coverage is available.
    4. The employer and employee share of the premium.
    5. Type of plan (e.g., managed care, fee-for-service).

n. Make calculations of cost effectiveness including:

    1. Wrap-around costs for insured individuals based on age group, gender, dental and prescription drug coverage and managed care versus fee-for-service coverage.
    2. Medicaid costs by county.
    3. Wraparound costs for members in Medicaid managed care programs.
    4. Administrative costs associated with HIPP.
    5. Other information that may be necessary for the determination of cost effectiveness for other programs.

o. Define specifications for reports to be produced that will allow the state to monitor caseload and savings associated with each HIPP program.

p. Generate transactions that identify plan information for HIPP members.

q. Generate transactions identifying HIPP payments to be made by the contractor.

r. Mail HIPP questionnaire Employer Verification of Insurance Coverage (EVIC) to the employers of those members determined eligible for HIPP programs.

s. Receive HIPP questionnaires from employers and review for accuracy and completeness of information.

t. Perform cost effectiveness test to determine whether the employer's health insurance is cost effective for the HIPP program.

8.1.14.2 Contractor Responsibilities

TPL function:

a. Generate TPL and trauma lead letters per the Department policy and produce a report of all letters.

b. Generate a file of all paid claims and member eligibility monthly.

c. Process all files weekly or as directed by the Department (TPL updates and claims updates) from Revenue Collection contractor.

d. Process TPL updates manually entered by Revenue Collection contractor.

e. Accept and process absent parent file from Child Support Recovery Unit weekly or as directed by the Department.

f. Update member files to include the TPL plan and coverage information for HIPP members.

g. Manage the premium payment process.

h. Create and issue HIPP remittance advice.

i. Produce state-defined reports.

j. Create a member file for HIPP enrollees who are not Medicaid members (i.e., AIDS/HIV, HIPP).

8.1.14.3 Performance Standards

a. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Department.

b. Generate TPL and trauma lead letters within 24 hours of receipt.

c. Process TPL updates within 24 hours of receipt from the Revenue Collection contractor.

d. Update member files to include the TPL plan and coverage information for HIPP members within 24 hours of receipt from the HIPP unit.

e. Generate a file of all paid claims and member eligibility by the fifth business day of each month for the previous month.

f. Produce state-defined reports within the required timeframe as determined by the Department.

g. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.15 Program Management Reporting

The Program Management Reporting module provides statistical information on key Medicaid program functions. Production reports are designed to assist management and administrative personnel monitoring of the MMIS and the performance of the Core MMIS contractor. This does not include preparation of federal reports.

8.1.15.1 State Responsibilities

The Department is responsible for the following Program Management reporting functions:

a. Determine the frequency, format, content, media and number of copies of reports.

b. Review and approve reports.

c. Submit appropriate information as deemed necessary by the Department to be merged with the MMIS history file for reporting.

d. Operate the Medicaid DW/DS.

8.1.15.2 Contractor Responsibilities

The Core MMIS contractor maintains responsibility for the Program Management reporting.

a. Produce all required reports and information in accordance with the timeframes and requirements specified by the Department.

b. Assume all costs associated with producing special reports that require no changes to the system such as reports generated through the use of reporting capabilities inherent to the system.

c. Review all process summaries to verify accuracy and consistency within and between reports before delivery of the reports to the Department.

d. Make recommendations on improvements to reporting process and assist the Department in designing reports.

e. Provide the flexibility to add, change or discontinue benefit plans, categories of service, special programs, member aid categories, provider types and provider specialties and other reporting data elements. Carry through corresponding changes in affected reports without additional cost to the Department.

f. Produce ad hoc reports on request.

g. Produce on a timeline approved by the Department data extracts for delivery to external entities.

h. When an error in a report is identified either by the Core MMIS contractor or by the Department, provide an explanation as to the reason for the error. Correct and rerun the reports at the Core MMIS contractor's expense, when the reason for an error in a report is the error of the Core MMIS contractor’s system.

8.1.15.3 Performance Standards

The following performance standards apply to all MMIS reports.

a. All standard production reports must be available on line for review by the Department staff pursuant to the following schedule:

1. Daily reports – by 6:00 AM of the following business day.
2. Weekly reports – by 6:00 AM of the next business day after the scheduled production date.
3. Monthly reports – by 6:00 AM of the first business day after month end cycle.
4. Quarterly reports – by 6:00 AM of the fifth business day after quarterly cycle.
5. Annual reports – by 6:00 AM of the (10th) business day after year end cycle (state fiscal year, federal fiscal year, waiver year or calendar year).
6. Balancing reports are to be provided to the Department within two business days after completion of the program management reporting production run.

b. When an error in a report is identified either by the Core MMIS contractor or by the Department, provide an explanation as to the reason for the error within one business day and correct the report within one business day following the date the error was identified unless the Department authorizes additional time for correction.

c. Data files for all reports must be made available on the state data center servers and accessible online within one business day of completion.

d. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Department.

e. Produce state-defined reports within the required timeframe as determined by the Department.

f. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.16 Federal Reporting Management

The federal reporting management module function supports the generation of all federal reports.

8.1.16.1 State Responsibilities

a. Provide direction on the requirements of each federal report.

b. Identify and approve changes to be made to the federal reporting.

c. Review all federal reports.

d. Initiate and interpret policy and make administrative decisions.

e. Determine the need, content, format, media and number of copies for each federal report.

f. Determine the schedule for production of all federal reports.

g. Monitor the performance of the contractor in all areas of the federal reporting function.

8.1.16.2 Contractor Responsibilities

a. Generate required reports to support federal reporting on demand and scheduled within timeframes and formats required by the state including but not limited to:

   1. CMS 21 report Quarterly State Children’s Health Insurance Program Statement of Expenditures for Title XXI.

2. CMS 21B.
3. CMS21E statistical report.
4. Quarterly ethnicity report.
5. CMS 64 - Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.
6. CMS 37 Quarterly Projections for the Medical Assistance Program.
7. MSIS Data according to CMS media requirements and timeframes and submit a copy to CMS on specified media for review and filing.
8. CMS 372 cost neutrality assessment for waivers and other specified waiver reports.
9. CMS 416 report information in accordance with the federal specifications and the Department specifications.
10. MSIS and CMS tapes according to CMS timeframes. Media may change based on CMS and state approval.
11. SF269 Federal Financial Status Report.

b. Support Payment Error Rate Measurement (PERM). In compliance with CMS quarterly claims sample frequency requirements, send the required data to the statistical contractor (SC) according to the claims extract approach using CMS-approved formats, media and security procedures.

c. Modify reports supporting federal reporting as requested by the Department. Modifications are made available within timeframes required by the state.

d. Generate CMS 64 Variance and CMS 21 Variance reports as specified by the state for the current and three prior quarters. The variance reports must be made available within timeframes and formats required by the state.

e. Conduct research and respond to questions from CMS, OIG and state auditors regarding the MSIS data and federal reports.

f. Prepare and deliver to the Department the Quarterly Report of Abortions (CMS 64.9b).

g. Prepare and deliver to the Department the report on expenditures under the Money Follows the Person program.

h. Identify and report the Federal Financial Participation (FFP) rate for each claim line.

i. Produce a report of pharmacy drug rebate amounts for inclusion on federal reports.

j. Regenerate, at no cost to the Department, the MSIS file and federal reports when errors are identified or when there has been a mass adjustment of federal reports codes.

8.1.16.3 Performance Standards

a. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Department.

b. Produce federal reports on the following schedule:

1. Quarterly reports – by 6:00 AM of the first business day following the final regular pay cycle of the quarter.

2. Annual reports – by 6:00 AM of the fifth business day after last pay cycle of the reporting year (state fiscal year, federal fiscal year, waiver year or calendar year).

c. Produce PERM data within the required timeframe determined by the Department.

d. Modify changes to federal reports within five business days of request by the state.

e. Respond to questions from CMS, OIG and state auditors within the timeframes determined by the Department.

f. Produce state-defined reports within the required timeframe determined by the Department.

g. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.17 Financial Management

The financial management module function supports accounts payable and accounts receivable activities including issuance of check-write and EFT files and remittance advices.

Currently, Wells Fargo is the entity that produces and transmits the electronic fund transfers. The Core MMIS contractor is responsible for producing checks for mailing.

8.1.17.1 State Responsibilities

a. Provide account coding and federal report coding requirements.

b. Approve manual payments and receivables.

c. Provide business rules for setting the status of accounts receivable to manage provider's due process rights.

d. Provide interface file layouts and business processing rules for payment, journal, deposit and receivable files.

e. Provide business rules for sending accounts receivables to the state warrant offset program or other collection agent.

f. Provide interface file layouts for state warrant offset processing.

g. Monitor the contractor's performance of its Financial Management functions.

h. Provide business rules for billing the non-federal share of benefit expenditures to other entities.

8.1.17.2 Contractor Responsibilities

The following are the requirements of the Core MMIS contractor.

a. Include the following data in the claims reporting function:

   1. All the claim records from each processing cycle.

   2. Online entered, non-claim-specific financial transactions, such as recoupment's, mass adjustments, cash transactions.

   3. Provider, member and reference data from the MMIS.

   4. Individual claim records for all claims not paid through the MMIS.

b. Perform mass adjustments as directed by the Department.

c. Provide electronic funds transfer and electronic remittance advices.

d. Provide paper checks and remittance advices to specific provider groups as directed by the Department.

e. Provide electronic copy of the check payment register to the Department following each check write, in the format and content approved by the Department.

f. Run a check-write payment cycle and EFT authorization on a schedule determined by the Department.

g. Issue remittance advices to all providers pursuant to the Department guidelines and timeframes.

h. Produce and mail a Explanation of Medicaid Benefits (EOMB) each month to a statistically valid random sample using a state approved sampling methodology of members who received Medicaid benefits (currently, a 1 percent sample is used). This sample is combined with state specified targeted members or a group of claims and the EOMB is mailed to each appropriate member. The EOMB lists all the Medicaid services the member received the previous month, including date of service, provider, procedure and amount paid.

i. Run a minimum of three cycles per week of claim history print requests and run a minimum of five cycles per week of member history requests and a minimum of one cycle per week for purged claim history requests.

j. Provide the Department with electronic copies of remittance advices and EOMB forms.

k. Provide the Department of Inspections and Appeals a file of all checks paid out and Electronic Fund Transfers (EFTs) made.

l. Produce electronic file of monthly billings for entities responsible for the non-federal share of claims.

m. Print billings for entities responsible for the non-federal share of claims as directed by the Department.

n. For ICF/MR provider assessment fee payments, identify the non-federal share and ensure these amounts are not transferred to the accounts receivable system for collection by the Department.

o. Maintain the table of Integrated Information for Iowa (I/3) financial accounting system codes in the system.

p. Extract information required for billing entities responsible for the non-federal share of benefit expenditures for download to an SQL-server based A/R system.

q. Produce and mail a paper report and invoice to entities responsible for the non-federal share of benefit expenditures with instructions to send the checks for payment to the Department.

r. Accept and process the Department of Administrative Services Vendor Offset file received weekly from the Department.

s. Transmit accounts that cannot be collected (e.g., provider overpayments) to the Revenue Collection contractor.

t. Generate provider remittance advices in electronic, paper (currently less than 1500 providers) and PDF media. Electronic remittance advices must meet ANSI X12 835 standards. Include all of the information identified below on the remittance advice. For the ANSI X12 835 format, information is limited to available fields on the authorized format.

1. An itemization of submitted claims that were paid, denied or adjusted and any financial transactions that were processed for that provider, including subtotals and totals.
2. An itemization of suspended claims.
3. Adjusted claim information showing both the original claim information and an explanation of the adjustment reason code.
4. The name of the insurance company, the name of the insured and the policy number for claims rejected due to TPL coverage on file for the member.
5. Explanatory Messages relating to the claim payment cutback or denial.
6. Summary section containing earnings information regarding the number of claims paid, denied, suspended, adjusted, in process and financial transactions for the current payment period, month-to-date and year-to-date.
7. Explanation of Benefits payment Messages for claim header and for claim detail lines.
8. Patient account and medical records numbers, where available.
9. Any additional fields as described by the Department.

u. Provide the capability to insert informational Messages on remittance advices or a supplemental document to accompany payment, with multiple Messages available on a user-maintainable Message text file, with selectable print parameters such as provider type, claim type and payment cycle date(s).

v. Provide the flexibility to suppress the generation of zero-pay checks and EFTS but to generate associated remittance advices.

w. Provide to the state each provider's 1099 information annually.

x. Accommodate manually issued checks by the state and the required posting to the specific provider's account to adjust the provider's 1099 earnings data and set up recoupment criteria.

y. Enter lien and assignment information to be used in directing or splitting payments to the provider and lien holder.

z. Identify providers with credit balances and no claim activity during the Department specified number of months and generate a quarterly report of credit account balance audits.

aa. Generate overpayment letters to providers when establishing accounts receivable.

bb. Provide paper, envelopes, check stock and all services associated with printing and mailing Residential Care Facility (RCF) letters and checks, including lien holder provider checks.

cc. Provide report on all financial transactions by source, including TPL recoveries, fraud and abuse recoveries, provider payments, drug rebates.

1. Transmit financial data electronically from the MMIS directly to the Department or the entity responsible for producing EFT.
2. Manage the billing process for entities responsible for the non-federal share of specified services.
3. Accumulate paid claims and Information on each claim line including member’s county of legal settlement.
4. Produce and mail a paper report and invoice to entities as directed by the Department.

5. Produce electronic file for entities as directed by the Department.
6. Manage account receivable function to track all amounts due the Department as a result of a transaction processed by the MMIS and POS.

8.1.17.3 Performance Standards

a. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Department.
b. Produce state-defined reports including, but not limited to accounts payable and receivable reports, within the required timeframe determined by the Department.
c. Produce, post and mail the Explanation of Medicaid Benefits (EOMB) within five business days of the pay cycle.
d. Produce, post and mail all remittance advices within one business day of the pay cycle.
e. Perform mass adjustments within five business days of being directed to do so by the Department.
f. Deliver the EFT and check file as directed by the Department.
g. Deliver the file of charges to entities responsible for the non-federal share of benefit expenditures to the state's accounts receivable system within one business day of the last pay cycle of the month.
h. Print and mail RCF letters and checks, including lien holder provider checks as determined by the Department.
i. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.18 Program Integrity Management

All Program Integrity functions are the responsibility of the Program Integrity contractor and or the Department staff. The contractor responsibilities for the MMIS Program Integrity functions are limited to producing files and reports indicated in this section.

8.1.18.1 State Responsibilities

The Department provides program oversight and specifies the parameters and criteria used by the Program Integrity contractor to develop exception, profile and informational reports of providers and support the Program Integrity member analysis functions, including investigation of potential member overuse or misuse of services and identification of members for the member lock-in program. The Member Services contractor will perform the member analysis and member lock-in functions. The Department performs the following functions related to the SUR module:

a. Oversight to all contractors involved with Program Integrity.
b. Details on the contents of files and reports.
c. Approve requests made to MMIS by the Program Integrity contractor.

8.1.18.2 Contractor Responsibilities

The contractor responsibilities for the MMIS Program Integrity functions are limited to the following:

a. Provide weekly or as required by the Department, a file of all paid claims to Program Integrity contractor, Member Services contractor and a Medicaid Fraud Control Unit (MFCU).

b. Provide weekly or as required by the Department, a copy of the provider claims history profile report to the Department of Inspection and Appeals.

c. Produce for the Department of Inspection and Appeals an electronic summary of LTC.

d. Provide to the Department Medicaid Fraud Control Unit, weekly or as directed by the Department an electronic copy of all checks paid and Electronic Fund Transfers (EFTs) made.

8.1.18.3 Performance Standards

a. All required reports must be available online for review by the Department staff pursuant to the following schedule:

   1. Daily reports - by 10:00 AM of the following business day.
   2. Weekly reports – by 10:00AM of the next business day after the scheduled production date.
   3. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Department.
   4. Produce the state-defined reports within the required timeframe as determined by the Department.

8.1.19 Managed Care

Iowa is committed to providing Medical Services to Medicaid members through managed health care wherever feasible. Iowa does not currently have a managed care-based fully capitated managed medical care program. There are currently five different managed care initiatives in Iowa:

a. A Primary Care Case Management (PCCM) program called the Medicaid Patient Access to Service System (MediPASS). Members enrolled in MediPASS are enrolled with a primary care provider who is responsible for providing primary care and coordinating or authorizing other necessary care. This is not a full risk form of managed care. The primary care provider is paid a set amount per member, per month, for managing the care and is paid fee-for-service (FFS) for other care delivered. All other care, provided the primary care provider approves it, is reimbursed on a FFS basis.

b. Iowa does not currently have a managed care-based fully capitated managed medical care program.

c. The State of Iowa has a managed behavioral health plan called the Iowa Plan for Behavioral Health (Iowa Plan). The Iowa Plan contractor operates under a capitated, risk-based contract.

d. Medicaid members enrolled with the Iowa Plan receive mental health and substance abuse treatment services from providers that subcontract with the contractor, who is the behavioral mental health contractor with the Iowa Plan. The Department eligibility system automatically enrolls Medicaid-eligible individuals in the Iowa Plan unless they are exempt.

e. A Medical Home is a location that serves a designated geographic area where primary health care (PHC) services, including care coordination, are delivered. Medical services are provided by persons appropriately licensed to provide such services in the state of Iowa. The Medical Home provides initial care and the majority of ongoing health care needs. If the Medical Home determines that a higher level of services are required than what it can provide, referrals to specialists may be made.

f. PACE (Program of All-inclusive Care for the Elderly) is a program designed to help members stay as healthy as possible, but also to provide for any other medical care that may be needed such as hospitalizations, specialty care, nursing facility care, hospice, emergency care and transportation. Each PACE provider must operate an adult day services-certified PACE center in which primary care plus other services will be provided. Providers enrolled as PACE providers have a designated service area per agreement with the Department. PACE is a fully capitated program. The PACE provider is responsible for all Medicaid covered services for members enrolled with Medicaid. No FFS claims are paid for the PACE provider or any other Iowa Medicaid provider. Eligible enrollees are those Medicaid members over age 55 who meet nursing facility level of care criteria and choose whether to enroll in PACE.

g. A non emergency medical transportation brokerage system was established effective October 1, 2010. The broker operates under a capitated, risk-based contract. Medicaid members eligible for non-emergency transportation make arrangements through the broker for transportation to medical or therapy appointments.

8.1.19.1 Activities

The primary activities of the Managed Care module function are listed below.

a. Support project coordination, technical analysis, data collection, analysis and reporting on the managed care contractors.

b. Support the quality assurance, utilization review and grievance resolution of managed care contractors and MediPASS providers through the provision of data which is analyzed to ensure adequate system entry and data integrity of all encounter-based data.

c. Support the Iowa Plan and PACE by issuing the capitation payments and remittance advices, receiving, processing and maintaining encounter data in MMIS, editing FFS payments to avoid duplication of payment for services covered by the Iowa Plan, responding to provider and member questions, loading Iowa Plan data in eligibility verification applications and generating administrative and federal reports.

d. Support the MediPASS and Medical Home by issuing the administrative and incentive payments and remittance advices, communicating member enrollment, editing FFS payments to avoid payment for unauthorized services, responding to provider and member questions, loading enrollment data in eligibility verification applications and generating administrative and federal reports.

e. Support the Medical Home program. A Medical Home is a location that serves a designated geographic area where primary health care (PHC) services, including care coordination, are delivered. Medical services are provided by persons appropriately

licensed to provide such services in the state of Iowa. The Medical Home provides initial care and the majority of ongoing health care needs. If the Medical Home determines that a higher level of services are required than what it can provide, referrals to specialists may be made.

f. Support the transportation brokerage by issuing the capitation payments and remittance advices receiving, processing and maintaining encounter data in MMIS and generating Administrative and federal reports.

g. Support the Accountable Care Organization program. Provide systems support for program administration and payment methods.

8.1.19.2 State Responsibilities

The Department provides the Core MMIS contractor the information to maintain the managed care enrollment data on the MMIS provider file and for making the monthly payments for managed care contractors. The Department responsibilities include:

a. Establishing policy and making administrative decisions concerning the managed care programs and the transportation brokerage system.

b. Developing contracts with managed care organizations and transportation broker.

c. Monitoring contract compliance and quality of care or service provided by the managed care organizations and transportation broker.

d. Define rules for managed care and transportation enrollment.

e. Establish the payment rates for each managed care program and the transportation brokerage.

8.1.19.3 Contractor Responsibilities

The specific responsibilities of the Core MMIS contractor are:

a. Accept and process member eligibility updates to enroll or disenroll members in managed care plans or the transportation brokerage based on the Department rules.

b. Accept and process managed care and transportation broker provider data from Provider Services contractor.

c. Calculate and issue administrative, incentive and capitation payments to the managed care contractors and the transportation broker.

d. Adjudicate fee-for-service claims in accordance with the Department rules.

e. Generate reports as required by the Department.

f. Manage the payment process and issue the payments.

g. Resolving fee-for-service and capitation payment errors.

h. Issue enrollment rosters.

i. Send electronic remittance advices to the managed care contractors and transportation broker.

j. Send paid claims and encounter data to actuarial contractor.

8.1.19.4 Performance Standards

The performance standards for the Managed Care function are:

a. Process payments on a schedule approved by the Department.

b. Meet a ninety-eight percent accuracy rate for all capitation rate assignments.

c. Meet a ninety-eight percent accuracy rate on appropriate payment or denial, of fee-for-service claims for managed care members.

d. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

e. Produce state-defined reports within the required timeframe determined by the Department.

8.1.20 Waiver, Facility and Enhanced State Plan Services Management

The purpose of the Waiver module function is to support Home and Community-Based Services (HCBS). The current HCBS waivers include:

a. AIDS and HIV.

b. Brain Injury.

c. Children's Mental Health (CMH).

d. Elderly.

e. Ill and Handicapped.

f. Intellectual Disability.

g. Physical Disabilities.

The HCBS waivers provide services to maintain individuals in their own homes or communities who would otherwise require care in medical institutions. Examples of services reimbursed under the waivers are: adult day care, homemaker services, personal care services, community supports, home health aide, nursing services and respite care. Currently, all HCBS waiver services are incorporated into care plans, which are approved by the Department and submitted to the MMIS.

The current long term care facility based programs include:

a. Hospice Residing in Facility.

b. Nursing Facility (NF).

c. Residential Care Facility (RCF).

d. Intermediate Care Facility for Individuals with Intellectual Disabilities (formerly ICFMR).

e. Skilled Nursing Facility (SNF).

f. Mental Health Institutes (MHI).

g. Psychiatric Medical Institutions for Children (PMIC).

h. Nursing Facility for the Mentally Ill (NFMI).

The current enhanced state plan and program services include:

a. Targeted Case Management (TCM).
b. Habilitation.
c. Remedial Services.
d. Program for the all-inclusive Care for the Elderly (PACE).
e. Money Follows the Person (MFP).
f. Allow for future Program changes and additions as directed by the Department.

8.1.20.1 State Responsibilities

a. Establishes waiver policy.
b. Establish rates.
c. Establish new waiver programs.

8.1.20.2 Contractor Responsibilities

a. Accept and process data from the Department and external entities.
b. Generate transactions to external entities.
c. Verify eligibility and program participation for members from the eligibility system.
d. Maintain level-of-care, dates of service and service plan data for waiver facility and enhanced state plan program members including tracking of services and expenditures.
e. Produces required reports.
f. Educate contractors and the Department users in the creation and modification of benefit plans and in the use of the rules engine to assign beneficiaries to benefit plans and to set the hierarchy of benefit plans.

8.1.20.3 Performance Standards

a. Update MMIS with transactions from external sources within 24 hours of receipt.
b. Send updates to external sources within 24 hours of update.
c. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.
d. Produce the state-defined reports within the required timeframe determined by the Department.
e. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.21 Optional Waiver, Facility and Enhanced State Plan Services Management

This scope of work is to be bid as an optional component to be considered by the Department. Refer to Attachment N for pricing.

The purpose of the Waiver module function is to support Home and Community-Based Services (HCBS). The current HCBS waivers include:

a. AIDS/HIV.

b. Brain Injury.

c. Children's Mental Health (CMH).

d. Elderly.

e. Ill and Handicapped.

f. Intellectual Disability.

g. Physical Disabilities.

The HCBS waivers provide services to maintain individuals in their own homes or communities who would otherwise require care in medical institutions. Examples of services reimbursed under the waivers are: adult day care, homemaker services, personal care services, community supports, home health aide, nursing services and respite care. Currently, all HCBS waiver services are incorporated into care plans, which are approved by the Department and submitted to the MMIS.

The current long term care facility based programs include:

a. Hospice Residing in Facility.

b. Nursing Facility (NF).

c. Residential Care Facility (RCF).

d. Intermediate Care Facility for Individuals with Intellectual Disabilities (formerly ICFMR).

e. Skilled Nursing Facility (SNF).

f. Mental Health Institutes (MHI).

g. Psychiatric Medical Institutions for Children (PMIC).

h. Nursing Facility for the Mentally Ill (NFMI).

The current enhanced state plan and program services include:

a. Targeted Case Management (TCM).

b. Habilitation.

c. Remedial Services.

d. Program for the all-inclusive Care for the Elderly (PACE).

e. Money Follows the Person (MFP).

f. Allow for future program changes and additions as directed by the Department.

8.1.21.1 State Responsibilities

a. Establish policy and rules.

b. Establish rates.

c. Establish programs.

8.1.21.2 Contractor Responsibilities

a. Accept and process data from the Department and external entities.

b. Maintain appropriate edits and controls to ensure the accurate processing of the programs.

c. Maintain accurate data and audit trails of changes to data.

d. Produce required reports.

e. Educate the Department users in the creation and modification of benefit plans and in the use of the rules engine to assign members to benefit plans and to set the hierarchy of benefit plans.

f. Manage the system and accommodate changes as defined by the Department.

g. Collect level of care determination, approval of services, date spans, units, rate and providers by member and use this as prior authorization for claims payment.

8.1.21.3 Performance Standards

a. Update MMIS with transactions from external sources within 2 hours of receipt.

b. Send updates to external sources within 2 hours of update.

c. Produce the state-defined reports within the Department defined timeframe.

d. Provide and integrate quarterly updates for all knowledge transfer materials and documentation.

e. Claims will not be paid without an approved level of care.

f. Claims will not be paid for dates that are not covered by the level of care effective dates.

g. Claims will not be paid without prior authorization.

h. Claims will not be paid for services that are not within the authorized service, units, provider and date spans.

i. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.22 Interactive Voice Response System (IVRS) Management

The existing Interactive Voice Response System (IVRS), also called Eligibility Verification System (ELVS) which is not being replaced, is a telephone voice and touch-tone response system maintained by the contractor that provides access to limited data elements from the MMIS. The purpose of the IVRS referred to as ELVS is to provide date-specific information to providers regarding member eligibility, provider payment amounts, TPL coverage and managed health care participation. The IVRS referred to as ELVS is provided at no charge to the providers.

IVRS operates seven days a week 24 hours a day. The information reported by IVRS is in the form of digitally recorded phrases stored on the IVR computer.

The purpose of the IVRS is to:

a. Support telephone inquiries.

b. Provide a response from the eligibility file and other files on information such as last check amount.

IVRS (referred to as ELVS) Data: Providers may query member eligibility or recent provider payment information by responding to prompts on their touch-tone telephones. Based on information supplied by the caller IVRS systematically retrieves data, interprets the data and then communicates the appropriate phrases back to the caller.

8.1.22.1 Activities

The primary activities of the IVRS function is to provide Medicaid member data, provider data and claims data to authorized providers 24 hours per day via automated access.

8.1.22.2 State Responsibilities

The Department is responsible for approving the data elements available in the IVRS and the configuration of the system, which includes methods for access, volume of calls supported and frequency of updates to information:

a. Approve the functionality and voice response scripts for the Core MMIS contractor's Interactive Voice Response System (IVRS).

b. Monitor performance.

c. Enter into contracts with telecommunication vendors.

8.1.22.3 Contractor Responsibilities

The Core MMIS contractor is responsible for the following IVRS (referred to as ELVS) activities:

a. Ensure that the IVRS referred to as ELVS, is updated with current accurate information from the MMIS. The data elements included and the frequency of updating is approved by the Department.

b. Send the necessary data elements to the IVRS referred to as ELVS.

c. Provide member eligibility and provider information through an automated voice response system (IVRS). Voice response is available to all providers with a touch-tone telephone.

d. Provide appropriate safeguards to protect the confidentiality of eligibility information, conform to all state and federal confidentiality laws and ensure that state data security standards are met.

e. Ensure the system checks member identification using predefined access keys approved by the Department.

f. Provide automated logging of all transactions and produce reports as required by the Department.

g. Track and identify caller statistics, including provider type, provider number, number of inquiries made, duration and errors or incomplete calls.

h. Coordinate with the Department to assure sufficient communication capabilities to accommodate all providers requiring utilization of the system.

i. Coordinate with telecommunication and software vendors to resolve operational and performance issues.

j. Override the system pronunciation of names as necessary to correct computer generated pronunciation.

k. Notify the Department designees of operational issues within one hour of identification.

l. Provide knowledge transfer to Provider Services' contractor in the use of IVRS options and respond to questions from Provider Services contractor.

m. Support and maintain the IVRS referred to as ELVS.

8.1.22.4 Performance Standards

The performance standards for the IVRS (referred to as ELVS) functions are provided below.

a. Assure a response time of less than five seconds on the IVRS referred to as ELVS. Response time is determined by measuring the elapsed time from speaking or entering the requested provider and member information to receipt of a response.

b. The IVRS referred to as ELVS must be available ninety-eight percent of the time, 24 hours a day and seven days a week.

c. Update IVRS referred to as ELVS within 24 hours following Core MMIS contractor receipt of the Medicaid Recipient Eligibility File or provider file updates or upon completion of each claims processing check write production.

d. Correction of system pronunciation of names within one business day of identification of problem.

e. Update voice response scripts to correct errors within one business day of identification of problem.

f. Notify the Department designees of operational issues within one hour of identification.

g. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

h. Produce the state-defined reports within the required timeframe determined by the Department.

i. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.23 Web Services

This section describes the operational requirements for the web services module function.

8.1.23.1 State Responsibilities

a. Approve all web content.

b. Provide wording for alerts.

c. Provide guidelines for authorizing users.

d. Provide all rules and policies.

8.1.23.2 Contractor Responsibilities

a. Update the content of the web portal within two days of receipt of the Department approval.

b. Comply with the Department usability and content standards (i.e., style guide) and provide a layout that has user-configurable resolution, fonts and color choices.

c. Update interactive content, such as, but not limited to, alerts or current fee schedule on the web, as required by the Department within approved timeframes.

d. Monitor the web environment to evaluate the adequacy of infrastructure to support access by providers and members.

e. Notify the Department immediately of the downtime in the event of unscheduled downtime. If the Department requires, provide a written and the Department-approved action plan to resume system activity and provide a time when the system is will be available. Weekly reports to the Department must be produced detailing all system downtime.

f. Obtain approval from the Department of all documents and functionality (e.g., applications, manuals, handbooks, notices, welcome packets and others) before being posted on the web portal.

8.1.23.3 Performance Standards

a. Create and or update operational procedure manuals within in 10 business days of the approval of the implementation procedure or change by the Department.

b. Produce the state-defined reports within the required timeframe determined by the Department.

c. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.24 Workflow Management

The Department workflow module is a software suite that combines document imaging, electronic document management and records management and workflow.

8.1.24.1 State Responsibilities

a. Provide guidelines for workflow processes.

b. Oversee and monitor contractor performance.

8.1.24.2 Contractor Responsibilities

a. Configure new workflow management system.

b. Import and reconstruct the current IME workflow processes.

c. Reconfigure workflows as required to support revised business processes.

d. Create the process for assigning and transferring claims within the workflow.

e. Monitor activities and distribute workloads.

f. Provide a demonstration of the workflow as requested by the Department.

g. Destroy source documents according to procedures defined by the Department.

8.1.24.3 Performance Standards

a. Create and or update operational procedure manuals within in 10 business days of the approval of the implementation procedure or change by the Department.

b. Produce the state-defined reports within the required timeframe determined by the Department.

c. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.1.25 Rules Engine

The Core MMIS contractor is responsible for populating the rules engine module initially and as required to implement rule revisions for:

a. Member Services.

b. Provider Services.

c. Benefit Plan Services.

d. Claim Receipt and Adjudication Services.

e. Reference Services.

f. Managed Care Services.

g. Financial Services.

h. Federal Reporting Services.

i. System Parameter Services.

8.1.25.1 State Responsibilities

a. Approve all rules prior to implementation.

b. Provide guidance on rule development.

c. Monitor contractors.

8.1.25.2 Contractor Responsibilities

a. Provide knowledge transfer to the contractors and the Department users in the use of the rules engine.

b. Maintain the rules within the rules engine and make all required modifications as directed by the Department.

c. Provide management summary reports on the overall status, all rules engine modifications during the period and have the reports accessible online, as directed by the Department.

d. Maintain a rules engine(s), which can be queried online.

e. Maintain the documentation to support the reason for each change to a rule as directed by the Department.

8.1.25.3 Performance Standards

a. Implement new rules within one business day after approval by the Department.

b. Revise or terminate rules within one business day after approval by the Department.

c. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

d. Produce the state-defined reports within the required timeframe determined by the Department.

e. The initial accuracy measurement upon submission of all documents and reports will be determined by the Department.

8.2 POS Operational Requirements

This section describes the operational requirement for the POS contractor which include the following module functions: Claims Processing, Reference, Prospective Drug Utilization Review (ProDUR) and Drug Rebate. The Pharmacy Medical Services contractor is responsible for the following functions: retrospective drug utilization review (RetroDUR), review and approval of prior authorization (PA) requests for prescription drugs, maintenance of the preferred drug list (PDL) and the supplemental rebate program.

Point-of-Sale (POS) refers to the online real-time claims processing and claims adjudication of provider claims. For this procurement, the POS requirements are limited to pharmacy claims.

The contractor will include a stand-alone POS prescription drug claim processing system with claim, provider and eligibility interfaces to the MMIS. The POS system must provide automated drug claim eligibility, ProDUR, adjudication and submission service to pharmacies.

8.2.1 Internal Quality Assurance

The contractor is responsible for monitoring its operations to ensure compliance with Department specified performance requirements. A foundation element of the contractor quality assurance function will be to provide continuous workflow improvement in the overall system and contractor operations. The contractor will work with the Department to identify quality improvement measures that will have a positive impact on the overall program. The quality assurance function includes providing automated reports of operational activities, quality control sampling of specific transactions and ongoing workflow analysis to determine improvements needed to ensure the contractor not only meets the performance requirements for its operational area, but also identifies and implements improvements to its operations on an ongoing basis.

8.2.1.1 State Responsibilities

The Department is responsible for the following contractor internal quality assurance functions:

a. Consult with the contractor on quality improvement measures and determination of areas to be reviewed.

b. Monitor the contractor’s performance of all contractor responsibilities.

c. Review and approve proposed corrective action(s) taken by the contractor.

d. Monitor corrective actions taken by the contractor.

8.2.1.2 Contractor Responsibilities

The contractor is responsible for the following internal quality assurance functions:

a. Work with the Department to implement a quality plan that is based on proactive improvements rather than retroactive responses.

b. Develop and submit to the Department for approval, a Quality Assurance Plan establishing quality assurance procedures.

c. Designate a quality assurance coordinator who is responsible for monitoring the accuracy of the contractor's work and providing liaison between the contractor and the Department regarding contractor performance.

d. Submit quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to the Department.

e. Provide quality control and assurance reports, accessible online by the Department and contractor management staff, including tracking and reporting of quality control activities and tracking of corrective action plans.

f. For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.

g. Implement a Department-approved corrective action plan within the timeframe negotiated with the Department.

h. Provide documentation to the Department demonstrating that the corrective action is complete and meets the Department requirements.

i. Perform continuous workflow analysis to improve performance of contractor functions and report the results of the analysis to the Department.

j. Provide to the Department with a description of any changes to the workflow for approval prior to implementation.

8.2.1.3 Performance Standards

The performance standards of the contractor's internal quality assurance functions are provided below.

a. Identify deficiencies and provide to the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.

b. Meet ninety-five percent of the corrective action commitments within the agreed upon timeframe.

8.2.2 Change Management Process

It is the Departments intention that all maintenance and enhancements be accomplished by staff required in this RFP. This staff will be responsible for maintenance, system changes as well as changes in the rules engine. The Change Management Process will be staffed with sufficient resources to satisfy the Service Level Agreements and the contractor must provide sufficient staff at no additional cost to the Department.

During the Operations Phase any system modification or operations improvement activity will be considered a project. The contractor will comply with all aspects of the approved Change Management Plan for any project undertaken during the Operations Phase required in this RFP,

as deemed appropriate by the Department, for the size of the project and comply with the development standards in this RFP for any system modification projects. CMR will be used to identify all changes for system maintenance and enhancements.

8.2.2.1 Contractor Responsibilities

Maintenance will include but not be limited to:

a. Repair defects.

b. Perform routine maintenance on reference files.

c. Complete or repair functionality that never worked.

d. Make additions and modifications to rules engine.

e. Make additions and modifications to benefit plans.

f. Add users to security levels of access.

Enhancements and modifications will include but not be limited to:

a. Make enhancements to system functionality.

b. Make modifications to the Department enterprise modules.

   1. Provide an online tracking tool for the Department and contractor to use to track and generate reports on the progress of all CMRs. The online tracking tool will be integrated with the Workflow Management System and provide the following capabilities:

      i. Allow online entry of new CMR requests.

      ii. Image and include all attachments pertinent to each CMR.

      iii. Provide flexible online reporting and status inquiry into the Change Management System.

      iv. Provide automatic notification to affected parties when a CMR status changes.

      v. Maintain and provide access to all changes made by the Department or the contractor to each CMR, identifying the change made, the person making the change and the date and time of the change.

      vi. Show status report coding changes, attach test results and record all notes from the Department and contractor staff related to each CMR.

   2. The system must produce Change Control Reports that are downloadable to other formats such as Excel. Information to be captured shall include at a minimum the following:

      i. Change Management Request number.

      ii. Priority number.

      iii. Modification description.

      iv. Modification related notes or comments.

      v. Request date.

      vi. Requester.

      vii. Modification starts date.

viii. Assigned resource(s).

ix. Estimated completion date.

x. Estimated hours.

xi. Hours worked to date.

xii. Documentation impact and status.

xiii. Testing status.

xiv. Department approval of the modification.

3. Be responsive to all requests from the Department for system modification, whether categorized as maintenance, defect, enhancement or modification.
4. Complete the CMR on or before the requested completion date.
5. Provide clear and complete responses to all CMRs including:
    i. Definition of the problem.
    ii. Proposed solution.
    iii. Proposed approach to implement the solution.
    iv. Proposed schedule for completion.
    v. Constraints and assumptions.
    vi. Financial impact.
    vii. Stakeholder impact (e.g., provider, members, Department).
    viii. Estimated effort detailed by:
        a. Labor in hours.
        b. Hours per task.
        c. Hours per full-time equivalent (FTE).
        d. Equipment.
        e. General and administrative support in hours.
        f. Ongoing support requirements.
        g. Provider knowledge transfer.
        h. Documentation.
6. Comply with the project management deliverable requirements for CMRs at the direction of the Department.
7. Maintain documented and proven code promotion procedures for promoting changes from the initiation of unit testing, through the final implementation to production.
8. Maintain documented version control procedures that include the performance of regression tests whenever a code change or new software version is installed, including maintaining an established baseline of test cases, to be executed before and after each update, to identify differences.
9. Maintain adequate staffing levels to ensure CMRs are completed within the specified timeframe determined by the Department.

10. Ensure that all CMRs are addressed within the agreed upon timeframe determined by the Department.
11. Provide before and after copies of documentation changes that affect the CMR.

8.2.2.2 Performance Standards

a. Within 10 business days of receipt of a CMR for an enhancement or modification, provide a written response in a Statement of Understanding (SOU) demonstrating understanding of the request and a schedule for completion or a more thorough assessment of the impact of the change on operations and Contract cost per Contract year as designated by the Department.

b. Provide updates to all documentation within 10 business days after the Department approves the enhancement or modification for production.

c. If the contractor finds an issue or defect, the contractor must notify the Department within 24 hours. Failure to do so will result in sanctions being assessed. The contractor will be responsible for the research, coding and testing of the issue or defect. Prior to implementing any changes in production, the contractor must present the test results to the Department for approval. This work must be done without impacting scheduled Department requests.

d. Randomly survey the submitters of CMRs to verify that the user was satisfied with the timeliness, communication, accuracy and result of the CMR process ninety percent of the time.

8.2.3 System Remediation

The contractor is required to deliver CMS certifiable POS modules for the proposed price. The contractor must expeditiously correct any item that CMS will not certify on a schedule to be approved by CMS and the Department. The contractor must correct all items not certified at no additional charge to the Department.

8.2.4 Activities

The primary activities of the POS claims processing function are:

a. Accept and process pharmacy claims submitted by pharmacy providers via POS devices or switch vendors.

b. Maintain control over submitted claims from receipt to final disposition.

c. Provide online adjudication of pharmacy claims and provide electronic notification to providers of the disposition.

d. Ensure that payments are made to eligible providers for eligible members for covered drugs.

e. Ensure that claims for members with third party coverage are denied or flagged for pay-and-chase activity.

f. Provide drug claims data to support functions performed by other MMIS modules.

8.2.4.1 State Responsibilities

a. Develop policies and rules.

b. Monitor contractors.

8.2.4.2 Contractor Responsibilities

The POS contractor will provide online, real-time adjudication of pharmacy claims submitted by pharmacy providers via POS device or through switch vendors. The POS system will return to the pharmacy provider the status of the claim and any errors or alerts associated with the processing, ProDUR alerts, member or coverage restrictions and coordination of benefits information for members whose claims are covered by a liable third party.

The contractor responsibilities for the POS claims processing function are:

a. Provide and maintain a POS adjudication system that is fully compliant with all federal and state laws, rules, regulations and guidelines, including the following HIPAA standards: Transaction and Code Sets, Privacy, Security and NPI and API. Such system must remain compliant throughout the contract term and be adaptable and capable of accepting all POS system updates and all future federal and state law, rule, regulation and guideline changes.

b. Provide an online POS claims adjudication system that is compliant with the current and all subsequent NCPDP D.0 standards and all subsequent CMS standards upon enactment or as required by the state at no additional cost to the state.

c. Accurately process real-time all POS pharmacy transactions, including eligibility verification, claims adjudication and claims reversals.

d. Provide and maintain a POS adjudication system that accurately adjudicates all state-approved program pharmacy claims according to state and federal coverage policies, reimbursement formulas and pharmacy program plan requirements (e.g. co-payments, coordination of benefits, monthly prescription limits, PDL exceptions and clinical prior authorization).

e. Provide and maintain a POS adjudication system that is available 24 hours per day, seven days per week and 365 days per year, except during the state approved routine system maintenance schedule.

f. Ensure that prior authorization has been obtained for drugs requiring prior authorization.

g. For Members designated as "pay and chase," process and pay the claim if it meets all other criteria for payment and report the claim for follow-up activities as directed by the Department via an electronic feed.

h. Provide adjudicated claims and payment processing data to the Core MMIS contractor for inclusion in the payment cycle as determined by the Department.

i. Develop a Contingency Plan that complies with the processes described in the State's Preferred Drug List Prior Authorization (PDL-PA) requirements documentation and addresses the potential loss of connection between the PA Vendor and the POS system. Submit such plan to the Department for approval no later than 30 days after contract award date, with content and in a media and format approved by the Department.

j. Produce all reports for the Department programs and the Department-approved business partners within timelines, with content and in a media and format approved by the Department.

k. Establish and maintain appropriate “dummy” provider numbers to execute production-like testing and testing for external pharmacies. Develop a process to allow pharmacies to send test claims with a “dummy” number through the production system. Conduct testing on

software companies, contracted pharmacy providers and switch vendors and provide the testing results to the Department staff within timeframes, with content and in a media and format approved by the Department.

l. Provide timely and accurate data exchanges with all program stakeholders and the Department-approved business partners.

m. Coordinate all data transfers between the claims processing system, the Department's pharmacy program contractors (e.g. PDL, PA contractors and state MAC contractors) and other designated state agencies and stakeholders, in compliance with the Department's file specifications. Establish and maintain a dedicated, secure connection for each required file or data exchange. Securely transfer all claims and protected health information and ensure HIPAA-compliance.

n. Perform mass updates to finalized POS claims, as directed and within the timelines approved by the Department.

o. Perform individual and gross adjustments for pharmacies, as directed and within the timelines approved by the Department.

p. Perform formulary management tasks and activities to support the viewing, updating and customization of drug formulary data for accurate, efficient claims processing and program administration activities.

8.2.4.3 Performance Standards

The performance standards for the POS claims processing function are provided below.

a. Provide POS function availability 24 hours a day, seven days a week, 365 days a year, except for scheduled and approved downtime.

b. The elapsed time from receipt of the transaction by the contractor from the switch vendor until the POS completes delivery of the transaction back to the switch vendor must not exceed two seconds for ninety five percent of the transactions and four seconds for one hundred percent of the transactions.

c. Provide adjudicated claims and payment data to the Core MMIS contractor by 10:00 pm on the day prior to the payment cycle.

d. Update provider, member and TPL data within one hour of receipt of the data from the Core MMIS contractor.

e. Process one hundred percent of pharmacy claims transactions timely and accurately.

f. Reimburse the Department in the event that a subsequent audit or re-adjudication of claims finds that the contractor incorrectly paid claims that should have been rejected or did not accurately apply the correct price, discount or co-pay (where applicable) to the claims billed, resulting in extra cost to the Department. Reimburse such cost to the Department, dollar-for-dollar plus interest, calculated from the date of payment, using the 13-week U.S. Treasury Bill (T-bill) coupon equivalent rate.

g. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

h. Produce the state-defined reports within the required timeframe determined by the Department.

8.2.5 POS Provider Help Desk

The POS help desk is to provide assistance to providers with claims submission.

8.2.5.1 Contractor Responsibilities

The pharmacy POS contractor must staff and operate a provider help desk 24 hours per day seven days a week to provide assistance and information to providers.

a. Help Desk staff must assist providers with claims submission and ProDUR issues.

b. Help desk staff must have access to and the ability to perform all POS functions available to pharmacy providers including the ability to override, modify and delete claims, in accordance with the Department policies.

8.2.5.2 Performance Standards

a. Calls must be answered within 30 seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The contractor shall provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of 30 seconds.

b. The contractor shall provide sufficient staff, facilities and technology such that ninety five percent of all call line inquiry attempts are answered. The total number of abandoned calls shall not exceed five percent in any calendar month.

c. All call line inquiries that require a call back, including general inquiries, shall be returned within one business day of receipt one hundred percent of the time.

d. Maintain a service level (SL) percentage of at least 80 percent for incoming calls as calculated by the following formula:

$$SL= ((T – (A+B)/T)*100$$

Where T = all calls that enter the queue

A= calls that are answered after 30 seconds

B= calls that are abandoned after 30 seconds

8.2.6 Reference Function

The Reference function contains rates and pricing information needed to determine allowable payments for pharmacy claims, coverage data needed to determine whether the Iowa Medicaid program covers a drug product and prior authorization data needed to determine whether a drug requires prior authorization.

8.2.6.1 Activities

The primary activities of the POS reference function are:

a. Maintain a drug file to identify covered and non-covered drugs, prior authorization requirements, pricing data and other data required for claims processing, drug utilization review activities and other MMIS functions.

b. Support the claims processing function by providing information used in adjudication and pricing of pharmacy claims.

c. Support the data requirements of other MMIS functions, such as Core MMIS functions, Data Warehouse and Decision Support, DUR, MARS and PI.

8.2.6.2 State Responsibilities

The Department is responsible for the following POS reference functions:

a. Determine and interpret policy and administrative decisions relating to drug file data.

b. Approve the POS contractor's selection of the drug file updating service.

c. Establish allowed rates and pricing algorithms.

8.2.6.3 Contractor Responsibilities

The contractor responsibilities for the POS reference function are:

a. Contract with MediSpan for drug data files.

b. Maintain a drug data set, which at a minimum includes:

   1. The 11 digit National Drug Codes (NDC).
   2. Pricing of compound, over- the-counter, brand and generic drugs.
   3. Ten date-specific pricing segments.
   4. Indicator for drug rebate.
   5. Indicator for preferred drug.
   6. The Department specific restrictions on conditions to be met for a claim to be paid, such as minimum and maximum days' supply, quantities, refill restrictions, member age, gender restrictions, and prior authorization requirements.
   7. English description of the drug code.
   8. Current prices, including unit dose packaging.
   9. Weekly updating of the drug code and pricing file, at a minimum, in accordance with the Department timeliness requirements.
   10. Identification of Drug Efficacy Study Implementation (DESI or the less than effective drug list) or recalled drugs and any drug codes for generic equivalents in the automated system.
   11. Drug therapeutic class coding.
   12. All current information on the Iowa drug master tape and current pricing tape.
   13. The information required to support the drug utilization review functions.
   14. Non-covered or limited drugs by drug classes or individual drug code.
   15. Pricing fields for each NDC code for at least the following: the federal and state MAC, EAC, AWP, Medicaid AWP or other ingredient cost definition as determined by the Department, professional fee, name of product, description of product, drug class, therapeutic class, unit of issue, family planning code, effective date of the price and size of package.
   16. For each code, information that will set various reimbursement limits and restrictions.

17. Online inquiry access to the drug code and pricing file by NDC number, partial number and drug product name.

c. Load and update the pricing files from MediSpan weekly, at a minimum, on a schedule agreed upon by the Department.

d. Apply updates and monitor the maximum allowable cost limitations in accordance with the Department coverage policy.

e. Accept the Department approved updates to the Preferred Drug List (PDL) and prior authorization (PA) drug criteria from the Pharmacy Medical Services contractor and update the formulary file with PDL and PA data. Generate an error and warning report within timelines, with content and in a media and format approved by the Department. Create and maintain a history of the PDL and PA status of all drug products and provide designated the Department staff with online, real-time inquiry access to PDL and PA status for individual products. Maintain a complete audit trail for all PDL and PA transactions.

f. Apply the current Department program methodology for distinguishing between brand and generic drug product and to determine co-pay.

g. Modify, enhance or develop pricing methodologies, at no additional cost to the Department, as mandated by federal and state laws, rules, regulations, guidelines or litigation settlements. Obtain prior Department approval for any such changes and implement them within the Department approved timelines.

8.2.6.4 Performance Standards

The performance standards for the POS reference function are provided below.

a. Update the formulary file within one business day of receipt of the file from the drug update vendor or receipt of online updates from the Department.

b. Provide update, error reports and audit trails to the Department within one business day of completion of the update.

c. Identify and correct any errors on the formulary file within one business day of error detection.

d. Provide the quarterly drug listings to the Department by 10:00 AM of the fifth business day after the end of the quarter.

e. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

f. Produce the state-defined reports within the required timeframe determined by the Department.

8.2.7 Prospective Drug Utilization Review (ProDUR)

POS supports the Prospective Drug Utilization Review (ProDUR) process, which provides alerts to possible drug-to-drug interactions and other therapeutic management requirements. The POS contractor performs the ProDUR functions.

The Department currently contracts with the Pharmacy Medical Services Unit to perform retrospective drug utilization (RetroDUR) review of pharmacy claims.

8.2.7.1 Activities

The primary activities of the ProDUR function are:

a. Provide a prospective and concurrent review of prescription practices at the pharmacy and member level to assure appropriate and beneficial use of pharmaceuticals.

b. Ensure that step therapy has been provided when appropriate.

8.2.7.2 State Responsibilities

The Department is responsible for the following ProDUR functions:

a. Approve the POS contractor's ProDUR criteria and methodology.

b. Approve all Messages used in ProDUR alerts.

c. Monitor the contractor's performance of the ProDUR function.

8.2.7.3 Contractor Responsibilities

The POS contractor will provide an integrated prospective drug utilization review system (ProDUR) system via the POS function to ensure appropriate use of pharmaceuticals and to identify potential abuse or misuse of drugs. This system must provide the capability to alert pharmacy providers to potential problems at the time a claim is submitted.

The contractor responsibilities for the ProDUR function are:

a. Update ProDur edits as directed by the Department.

b. Support prospective drug utilization (ProDUR) review activities through the POS system, as required by the Department.

c. Compare a prescription claim against member claims history and ProDur edits, including monitoring for:

    1. Therapeutic appropriateness.
    2. Overutilization.
    3. Underutilization.
    4. Appropriate use of generic products.
    5. Therapeutic duplication.
    6. Drug-disease contraindications.
    7. Drug-pregnancy contraindications.
    8. Drug- interactions.
    9. Incorrect drug dosage or duration of drug treatment.
    10. Clinical abuse or misuse.

d. Generate alerts based on clinical or program compliance issues associated with a member's prescription for the pharmacist to evaluate.

e. Provide information and data as required by the Department to support ProDUR criteria or criteria enhancements.

f. Provide a quarterly report of drug ranking by ProDUR alerts generated with user-defined sort capabilities.

g. For ProDUR editing, update both the database and algorithms on at least a monthly basis or upon request by the Department.

h. Generate a quarterly report showing cost-savings as a result of ProDUR alerts and denials.

i. Develop recommendations for new ProDUR edits or changes, quarterly at a minimum, to current ProDUR edits and submit to the state for approval.

j. Provide a mechanism to incorporate NDCs collected for covered outpatient physician administered drugs into ProDUR edits.

8.2.7.4 Performance Standards

The performance standards for the ProDUR function are provided below.

a. Provide ProDUR criteria for new drugs within two weeks of a drug's introduction.

b. Provide the ProDUR criteria update and error reports within one business day of the update.

c. Provide the monthly ProDUR reports by 10:00 AM of the third business day after the end of the month.

d. Provide quarterly reports by 10:00 AM of the fifth business day after the end of the quarter.

e. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

f. Produce the state-defined reports within the required timeframe determined by the Department.

8.2.8 Drug Rebates

The purpose of the Medicaid drug rebate program is to identify drugs dispensed and request any associated rebate from the manufacturers consistent with federal regulations. Using the NDC number and the Drug Rebate Manufacturer Agreement data, the contractor determines totals, by manufacturer of the amount of all drugs prescribed for Iowa Medicaid members covered by the agreement. The POS contractor is responsible for the administration of the entire drug rebate function under the direction of the Department, excluding negotiation of and contracting for state supplemental rebates.

Claims for pharmacies receiving drugs under the 340B program as identified by the Health Resource Services Administration (HRSA) are not included in the totals.

In Iowa, the POS contractor performs all drug rebate functions, as prescribed by state and federal regulations. This contractor calculates the amount of rebate owed by each manufacturer and generates the respective invoices. As rebates are received, the contractor updates the rebate management system.

The contractor also tracks drug manufacturer disputes and resulting resolution, as part of their rebate management responsibility. If the contractor determines that there was an error with units submitted, the pharmacy will be contacted by the staff and asked to reverse and resubmit the claim for the correct quantity.

The contractor provides MMIS with feeds of pharmacy claims three times a week, for adjudication. MMIS provides the contractor verification of claims adjudication weekly for rebate collection.

Updates to the CMS 64 financial tracking are also required to report drug rebate collections. The quarterly Drug Rebate Manufacturer Agreement data from CMS is processed as part of the drug rebate function.

In addition to Drug Rebates, state supplemental rebates are also collected on select Diabetic Supplies and durable medical equipment (DME) when processed through the Point-of-Sale (POS) system. All rebate functions related to Diabetic Supplies is the responsibility of the POS contractor, excluding negotiation of and contracting for state supplemental rebates.

8.2.8.1 Activities

The primary activities of the Drug Rebate function are:

a. Identify drug claims eligible for rebates.

b. Invoice drug manufacturers for rebates due.

c. Collect drug rebate funds from manufacturer.

d. Provide a complete accounting of rebates due corrected and outstanding.

8.2.8.2 State Responsibilities

a. The Department is responsible for developing and providing policy to the Pharmacy POS contractor on the drug rebate program.

b. The Department also sets performance standards for timeliness, accuracy and funds recovery under the rebate function.

8.2.8.3 Contractor Responsibilities

To effectively and accurately administer the Medicaid program's state's Omnibus Budget Reconciliation Act (OBRA) 1990 drug rebate program (federal Medicaid outpatient drugs), Deficit Reduction Act of 2005 physician-administered drug rebates, including J-Codes), state supplemental rebate program, diabetic supply (Durable Medical Equipment) state supplemental rebate program and any other rebate programs as required by federal and state laws, rules, regulations, guidelines or policies. The Pharmacy POS contractor has the following responsibilities under the drug rebate program:

a. Administer the state's OBRA 1990 rebate programs using historical data beginning in 1991, as required by federal and state laws, rules, regulations, guidelines and policies.

b. Comply with and be knowledgeable about, all guidance and instructions from CMS on the implementation of and reporting requirements for the Patient Protection and Affordable Care Act(PPACA) (P.L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act. Specifically section 2501 of PPACA and section 1206 of HCERA concerning the increased rebate percentages for covered outpatient drugs dispensed to Medicaid patients, the extension of prescription drug rebates to covered outpatient drugs dispensed to enrollees of Medicaid managed care organizations (MCOs) and the rebate offset associated with the increase in the rebate percentages (including the process used to estimate and collect these offsets).

c. Provide and maintain historic and current data at the National Drug Code 11- digit (NDC 11) level for: manufacturers participating in each drug rebate program, claims data, quarterly unit rebate amounts (URAs), quarterly rebate invoiced amounts, quarterly utilization, all utilization and rate changes, along with a reason for the change, the outstanding balances (both units and dollars), collections, postmark dates for each invoice and payment and other data as defined by the Department. Maintain a complete online audit trail for all activity.

d. Maintain a drug manufacturer data set with data necessary for processing drug rebate claims, including the capability of calculating variable Federal Medical Assistance Percentage and billing interest on past due accounts. The rebate labeler information management must include the ability to view, add, update and terminate labelers based on the CMS listing.

e. Maintain the drug rebate system, including programs and data in a configuration that can be easily transferred to a new contractor through a standard procurement process or to the Department.

f. Assume all administrative and management tasks (e.g. prior period adjustments, payment posting, deposit corrections, deposit reconciliation and dispute resolution) related to drug rebate programs for all previous and future quarters.

g. Process all data on the CMS drug rebate file and all federal and state rebate billings, on a quarterly basis. Rebates for Medicaid Program, physician administered, Medicaid Supplemental and Diabetic Supply (DME) Supplemental rebates must be tracked and processed separately.

h. Calculate the quarterly rebate invoice amount for each program, based on the NDC 11 codes, drug quantity units on paid claims (original, coordinated and adjusted claims), unit rebate amounts, interest owed and prior period adjustments.

i. Use CMS units of measure for all invoice quantities (current and prior quarter adjustments). Apply a conversion factor to convert paid claim quantities to CMS units of measure, when needed.

j. Provide the capability to accept decimal amounts in the quantity field, regardless of where such fields are stored, displayed or reported. The quantity field must accept no less than three digits right of the decimal point and six digits right of the decimal for the unit rebate amount field.

k. Perform state-approved pre-invoice edits quarterly, to identify outlier claims and proactively reduce the number of manufacturer disputes for rebate invoices. Such pre-invoicing quality control edits include, for example, a quarter-to-quarter percentage change in the rebate amount invoiced by NDC 11 and a rebate amount which exceeds the reimbursed amount.

l. Exclude from rebate processing those prescription claims submitted by entities covered under Section 340B of the Public Health Service (PHS) Act.

m. Maintain all documentation related to any adjustments to units, rates or balances and any dispute resolution settlements, throughout the term of this contract and retain such documentation in accordance with the state-approved record retention guidelines. Maintain confidential records in accordance with federal and state laws, rules, regulations and guidelines. Provide copies of any such records as requested by the Department and within Department specified timelines.

n. Invoice drug manufacturers on a quarterly basis, in accordance with federal and state mandated timelines and standards. Mail invoices for Medicaid including physician-administered, Medicaid supplemental and any other state rebate programs.

o. Maintain a mechanism to identify drugs with Healthcare Common Procedure Coding System (HCPCS) J-codes by their National Drug Codes (NDCs) (using a crosswalk for J codes and units) and bill manufacturers for rebates for these drugs.

p. When NDCs are provided on the claim form, utilize the J code, quantity billed and NDC number to bill manufacturers for rebates on these drugs, using a crosswalk for the units.

q. Provide access to a minimum of five years of drug rebate data online; archive data over five years and allow retrieval within 24 hours of a request.

r. Receive and process drug rebate payments from the drug manufacturers, a process that includes the following functions:

   1. Obtain a completed CMS form 304, Reconciliation of State Invoice (ROSI), from each manufacturer within 37 calendar days of mailing the drug utilization information.

   2. Follow-up by e-mail or phone, with each manufacturer who has not submitted payment and or a completed ROSI form within the 37 day time period. Maintain an accounts receivable system to track all paid and unpaid invoices and adjustments. This accounts receivable system must meet all Iowa and the Department accounting requirements.

   3. Compare invoices to the ROSI form or Prior Quarter Adjustments (PQA) form returned by the manufacturer with the payment and determine which NDC 11 line items are different than the invoice and or in dispute.

   4. Recalculate invoices if it is determined that the invoice units are incorrect. Document all changes to the unit quantity, unit rebate amount or outstanding balances in the system and make such data available for reporting.

   5. Maintain online records of original and corrected Prior Period Adjustment (PPA) invoice information, at the NDC 11 level and retain such information in accordance with the Department approved record retention guidelines.

   6. Log rebate checks into On-Base following deposit into Lockbox 3010195 at Wells Fargo in Des Moines, Iowa. Wells Fargo picks up the rebate checks from P.O. Box 310195 where the manufacturer directly mails the rebate check. Send, on a monthly basis, all drug rebate funds collected to the Department.

s. Submit a quarterly report to the Department on the drug rebate information required for the CMS 64.9R report. Identify and submit to the Department the state drug rebate amounts by eligibility category (e.g. Family Planning) to maximize the federal match for these categories.

t. Calculate interest owed to the state, at the NDC 11 level, as specified in the manufacturer program rebate contracts and report outstanding interest balances to the manufacturer with the quarterly invoice.

u. Process and apply interest payments to the Drug Rebate accounts receivable system, at the NDC 11 level, using a methodology and within the timeframes approved by the Department.

v. Submit a monthly report to the Department, showing by quarter, the total amount invoiced, amounts collected and unpaid amounts of drug rebates.

w. Generate and transmit a quarterly file to CMS of drug utilization data invoiced to drug manufacturers for the quarter, in the format and timelines required by CMS.

x. Develop and implement state-approved dispute resolution processes that comply with published CMS dispute resolution policies and federal and state laws, rules, regulations and guidelines. Perform dispute resolution on invoices questioned by manufacturers. Attempt to resolve any data inconsistencies identified by manufacturers prior to submission of the

Remittance Advice Form from the manufacturer. Perform the following dispute resolution activities:

1. Contact the manufacturer by email within 30 calendar days of the postmark of a manufacturer's check where a Reconciliation of State Invoice Form contains disputed amounts to discuss the dispute and to present a preliminary response to the disputed items. A Claim Level Detail Report with drug utilization data that supports the quantity for quarters disputed is attached to the email. Provide the functionality to furnish extracts containing claims level details and other documentation to the manufacturer, for NDC 11 line items that are in dispute and supply within timeframes, with content and in a media and format approved by the Department.
2. Provide the system functionality to enable manual correction of invoice records to the NDC 11 level, in support of the dispute resolution process.
3. Maintain an automated drug rebate dispute tracking system. Such system must track the following, by labeler and NDC 11: the manufacturer's name, the manufacturer's number, the invoiced amount, the invoiced quantity, the manufacturer's paid quantity for the NDC 11, the unpaid quantity (positive or negative), the rebate amount per unit, the unpaid rebate amount (positive or negative), reason for the dispute and interest owed, by year, quarter and program type. Report such information to the Department upon request, within timelines, with content and in a media and format approved by the Department.
4. Retain supporting documentation of resolved disputes for at least seven years from the date of the resolution.
5. Complete negotiations within two quarters of the original invoice. If disputes remain unresolved longer than this and no progress is shown towards resolution the assigned rebate specialist reports the matter to their Team Lead. If agreement cannot be reached between a manufacturer and the POS contractor the matter is elevated to the Department.
6. Calculate the interest due, as specified by CMS on late payments including payment due as a result of a prior period adjustment (PPA) or unpaid disputed rebate payments resolved in the Department's favor.
7. Attend and actively participate in CMS dispute resolution meetings, on behalf of the Department. Notify the Department within five business days of registration when contractor staff intends to participate in such meetings. Prepare meeting minutes and submit to the Department within five business days after the conclusion of the meeting.

y. Drug Rebate Team will work all disputes, regardless of whether disputed previously or not.

1. If neither party has the Claim Level Detail (CLD) the dispute will not be worked, the burden of proof falls on the party presenting the dispute. Note: IOWA sent claims to Data Niche from 1991 through 2005 and resumed this in 2009, including 2005 forward.
2. If one party has the Claim Level Detail (CLD), it will be shared with the other party so the dispute can be worked.
3. The POS contractor will load historical CMS Rebate Data sent by the Department to assist them in resolving these disputes. Note: This will provide information about the original units invoiced, the price invoiced and the rebate at the NDC level. It will not have any payment or adjustment information. Labeler will be asked to provide copies of Checks, ROSI and PQA forms and current balance information, dispute resolution letters or any other supporting documentation they have to support the dispute and audit. They

will need to send their proposed resolution with the documentation and claim detail in order for the POS contractor to review and come to resolution or counter proposal.

4. Standard CMS Best Practices will be followed in resolving these claims.
5. If resolved, both parties will sign a copy of a resolution letter (if appropriate) similar to the one posted at the CMS website at: *http://www.cms.hhs.gov/MedicaidDrugRebateDispR/downloads/sampleresoltr.pdf*.
6. A separate letter will be prepared for each quarter resolved in the event of a future issue the entire dispute period is not reopened, only a smaller period.
7. If no resolution can be reached, as a last resort, appeal rights will be provided to the manufacturer and or labeler.

z. Non-Responsive Labelers- If a labeler has not responded to requests for payment within one month of the original request, the rebate specialist should first talk to colleagues to see if there is another contact that could be used or if there is any reason (such as bankruptcy or a labeler being bought by another company) that explains this. If no contact can be established one week after this, the labeler should be included in the Iowa reporting documents as being unresponsive. The rebate specialist should also send an email to CMS Operations, with a cc: to the Department Pharmacy Consultant and POS Account Manager alerting them of the situation.

aa. Dropped-Off NDCs from CMS NDC Tape- With the receipt of each quarterly CMS NDC tape, a comparison will be done with the previous tape. The comparison will identify NDCs that have been “dropped off”. Each labeler will be contacted to verify that the NDC in question should have been excluded from the tape. The rebate specialist should also send an email to CMS Operations, with a cc to the Department Pharmacy Consultant and POS Account Manager alerting them of the situation.

bb. Business Rule for Bankrupt Labelers:

1. Notice of bankruptcy is received. The notice is sent to the Department, the Attorney General’s Office and the POS Account Manager as soon as possible.
2. Receipt of the notice will automatically trigger the rebate specialist to look at the State of Iowa’s estimated exposure.
3. The estimated exposure will be sent to the Department, the Attorney General’s Office and the POS Account Manager as soon as possible.
4. The Department makes an assessment of whether or not to make the claim in bankruptcy.
5. Ongoing notices of the process related to any bankruptcy will be relayed to the same individuals. The POS contractor will keep a paper and electronic folder by labeler of all notices received.
6. A full account review will be done only for labelers with an estimated exposure equal to or greater than $1000.00 based on OBRA and or Supplemental Rebate receivables from 2004Q4 and forward.

8.2.8.4 Performance Standards

The performance standards for the drug rebate functions are provided below.

a. Update the manufacturer rebate data within five business days of receipt of the update from CMS.

b. Generate and mail invoices to manufacturers within five business days of the receipt of the CMS drug rebate tape and the Department Pharmacy Medical Services contractor supplemental drug and diabetic supply (DME) rebate data.

c. Generate initial collection letters or make phone calls to non-responding manufacturers within 38 calendar days from the mailing date of the invoice.

d. Collect at least ninety percent of the total of accounts receivables outstanding at the beginning of the quarter plus invoices issued during the current quarter by the end of the current quarter.

e. Deposit all payments from drug manufacturers into designated state accounts within one business day of receipt.

f. Generate and mail invoice letters for the J-Code rebate within five business days of receipt from MMIS.

g. Create and update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

h. Produce the Department-defined reports within the required timeframe determined by the Department.

8.2.9 Rules Engine

The POS contractor is responsible for populating the rules engine module initially and as required to implement rule revisions.

8.2.9.1 State Responsibilities

a. Approve all rules prior to implementation.

b. Provide guidance on rule development.

c. Monitor contractors.

8.2.9.2 Contractor Responsibilities

a. Provide knowledge transfer to the contractors and the Department users in the use of the rules engine.

b. Maintain the rules within the rules engine and make all required modifications as directed by the Department.

c. Provide management summary reports on the overall status, all rules engine modifications during the period and have the reports accessible online as directed by the Department.

d. Maintain a rules engine(s) which can be queried online.

e. Maintain the documentation to support the reason for each change to a rule as directed by the Department.

8.2.9.3 Performance Standards

a. Implement new rules within one business day after approval by the Department.

b. Revise or terminate rules within one business day after approval by the Department.

c. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Department.

d. Produce the state-defined reports within the required timeframe determined by the Department.

8.3 Certification Phase

The Department must apply for and receive certification of their system from CMS, by demonstrating that the system meets all requirements and performance standards before receiving enhanced federal funding. The Core MMIS contractor will be the lead contractor for the certification phase. The objective of this phase is to obtain federal certification of the MMIS and POS.

8.3.1 Systems Certification

Section 1903(a) (b) (d) of Title XIX of the Social Security Act provides 75 percent Federal Financial Participation (FFP) for operation of mechanized claims payment and information retrieval systems approved by the federal Department of Health and Human Services (DHHS). Up to ninety percent 90 percent FFP is available for MMIS-related development costs receiving prior approved by DHHS. The Iowa MMIS and POS must, throughout the contract period, meet all certification and re-certification requirements established by DHHS.

The contractor(s) must ensure that their area of system responsibility will meet federal certification approval for the maximum allowable enhanced FFP retroactive to the day the system becomes operational and is maintained throughout the term of the contract. If the MMIS, POS or any module, does not become certified or fails to maintain certification because of failure on the part of any contractor(s), the Department may allocate a portion of the loss of federal funds as actual damages to the responsible Professional Services contractor(s).

The contractor(s) will be liable for the difference between the maximum allowable enhanced FFP and that actually received by the Department, including any losses due to loss of certification, failure to obtain approval retroactive to the operational start date or delays in readiness to support certification.

All FFP penalty claims assessed by DHHS will be withheld from amounts payable to the contractor(s) until all such damages are satisfied. Damage assessments will not be made by the Department until DHHS has completed its certification approval process and notified the Department of its decision in writing.

8.3.1.1 State Responsibilities

a. Serve as the point of contact with CMS. Communicate all pertinent information from the contractor(s) to CMS and from CMS to the contractor(s).

b. Review and approve the CMS Certification Readiness Checklist.

c. Facilitate certification meetings.

d. Review and approve all enterprise changes and schedule.

8.3.1.2 Contractor Responsibilities

During this task, the contractor(s) must provide technical support and assistance with federal certification as described in this section. The contractor(s) must perform the following tasks:

a. Update the CMS Certification Checklists to reflect changes or additions to system requirements that were submitted with the implementation advance planning document IAPD.

b. Validate the RTM against the CMS Certification Checklists to affirm the readiness of the systems to be reviewed for certification.

c. Complete the Certification Readiness documentation. Collect the information and documentation needed by CMS to verify that the MMIS and POS has been successfully operating for at least six months by the time of the visit. This information and documentation must be collected beginning on the first day of operations and cover a period of at least six months of full operation. The contractor(s) must provide an electronic “folder” (a type of repository for information that demonstrates that a system criterion is satisfied) for each criterion that contains reports, print screens or other documentation that demonstrate that the criterion is satisfied. The contractor(s) will provide a plan for data collection no less than 60 days prior to beginning operations. The plan must specify the documentation and information to be collected after reviewing the CMS Certification Readiness Protocol. For example, if a monthly report is produced, CMS will require to see monthly copies of the report. If a criterion applies to daily operations CMS will want to see evidence from the beginning, middle and end of the operational period prior to certification.

d. Assist the Department in responding to CMS requests prior to the on-site certification visit and during the site visit.

e. The contractor(s) must provide necessary resources to the Department for certification.

f. Contractor(s) will assign an individual to coordinate all IME activities for the certification process.

8.3.1.3 Change Control for Certification

The contractor(s) must execute appropriate controls for changes made during the certification process including testing requirements. Change must be managed in accordance with the requirements of the change control requirements in this RFP.

8.3.1.4 Deliverables

Deliverables to be produced by the contractor(s) for the certification phase include the following:

a. Updated CMS Certification Checklists.

b. CMS Certification Readiness Checklists.

c. Required information and documentation.

d. Revised system documentation resulting from system remediation.

8.4 Turnover Phase

This phase will begin 12 months before the end of the contractor(s) operations phase and end six months after the end of the contract period or as extended by the exercise of contract

provisions or amendments to the contract. The contractor(s) must prepare for turning over responsibilities and operations at the end of the contract. The contractor(s) must cooperate with the successor contractor(s), other contractors and the Department in the planning and transfer of operations. The final contract payment will be based on the contractor(s) meeting all turnover deliverables and must receive approval from the Department. The contractor(s) must dedicate special additional resources to this phase.

8.4.1 State Responsibilities

a. Notify the contractor(s) of the Department's intent to transfer or replace the system, at least 12 months prior to the end of the contract.

b. Review and approve a Turnover Plan to facilitate transfer to the Department or to its designated agent.

c. Review and approve a statement of resources, which would be required to take over operation of the Department.

d. Make the Department staff or designated agent staff available to be trained in the operation of the Department.

e. Coordinate the transfer of the Department documentation in hard and soft copy formats, software and data files.

f. Review and approve a turnover results report that documents completion of each step of the Turnover Plan.

g. Obtain post turnover support from the contractor(s) in the event of software malfunction.

8.4.1.1 Contractor Responsibilities

During this task, the contractor(s) must provide technical support and assistance with Turnover, as described in this Section. The contractor(s) must perform the following tasks:

a. Create a schedule for turnover activities and submit the schedule for Department approval.

b. Track both the Department's and contractor's responsibilities associated with the Turnover Phase.

c. Work closely with the successor contractor(s) during the planning for the Turnover Phase.

d. Provide a Turnover Plan to the Department within six months before the start of the Turnover Phase. This Plan must include:

    1. Proposed approach to the turnover.

    2. Tasks and sub-tasks for the turnover.

    3. Schedule for the turnover.

    4. All enterprise production data, program libraries and documentation, including documentation update procedures for the turnover.

    5. Furnish to the Department a statement of resource requirements that would be required by the Department or a successor contractor(s) to take over the MMIS and POS.

e. Provide the required turnover services. The contractor(s) will cooperate with the successor contractor(s), while providing all required turnover services. This will include meeting with

the successor and devising work schedules that are agreeable for both the Department and the successor contractor(s).

f. Transfer all non-proprietary source program code onto media approved by the Department. The contractor(s) must submit a letter stating all proprietary source code is held by an escrow agent approved by the Department and is current as of the date of system turnover.

g. Ensure that the Department will be error free and complete when turned over to the Department or the successor contractor(s).

h. Correct, at no cost to the Department, any malfunctions that existed in the system prior to turnover or were caused by the lack of support by the contractor(s) as may be determined by the Department.

i. Supply a detailed organizational chart and an estimate of the number, type of personnel to operate the equipment and other functions of the Department. The estimate shall be separated by type of activity of the personnel, including, but not limited to, the following categories:

   1. Data processing staff.
   2. Computer operators.
   3. Systems analysts.
   4. Systems programmers.
   5. Business analysts.
   6. Project management staff.
   7. Data entry and imaging operators.
   8. Provider services staff.
   9. Administrative staff.
   10. Provider field representatives.
   11. Clerks.
   12. Managers.

j. The contractor(s) must provide a statement that includes all resources required to operate the MMIS and POS including but not limited to:

   1. Data processing and imaging equipment.
   2. System and special software.
   3. Other equipment.
   4. Telecommunications circuits.
   5. Telephones.
   6. Office space.

All turnover data must be delivered in an organized and structured format as it applies to k, l and m and must be approved by the Department.

k. At the turnover date, transfer to the Department or the successor contractor(s) as needed a copy of the MMIS and POS data including but not limited to:

1. All necessary data and reference files.
2. Imaged documents stored on optical and magnetic disk.
3. All production computer programs.
4. All production scripts, routines, control language and schemas.

l. Provide all production documentation including but not limited to user and operations manuals, system documentation in hard and soft copy, needed to operate and maintain the MMIS and POS and the procedures of updating computer programs and other documentation.

m. Provide knowledge transfer to the successor staff in the operation of the MMIS and POS. Such knowledge transfer must be completed at least two months prior to the end of the Contract. Such knowledge transfer shall include:

1. Data entry, imaging and claims processing.
2. Computer operations.
3. Controls and balancing procedures.
4. Exception claims processing.
5. Other manual procedures.

n. On a schedule to be determined by the Department, the contractor(s) must package, insure and deliver all hardware used in the MMIS and POS to a location designated by the Department.

o. At a turnover date to be determined by the Department, the contractor(s) must provide to the Department or the successor contractor(s) all updated computer programs, data and reference files and all other documentation and records, as will be required by the Department or its agent to operate the MMIS and POS.

p. Turn over all:

1. Paper claims and paper claim adjustments.
2. Paper provider files.
3. Paper file maintenance forms.
4. Paper financial records.
5. All reports associated with the contract(s) throughout the Operations Phase must be provided to the Department and placed in a designated folder determined by the Department.
6. A turnover results report.

8.4.1.2 Deliverables

a. Schedule of turnover activities.

b. Turnover Plan.

c. Non-proprietary source code.

d. Proprietary source code letter.

e. Current staffing plan.

f. Facility and resource statement.

g. The Department data, files and user and operations documentation in hard and soft copy format.

h. All reports associated with the contract(s) created during the Operations portion of the contract.

i. Turnover results report.

8.4.1.3 Performance Standards

a. One hundred percent of all turnover activities must be completed and approved by the Department prior to final payment to the contractor(s).

9 PROPOSAL FORMAT AND CONTENT

The instructions below describe the format and content of the bid proposal and are designed to facilitate the submission of a bid proposal that is easy to understand and evaluate. Failure to adhere to the bid proposal format may result in the disqualification of the bid proposal. This section contains the following topics:

9.1: Instructions

9.2: Technical Proposal

9.3: Cost Proposal

9.4: Company Financial Information

9.1 Instructions

a. A bid proposal consists of three distinct parts: a Technical Proposal, a Cost Proposal and the Company Financial Information.

b. Each bid proposal (Technical Proposal, Cost Proposal and the Company Financial Information) shall be sealed in a box or boxes, with the Cost Proposal and Company Financial Information portions each sealed in separate, labeled envelopes inside the same box or boxes.

c. When multiple boxes are being used for each bid proposal, the boxes shall be numbered in the following fashion: 1 of 4, 2 of 4 and so forth.

d. Boxes shall be labeled with the following information:

   1. Bidder's name and address.
   2. Issuing officer's name and delivery address:
      Mary Tavegia, Issuing Officer
      Iowa Department of Human Services
      Iowa Medicaid Enterprise
      200 Army Post Road, Suite 2
      Des Moines, Iowa 50315
   3. RFP title and RFP reference number:
      Iowa Medicaid Enterprise System Services Procurement
      RFP MED-12-001
   4. RFP contracts for which the bid proposal is being submitted for consideration are listed below:
      i. MMIS and Core MMIS Operations.
      ii. Pharmacy Point-of-Sale (POS) and POS Operations.

e. Bidders submitting bid proposals for more than one of the separate contract awards must box each bid proposal separately.

f. All bid proposal materials shall be printed two-sided on 8.5" x 11" paper.

g. The Technical Proposal, Cost Proposal and Company Financial Information materials shall be submitted in separate spiral, comb or pasteboard binders.

h. Technical Proposals, Cost Proposals and Company Financial Information materials received in 3-ring, loose-leaf binders will not be accepted and will be returned without evaluation.

i. If the bidder designates any information in its bid proposals as confidential, the bidder must submit one sanitized copy of each proposal material(s) from which any confidential or proprietary information has been excised or redacted. The confidential material must be excised in such a way as to allow the public to determine the general nature of the material removed and to retain as much of the bid proposal as possible. Bidders cannot designate their entire proposal as confidential or proprietary. Sanitized versions of bid proposals must provide a sufficient level of information to understand the full scope of services to be provided. Bidder cannot designate Cost Proposals as confidential.

j. Bidders will submit one original and ten copies of the Technical Proposal and Cost Proposal and one original and three copies of the Company Financial Information – each in a separate binder (or set of binders) – for each bid proposal submitted. As explained above, bidders submitting bid proposals for more than one of the separate contract awards would therefore submit one original and ten copies of the Technical and Cost Proposals and one original and three copies of the Company Financial Information. If applicable, one sanitized copy of each proposal for each separate RFP contract under consideration.

k. All materials shall be submitted in a timely manner to the issuing officer.

l. The bound original bid proposal materials shall be labeled “Original.” The bound copy of the bid proposal materials shall be labeled “Copy.” The bound sanitized copy of the bid proposal materials shall be labeled “Sanitized Copy.”

m. The Technical Proposal and Cost Proposal must also be submitted on CD-ROM or DVD. The Company Financial Information should not be included on the CD-ROM. The Department is requiring two CD-ROM or DVD copies per bid proposal. One submitted CD-ROM or DVD will contain one full version of the Technical Proposal and the Cost Proposal. The second CD-ROM or DVD will contain the “sanitized” version of the Technical Proposal and a copy of the Cost Proposal if applicable. Electronic proposal files must be submitted as PDF files that individually identify the system services (MMIS or POS), proposal volume title and full or excised status (such as Core MMIS Operations Cost Proposal Sanitized). Additionally, the CD-ROM(s) or DVD (s) must be compatible with Microsoft 7 software and must be saved in less than five files. Files shall not be password protected or saved with restrictions that prevent copying, saving, highlighting or reprinting of the contents.

n. As much as possible, Technical Proposal sections should be limited to discussion of elements relevant to the proposed solution for Iowa. The “Executive Summary” and “Corporate Qualifications” sections of the Technical Proposal allow bidders to expound in greater detail about past or current projects.

9.2 Technical Proposal

The Technical Proposal will consist of the following sections in the order listed below and separated by tabs.

Table 9: Technical Proposal Sections

Section Title	Tab Number
Table of Contents	1
Transmittal Letter	2
Checklist and Cross-References	3
Executive Summary	4
Corporate Qualifications	5
Project Management	6
General Requirements	7
Start-Up and Implementation Phases	8
MMIS or POS System Requirements	9
MMIS or POS Operational Requirements	10
Certification Phase	11
Turnover Phase	12

9.2.1 Table of Contents (Tab 1)

The Table of Contents will identify all sections (which are separated by tabs), all subsections contained therein and the corresponding page numbers. The Table of Contents found at the beginning of this RFP provides a representative example of what is required for the Technical Proposal Table of Contents.

9.2.2 Transmittal Letter (Tab 2)

An individual authorized to legally bind the bidder shall produce and sign a transmittal letter on official business letterhead. Transmittal letters should be numbered in sequence with the remainder of the Technical Proposal.

The designated original copy of the Technical Proposal will include the original signed letter. A photocopy of the transmittal letter shall be included in each of the remaining copies of the

Technical Proposal. The transmittal letter is evaluated as part of the screening for bid proposal mandatory submittal requirements and shall include:

a. The bidder's mailing address.

b. Electronic mail address, fax number and telephone number for both the authorized signer and the point of contact designated by the bidder.

c. A statement indicating that the bidder is a corporation or other legal entity.

    1. All subcontractors should be identified and a statement included that indicates the exact amount of work to be done by the prime contractor and each subcontractor as measured by percentage of total contract price.

    2. The technical proposal must not include actual price information.

d. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed to work in Iowa.

e. A statement identifying the bidder's federal tax identification number.

f. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP and sample contract in Attachment O. If a bidder objects to any term or condition of the RFP or sample contract in Attachment O, specific reference to the RFP page and section number shall be identified. In addition, the bidder shall set forth in its bid proposal the specific language it proposes to include in place of the RFP or sample contract provision and cost savings to the Department should the Department accept the proposed language. Exceptions that materially change these terms or the requirements of the RFP may be deemed non-responsive by the Department, in its sole discretion, resulting in possible disqualification of the bid proposal. The Department reserves the right to either execute a contract without further negotiation with the successful bidder or to negotiate contract terms with the selected bidder if the best interests of the Department would be served.

g. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal.

h. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, political affiliation, national origin or handicap.

i. A statement that no cost or pricing information has been included in this letter or the Technical Proposal.

j. A statement identifying all amendments to this RFP issued by the state and received by the bidder. If no amendments have been received, a statement to that effect shall be included.

k. A statement that the bidder certifies in connection with this procurement that:

    1. The prices proposed have been arrived at independently, without consultation, communication or agreement as to any matter relating to such prices with any other bidder or with any competitor for the purpose of restricting competition; and

    2. Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor.

l. A statement that the person signing this proposal certifies that he or she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he or she has not participated and will not participate in any action contrary to item k.

m. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:

   1. The general scope of work to be performed by the subcontractor;
   2. The subcontractor's willingness to perform the work indicated; and
   3. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, political affiliation, national origin or handicap.

n. Any request for confidential treatment of information shall also be identified in the transmittal letter as well as the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public. The bidder must mark conspicuously on the transmittal letter any bid proposal that contains confidential information, itemize all pages with confidential material under the above-referenced "request for confidential treatment of information" section of the transmittal letter, and conspicuously mark (in the footer) as containing confidential information each page upon which confidential information appears.

o. The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information.

p. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal.

q. A statement that the bidder acknowledges the acceptance of all term and conditions stated in the RFP including Attachment O Sample Contract.

9.2.3 Checklist and Cross-References (Tab 3)

Bidders will complete three exhibits in each Technical Proposal to confirm their responsiveness to requirements:

9.2.3.1 Bid Proposal Mandatory Requirements Checklist

9.2.3.2 General Requirements Cross-Reference

9.2.3.3 MMIS and POS System Services Requirements Cross-Reference

9.2.3.1 Bid Proposal Requirements Checklist

Bidders will complete a checklist of the submittal requirements. The Department will use this checklist to confirm that bidders have produced and submitted bid proposals according to Department specifications. The Bid Proposal Requirements Checklist form appears in RFP Attachment L.

9.2.3.2 General Requirements Cross-Reference

The Department requests that bidders complete a General Requirements Cross-Reference for each Technical Proposal under consideration using the sample RFP cross-reference form in

RFP Attachment M Sample Cross-Reference. In Column A, bidders will list requirements by reference number from Section 5 General Requirements in the RFP (such as 5.2.1). In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (such as Tab 5, Page 5).

9.2.3.3 MMIS and POS System Services Requirements Cross-Reference

The Department requests that bidders develop a System Services Requirements Cross-Reference for section 7 MMIS and POS System Requirements for each Technical Proposal under consideration based upon the sample RFP cross-reference form in RFP Attachment M Sample Cross-Reference. In Column A, bidders will list requirements by reference number (such as 9.2.3.3). In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (such as Tab 3, page 32).

9.2.4 Executive Summary (Tab 4)

The bidder shall submit an executive summary that provides the evaluation committees and state management with a collective understanding of the contents of the entire bid proposal. The Executive Summary should briefly summarize the strengths of the bidder and the key features of its proposed approach to meet the requirements of the RFP toward which the individual bid proposal is targeted.

The Department requires bidders to provide a comprehensive overview of the services that they are proposing to provide to the state. For bidders who have submitted bid proposals for more than one service, this overview provides an opportunity to discuss how the services integrate with one another. Bidders may also articulate other added-value services that are relevant to the scope of services for the submitted bid proposals.

Due to the complex nature of this procurement, the Department requests that bidders describe within the Executive Summary their understanding of the Iowa Medicaid Enterprise (IME). The Department is looking for evidence that bidders understand how multiple contractors work together in a common, integrated environment, operating a unified Iowa Medicaid Program from a single location.

This section shall also include a summary of the bidder's project management plans for all phases of the resulting contract. In addition, bidders will identify the risks inherent in the IME and identify the strategies that the bidder will use to mitigate each risk.

9.2.5 Corporate Qualifications (Tab 5)

Information about contractor qualifications includes the following topics:

9.2.5.1 Corporate Organization

9.2.5.2 Corporate Experience

9.2.5.3 Corporate References

9.2.5.4 Felony Disclosures

9.2.5.5 Certifications and Guarantees

9.2.5.1 Corporate Organization

The bidder must provide an organization chart for the firm that is submitting the proposal. If the firm is a subsidiary of a parent company, the organization chart should be that of the subsidiary firm. The chart should display the firm's structure and the organizational placement of the oversight for the IME project. The bidder must identify the name of the person who will be responsible for signing the contract and indicate the signing person's relationship with the firm. The bidder must include the following information in the proposal:

a. History of the organization.

b. Description of the executive, management and any other staff assigned to oversight of this project, their roles on this project, their expertise and experience in providing the services described in the RFP and their tenure with the organization.

c. Legal structure of the organization, names and credentials of the owners, executives and state in which the organization is registered.

d. Evidence of an Iowa business license and any necessary applicable professional license required by law.

e. Any established partnership relationships with the community.

f. Other projects in which the bidder is currently providing or has provided services similar to the services described in this RFP with names and contact information for the clients' contract administrators.

g. Other contracts or projects currently undertaken by the bidder information for the clients' contract administrators with names and contact.

9.2.5.2 Corporate Experience

Bidders will describe all relevant experience within the last five years, including all Medicaid contracts. As appropriate, bidders also will specify their participation as primary contractor or subcontractor on each project. Bidders will include projects that demonstrate at a minimum:

a. Relevant governmental experience with the functional areas and proposed requirements of the RFP considered by the bid proposal.

b. Relevant commercial experience with the functional areas and proposed requirements of the RFP component considered by the bid proposal.

c. Other experience with governmental healthcare programs.

d. For up to five projects in each category, the bidder shall provide the following items in the project summaries:

    1. Project title.
    2. Client organization name.
    3. Client reference contact name, title and current telephone number.
    4. Original contract start and end dates.
    5. Total contract value to the bidder's organization.
    6. Average staff hours in FTEs during operations.
    7. Workload statistics.

8. Brief description of scope of work that demonstrates relevance to this contract.

Project summaries are limited to one project per page. The state reserves the right to contact other references on the project.

9.2.5.3 Corporate References

The bidder shall provide letters of reference from three existing or previous clients knowledgeable of the bidder's performance in providing services similar to the services described in this RFP and a contact person and telephone number for each reference.

9.2.5.4 Felony Disclosures

The bidder must state whether it or any owners, officers or primary partners have ever been convicted of a felony. Failure to disclose such matters may result in rejection of the bid proposal or in termination of any subsequent contract. This disclosure must continue for the life of the contract. Any such matter commencing after submission of a bid proposal and with respect to the successful bidder after the execution of a contract, must be disclosed in a timely manner in a written statement to the Department.

9.2.5.5 Certifications and Guarantees

The bidder must include signed copies of Attachments B through J. Signature must be from an individual authorized to bind the company.

9.2.6 Project Management (Tab 6)

The Department requires that bidders produce a project management methodology which includes the project work plans for each phase of the contract: Start-Up and Implementation Phases which includes Transition to Operations, Operational Phase, Certification and Turnover Phases.

Bidders should include their proposed approach for communication management, quality management, risk management and time management as part of their overall project plan. The Department will need to consider this approach in determining the overall master project plan for the IME.

In addition to task lists and corresponding start and end dates, the project plans for each phase will include a calendar-year-based schedule for all tasks (including operational tasks), specify the allocation of resources by job for those tasks and identify the timeframes in which the tasks will occur (expressed in hours and days for all contract phases). The bidder must be capable of updating and maintaining this information systematically throughout the contract.

The project work plan and schedules required for Start-up and Implementation which includes Transition to Operations, Certification, Operations and Turnover phases must include a detailed project work plan broken down by tasks and subtasks and a schedule for the performance of each task included in each phase of the contract. The schedule should allow 10 business days for the Department approval of each submission or 5 business days for re-submission of each deliverable. The work plan to be proposed must include <u>all</u> responsibilities, milestones and deliverables outlined previously in this RFP. This section shall cover:

a. Personnel by name and level of effort in hours for each task or subtask, showing contractor personnel and the Department personnel efforts separately.

b. A network diagram, showing the planned start and end dates for all tasks and subtasks,

indicating the interrelationships of all tasks and subtasks and identifying the critical path.

c. A Gantt chart showing the planned start and end dates of all tasks and subtasks.

d. A discussion of how the project work plan provides for handling of potential and actual problems.

e. A schedule for all deliverables, with 10 business days for the Department to review.

Project work plan requirements are described in Section 6 Start-Up and Implementation Phases of this RFP.

9.2.7 Project Organization

The proposed organization and staffing must meet the requirements of section 5 General Requirements. Bidders respond to the project organization requirements for the System Services contractors supporting the IME in this section. This section of the proposal is the bidder's opportunity to describe the merits of its planned approach to the following topics:

9.2.7.1 Organization Charts

9.2.7.2 Staffing

9.2.7.3 Key Personnel

9.2.7.4 Subcontractors

9.2.7.1 Organization Charts

For each phase of the project, the bidder will provide a narrative description of the proposed organization, roles and responsibilities of key personnel and representative job descriptions for all positions within the organization for all phases of the contract. Bidders will include an organization chart of proposed key personnel and counts of full-time equivalent (FTE) workers in each staff position in each organizational unit during each project phase.

Organization charts must identify the percentage of allocation of key personnel to the IME. Bidders may include separate charts for the transition phase to reflect staff loading in the individual tasks but must provide the FTE counts on each one for each organizational unit.

9.2.7.2 Staffing

Bidders are to propose sufficient staff who have the requisite skills to meet all requirements in this RFP and who can attain a satisfactory rating on all performance standards. Unless otherwise specified by the bidder and approved in advance by the Department, staff positions are effective for the entire duration of the Project Phase.

The Department encourages bidders to describe their approaches to acquiring qualified staff with experience in the IME. Special attention should be paid to retaining expertise that exists within the IME today.

9.2.7.3 Key Personnel

The bidder must provide resumes and references for all identified key personnel, including the bidder's account manager who will be involved in the Implementation Phase contemplated by this RFP. Resumes and references must meet the requirements of section 5 General

Requirements. All staff identified as key personnel must be employees of the bidder, unless specified otherwise by the key personnel subsections of the RFP.

9.2.7.4 Subcontractors

The bidder shall disclose the planned use of another company or individual staff member with which the bidder will contract to perform the services described in this RFP. The information that the bidder must provide includes:

a. Subcontractor name and address.

b. Subcontractor qualifications.

c. Work that the subcontractor will perform.

d. The estimated percentage of total contract dollars for each subcontract.

Special services project staff members that are hired on a retainer or as-needed basis (such as physicians, attorneys and similar professional staff) are excluded from subcontractor percentage calculations.

9.2.8 General Requirements (Tab 7)

In the General Requirements section bidders will explain their approach to Section 5 General Requirements. For the General Requirements section of the Technical Proposal, the Department requires bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them.

9.2.9 Start-Up and Implementation Phases (Tab 8)

The Bidder must provide a detailed description of the approach to completing the contractor's responsibilities and producing the deliverables for each of the following:

- Start-Up Tasks.
- Analysis and Design Tasks.
- Development Tasks.
- Conversion Tasks.
- Testing Tasks.
- Training Tasks.
- Implementation Tasks.
- Post Implementation Tasks.

The description shall encompass the requirements of this RFP as outlined in section 6 Start-Up and Implementation Phases and must describe the methodology to be followed in sufficient detail to demonstrate the Bidder's direction and understanding of this RFP.

The proposal must summarize how the IME staff will be used as resources in this project. It is the State's desire that agency staff be advised of all aspects of the engagement.

The Bidder must prepare a table listing each deliverable for these tasks in column 1. In column 2 the Bidder must indicate agreement to meet the RFP requirements for that deliverable. In column 3, the Bidder must indicate the section in the proposal that describes the approach to producing the deliverable.

The Bidder must present a description of quality management practices applicable to the DDI phase.

9.2.10 MMIS or POS System Requirements (Tab 9)

The bidder shall address each contract requirement within section 7 MMIS and POS System Requirements of the RFP the bidder is addressing in the proposal.

Complete Columns A-E below using the following information for each column.

COLUMN	DESCRIPTION	VALUE
A	Agree to meet the requirement as stated	Yes or No
B	Existing capability	Yes or No
C	Requirement will be met with system modification (SM) or Commercial off- the-shelf (COTS) solution (Required entry for any Requirement with a “No” in Column B)	SM or COTS
D	DDI Hours (Required entry for any Requirement with a “No” in Column B)	# of DDI Hours
E	Reference to Proposal Section for proposed solution	Proposal Reference

The proposal description referenced by Column E should have a description of how the requirement will be met. COTS solutions should address the description of the product and the implementation process; system modifications should explain the type of modification (i.e., change rules engine, modification and addition to system code). The reference number in the table below will be used to track the requirement throughout the project. System Requirements are grouped for convenience only and may apply to more than one module or group.

Bidders will also explain in detail how they plan to approach each MMIS and POS system requirement for the contract function.

Bidders are to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them.

9.2.10.1 MMIS External Interfaces

The MMIS Bidder must provide a detailed description of the approach to meeting the MMIS external interface requirements in section 7 MMIS and POS System Requirements of the RFP. In addition, this section must provide the detailed description of how each of the requirements in section 7 will be met.

9.2.10.2 MMIS and POS Infrastructure Requirements

The Bidder must provide a detailed description of the approach to meeting the architectural requirements in section 7. In addition, this section must provide the detailed description of how each of the requirements in section 7 will be met.

9.2.11 MMIS or POS Operational Requirements (Tab 10)

The bidder shall address each contract requirement within section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases of the RFP the bidder is addressing in the proposal. Bidders also will explain in detail how they plan to approach each contractor responsibility and operational requirement for the contract function.

This section should provide a comprehensive integrated narrative that describes how the contractor will meet the requirements, including a description of the bidder's processes, control procedures and quality assurance procedures for each function. In addition, the bidder may provide process flow diagrams to supplement the narrative.

Bidders are to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them. The Department also requires that bidders will format the System Services Requirements section of the Technical Proposal in a manner similar to the following outline:

Table 10: Section 6 Organization

Section 6 Numbering	Section 6 Content
6.x	RFP introduction
6.x.1	Name of contract function 1
6.x.2	Name of contract function 2
6.x.3	Name of contract function 3
6.x.4	Name of contract function 4
6.x.5	Name of contract function 5
6.x.6	Name of contract function 6

Bid proposals must be fully responsive to the service requirements. Merely repeating the requirement statement will be considered nonresponsive and disqualify the bidder. Bid proposals must identify any deviations from the requirements of this RFP or requirements that the bidder cannot satisfy.

9.2.12 Certification Phase (Tab 11)

The Bidder must provide a detailed description of the approach to completing the contractor's responsibilities and producing the deliverables for this phase which is located in section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases of the RFP.

9.2.13 Turnover Phase (Tab 12)

The Bidder must provide a detailed description of the approach to completing the contractor's responsibilities and producing the deliverables for this phase which is located in section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases of the RFP.

9.3 Cost Proposal

The Cost Proposal will consist of the following sections in the order listed below and separated by tabs.

Table 11: Cost Proposal Sections

Section Title	Tab Number
Table of Contents	1
Bid Proposal Security	2
Pricing Schedules	3

9.3.1 Table of Contents (Tab 1)

The Table of Contents will identify all sections (which are separated by tabs), all subsections contained therein and the corresponding page numbers. The Table of Contents found at the beginning of this RFP provides a representative example of what is required for the Technical Proposal Table of Contents.

9.3.2 Bid Proposal Security (Tab 2)

Each bidder's original copy of the Cost Proposal shall be accompanied by the original proposal bid bond payable to the Department or original letter of credit equal to five percent of the total costs listed in the pricing schedules in the Cost Proposal. Copies of the Cost Proposal can include copies of the bond or letter. If the bidder elects to use a bond, a surety licensed to do business in Iowa must issue the bond in a form acceptable to the Department.

The submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal. The Bid Proposal Security shall be forfeited if the bidder chosen to receive the contract withdraws its bid proposal after the Department issues a Notice of Intent to Award, does not honor the terms offered in its bid proposal or does not negotiate contract terms in good faith. The Bid Proposal Security should remain in force and in the Department's possession until the firm-terms period for bid proposals expires (which is 120 days).

Upon the signing of contracts and approval of the contracts by CMS, the Bid Proposal Securities will be returned to the bidders. In the event that all bid proposals are rejected or the RFP is cancelled, Bid Proposal Securities will be returned to the bidders.

9.3.3 Pricing Schedules (Tab 3)

Bidders are to include the appropriate pricing schedules in RFP Attachment N (which includes parts N-1 through N-12). Fields on the pricing schedules are designated for pricing for transition, any additional software that the bidder proposes for Department approval and operations.

9.4 Company Financial Information

The bidder must submit the following documents to be used in the evaluation of financial viability:

a. Audited financial statements (annual reports) for the last three years.

b. A minimum of three financial references (such as letters from creditors, letters from banking institutions, Dunn & Bradstreet supplier reports).

c. A description of other contracts or projects currently undertaken by the bidder.

d. A summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services.

e. A disclosure of all contracts during the preceding five-year period in which the bidder or any subcontractor identified in the bid proposal has defaulted, including a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract.

f. A disclosure of all contracts during the preceding five-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term, including a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract.

g. The company's five-year business plan that would include the award of the state's contract as part of the plan.

The company financial information must be submitted in a separate sealed envelope and will be opened only for those bid proposals that are selected as apparent successful bidders for each proposal during the proposal evaluation. This information will be used in the screening for financial viability. After contracts have been signed for all system services or if the Department elects not to award any contracts, the sealed corporate financial information will be returned unopened to unsuccessful bidders.

10 EVALUATION PROCESS

This section describes the evaluation process that will be used to determine which bid proposal provides the greatest benefits to the Department. The evaluation process is designed to award the contract to the bidder with the best combination of attributes to perform the required services. RFP section 9 Proposal Format and Content describes the content that the committee will evaluate. The evaluation process will ensure the selection of the best overall solution for the Iowa Medicaid Enterprise (IME). The evaluation process includes the following components:

10.1: Evaluation Committees

10.2: Requirements

10.3: Technical Proposals

10.4: Points and Evaluation Criteria

10.5: Cost Proposals

10.6: Bid Proposal Security

10.7: Combined Score

10.8: Oral Presentations

10.9: Best and Final Offers (BAFO)

10.10: Financial Viability Screening

10.11: Recommendation

10.12: Notice of Intent to Award

10.13: Acceptance Period

10.14: Federal Approvals

10.1 Evaluation Committees

The Department intends to conduct a comprehensive, fair and impartial evaluation of all bid proposals received in response to the contract awards designated by this RFP. In making its award determinations, the Department will be represented by a set of evaluation committees; subject matter experts from Department staff and the technical assistance contractor will be assigned to each evaluation committee. Finally, a separate evaluation committee will consist of members from the Department's Division of Fiscal Management will evaluate each cost proposal and the financial stability and viability of the recommended bidders.

10.2 Requirements Checklist

As part of its initial screening, the Department will assess all bid proposals submitted in response to this RFP to assure that proposals have satisfied the requirements checklist. Any one requirement that a proposal does not meet may cause the Department to declare a bid proposal nonresponsive and return it to the bidder. The requirements checklist form appears in RFP Attachment L Bid Proposal Requirements Checklist.

10.3 Technical Proposals

Members of the appropriate evaluation committees will evaluate independently each proposal that passes the submittal criteria. Committee members will score each technical proposal using criteria established by the Department and using the point values that appear in the technical proposal scoring table.

The evaluation committees will meet during their evaluation process to address any technical questions raised by their respective reviews and discuss the relative merits of each bidder's bid proposal. The Technical Proposal evaluation committee may review bidders' cost proposals during the Technical Proposal review process.

10.3.1 Scoring Technical Proposals

Technical Proposal volumes meeting all requirements will be evaluated and scored by an evaluation committee. A weighted scoring system will be used. The weighted score will provide numerical scores that represent the committee's assessment of the relative merits of the technical bid proposals. The Technical Proposal will be evaluated and a minimum score of 9,000 points out of the maximum of 15,000 points must be accumulated for the Technical Proposal to be considered competitive. ***If a bidder does not meet a minimum score of 9,000 points, the cost proposal will not be evaluated or scored.***

Table 12: MMIS Technical Proposal Scoring

Section	Points	Weight	Maximum Points
Executive Summary	100	1-5	500
Corporate Qualifications	100	1-5	500
Project Management	300	1-5	1500
General Requirements	300	1-5	1500
Start-Up and Implementations Requirements	700	1-5	3500
System Requirements	700	1-5	3500
Operational Requirements	700	1-5	3500
Oral Presentations	100	1-5	500
Total	**3,000**	**5**	**15,000**

Table 13: POS Technical Proposal Scoring

Section	Points	Weight	Maximum Points
Executive Summary	100	1-5	500
Corporate Qualifications	100	1-5	500
Project Management	300	1-5	1500
General Requirements	300	1-5	1500
Start-Up and Implementations Requirements	700	1-5	3500
System Requirements	700	1-5	3500
Operational Requirements	700	1-5	3500
Oral Presentations	100	1-5	500
Total	**3,000**	**5**	**15,000**

The Department will hold oral presentations for all bidders. Following oral presentations, the evaluation committees will convene to discuss the results of the oral presentations. After the meeting, each member of the evaluation committee will independently evaluate and score the proposals. After scoring the proposal individually, members of the evaluation committee may change their scores based on the group discussion with their respective evaluation committee members. Upon completion of the group discussion, each evaluation committee will average the bidder's scores (from each of its members) for each section of the bidder's technical proposal to facilitate a composite and final technical proposal score for each bidder. For those bidders whose technical proposals receive the minimum technical score of 9,000 points their cost proposals will advance to the appropriate evaluation committee.

10.3.2 Executive Summary

Each evaluation committee will review the proposal's executive summary, the overall quality of the proposal and the general qualifications of the bidder. It will also include a review of subcontracting or joint venture arrangements and how these may affect the overall contract.

Also in the executive summary, each evaluation committee will evaluate the bidder's understanding of the IME and the roles of the stakeholders, including the responsibilities of the Department and other agencies that are involved in administration of the Iowa medical assistance programs. In addition, each evaluation committee will evaluate the overview of the proposed services and solutions to meet the Department's needs.

10.3.3 Corporate Qualifications

The corporate background, organization and relevant experience of the bidder and any subcontractors are significant factors in the evaluation process. The experience and reputation of the bidder in managing large projects of this nature and how the bidder's corporate local teams interact with its clients is important. Experience in Medicaid, large health care delivery systems, managed care operations and recent technological advancements in the arena of healthcare systems will carry significant weight in the evaluation of submitted proposals.

10.3.4 Project Management

The evaluation committees will assess the bidder's approach to project management and evaluate the bidder's work plan and approach to the start-up and implementation and operations phases. Also of interest to the committee will be the bidder's organization of the project teams and approach to quality control in all phases of the contract.

The committee will review proposed staffing levels at each phase of the project, job descriptions, roles and responsibilities. The evaluation committees will examine closely the resumes of all key personnel and review references. Reference checking may not be limited to those references supplied by the bidder. Onsite visits may be arranged by the Department with other states running the bidders proposed solution. Results of these visits may impact scoring by the evaluation committees. Special attention will be given to the bidder's intended use of existing IME contractor staff.

10.3.5 MMIS General Requirements

The evaluation committees will evaluate how well the bidder explains their approach to RFP section 5 General Requirements. In addition, the evaluation committees will evaluate the bidder's response to other general requirements that are identified in RFP section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases.

10.3.6 MMIS Start-Up and Implementation Requirements

The evaluation committees will assess the bidder's approach to meeting all the functional, system and technological requirements of section 6 Start-Up and Implementation of the RFP. The bidder's response will be evaluated based upon the functional, system and technological description of the bidder's solution and how their proposal meets the requirements listed in this RFP.

10.3.7 MMIS System Requirements

The evaluation committees will assess the bidder's approach to meeting all the system and technological requirements of section 7 MMIS and POS System Requirements of the RFP. The bidder's response will be evaluated based upon the system and technological description of the bidder's solution and how their proposal meets the requirements listed in this RFP.

10.3.8 MMIS Operational Requirements

The evaluation committees will assess the bidder's approach to meeting all functional and system requirements of section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases of the RFP. The bidder's response will be evaluated based upon the functional and system description of the bidder's solution and how their proposal meets the requirements listed in this RFP.

10.3.9 POS General Requirements

The evaluation committees will evaluate how well the bidder explains their approach to RFP section 5 General Requirements. In addition, the evaluation committees will evaluate the

bidder's response to other general requirements that are identified in RFP section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases.

10.3.10 POS Start-Up and Implementation Requirements

The evaluation committees will assess the bidder's approach to meeting all the functional, system and technological requirements of section 6 Start-Up and Implementation of the RFP. The bidder's response will be evaluated based upon the functional, system and technological description of the bidder's solution and how their proposal meets the requirements listed in this RFP.

10.3.11 POS System Requirements

The evaluation committees will assess the bidder's approach to meeting all the system and technological requirements of section 7 MMIS and POS System Requirements of the RFP. The bidder's response will be evaluated based upon the system and technological description of the bidder's solution and how their proposal meets the requirements listed in this RFP.

10.3.12 POS Operational Requirements

The evaluation committees will assess the bidder's approach to meeting all functional and system requirements of section 8 MMIS and POS Operational Requirements, Certification and Turnover Phases of the RFP. The bidder's response will be evaluated based upon the functional and system description of the bidder's solution and how their proposal meets the requirements listed in this RFP.

10.4 Weights and Evaluation Criteria

For the purposes of evaluation, weights will be assigned for each component of the evaluation criteria as follows:

5 – Exceeds all requirements

4 – Exceeds many requirements

3 – Meets all requirements

2 – Meets most requirements

1 – Does not meet requirements

10.5 Cost Proposals

A separate evaluation committee within the Department's Division of Fiscal Management will review and score the cost proposals from all bidders meeting a minimum technical score of 9,000 points. This committee will note any bidder-imposed cost limitations that could prevent the Department from achieving the objectives of the procurement and report these limitations to the State Medicaid Director for a decision on the proposal.

10.5.1 Scoring Cost Proposals

Cost Proposal points for each set of system services are determined as follows:

Bidder's Cost = Implementation Cost + Base Operational Cost + Extension Operational Cost. Optional Services Costs are NOT included in Cost Scoring.

The bidder with the lowest price will receive the maximum points of 5,000.

To calculate every other bidder's score (other than the bidder who received the maximum points) for each Cost Proposal will be divided into the corresponding value of the lowest bidder and then multiplied by the maximum points. The formula for each is expressed as follows:

Bidder's cost score = (lowest cost/bidder cost) x maximum points.

10.6 Bid Proposal Security

The bid proposal security is evaluated on a pass or fail basis as part of the submittal requirements and is not considered in the scoring.

10.7 Combined Score

Technical and cost proposal scores will be combined to establish a final score for each bidder. The maximum total score is 20,000 points. Proposals will be ranked according to the total score to facilitate a recommendation for each successful bidder from the evaluation committees.

10.8 Oral Presentations

The Department will request oral presentations from each bidder and request a subsequent "best and final offer" (BAFO) from those bidders that have demonstrated to the evaluation committee their ability to satisfy the requirements of the RFP. Through the issuing officer, the evaluation committee will notify each bidder of their selection as a finalist and arrange for a presentation of their respective services.

Oral presentations will take place at a location to be determined and bidders are required to have all designated key personnel on hand. The determination order and schedule for the presentations is at the sole discretion of the Department.

The presentation may include slides, graphics and other media selected by the bidder to illustrate the bid proposal. The presentation should not materially change the information contained in the bid proposal. At its option, the Department may require site visits by select Department staff to a bidder's current client site to view current operations.

Upon completion of oral presentations, individual evaluation committee members may amend their original score on bidder's Technical Proposal based on any clarifications received during that bidder's oral presentation.

10.9 Best and Final Offers (BAFO)

The Department may request a subsequent best and final offer from those bidders that have demonstrated to the evaluation committee their ability to satisfy the requirements of the RFP. Best and final offers must be submitted via delivery service (such as UPS, FedEx or USPS Priority Mail) by 3:00 p.m. Central Time on the requisite business day. The BAFO must be in writing, accompanied by a transmittal letter binding the bidder to the financial terms described therein. BAFOs are to be sent to the issuing officer of this RFP at the same address identified in RFP section 2.11 Proposal Submission.

10.10 Financial Viability Screening

The Department's Division of Fiscal Management will evaluate the financial stability and viability of the recommended bidder(s). Only the bidder(s) that the evaluation committee members are prepared to recommend will have their company financials opened. The committee will review the bidder(s) financial stability to ensure that the State of Iowa will be fully covered against any financial difficulties that the company may experience during any period of the contract. After the oral presentations and the bidder(s) Technical and Cost proposal scores are combined, the bid proposal that receives the most points for each component will be reviewed for the bidder's financial stability and viability to sustain the operation and to assume the ongoing enterprise. This will include a review of the requested corporate financial information. The bidder's financials will be evaluated on a pass or fail basis.

10.11 Recommendation

Following the financial viability screening process, the evaluation committees will forward their final recommendations to the State Medicaid Director for a final decision and contracts award if appropriate. The recommendations shall be based on all information received through the evaluation process and shall provide the evaluation committee's assessment of bidders that will provide the greatest benefit to the Department. The evaluation committees will recommend the bidder with the greatest point value; in the absence of same, evaluation committees may recommend that no bidder be selected.

The Department reserves the right to take any additional steps deemed necessary in determining the final awards which may include negotiations with the selected bidders. The State Medicaid Director may accept or reject the recommendation of the evaluation committees. If the State Medicaid Director rejects the recommendation of any of the evaluation committees, those services may be cancelled or rebid at the sole discretion of the Department.

The State Medicaid Director's decision is final for purposes of Iowa Administrative Code Chapter 17A.

10.12 Notice of Intent to Award

After a review of the evaluation process by CMS, a notice of intent to award for each contract will be sent by mail to all bidders who have submitted a timely bid proposal. The notice of intent to award is subject to execution of a written contract. As a result, the notice does not constitute the formation of a contract between the Department and the apparent successful bidder.

10.13 Acceptance Period

Negotiation and execution of the contracts shall be completed by the date specified in RFP section 2.1 procurement timetable. If the apparent successful bidder(s) fails to negotiate and execute a contract, the Department (in its sole discretion) may revoke the award and award the contract to the next highest ranked bidder or withdraw the RFP. The Department further reserves the right to cancel the award at any time prior to execution of a written contract or receiving federal approval.

10.14 Federal Approvals

The contract award is subject to federal approval**.** The Department will make every effort to obtain and expedite federal approval**.** The Department reserves the right to not award a

contract if federal approval is not obtained or if the Department does not receive enhanced federal financial participation (FFP).

11 ATTACHMENTS

This section includes the attachments to the RFP as listed in the following table.

Table 14: IME System Services RFP Attachments

Identifier	Title of Attachment
A	Glossary of Acronyms and Terms
B	Proposal Certification
C	Certification of Independence and No Conflict of Interest
D	Certification Regarding Debarment Suspension Ineligibility and Voluntary Exclusion
E	Authorization to Release Information
F	Certification Regarding Registration, Collection and Remission of State Sales and Use Taxes
G	Certification of Compliance with Pro-Children Act of 1994
H	Certification Regarding Lobbying
I	Business Associate Agreement
J-1	Certification of Available Resources
J-2	Certification of Drug Free Workplace
J-3	Primary Detail Form and Certification
J-4	Subcontractor Disclosure Form
K	Resource Library Content
L	Mandatory Requirements Checklist
M	Sample Cross-Reference
N	Pricing Schedule
O	Sample Contract

ATTACHMENT A: GLOSSARY OF ACRONYMS AND TERMS

Acronym and Terms	Definition
ACD	Automatic Call Distributor
ACIP	Advisory Committee on Immunization Practices
ADA	American Dental Association
AIDS/HIV	Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus
ANSI	American National Standards Institute
APC	Ambulatory Payment Calculation
APG	Ambulatory Patient Groups
API	Application Program Interface
AR	Accounts Receivable
ARNP	Advanced Registered Nurse Practitioner
ASC	Accredited Standards Committee
ATP	Automated Test Panel
AWP	Average Wholesale Price
BAFO	Best and Final Offer
BCP	Business Continuity Plan
BENDEX	Beneficiary and Earnings Data Exchange
BI	Brain Injury
BPEL	Business Process Execution Language
BPMN	Business Process Modeling Notation
CA	Claims Adjudication
CAO	Contract Administrative Office
CAP	Corrective Action Plan
CCI	Correct Coding Initiative
CCO	Consumer Choice Option
CDAC	Consumer Directed Attendant Care
CD-ROM	Compact Disc Read Only Memory
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CICS	Custom Information Control System
CLD	Claim Level Detail
CLIA	Clinical Laboratory Improvement Amendments

Acronym and Terms	Definition
CM	Clinical Modification
CMAP	Children's Medical Assistance Program
CMH	Children's Mental Health
CMHC	Community Mental Health Center
CMMI	Capability Maturity Model Integration
CMP	Configuration Management Plan
CMR	Change Management Request
CMS	Centers for Medicare & Medicaid Services
CMS FUL	Centers for Medicare & Medicaid Services Federal Upper Limit
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor/Carrier
COLD	Computer Output to Laser Disc
COTS	Commercial off-the-shelf
CPAS	Claims Processing Assessment System
CPT	Current Procedural Terminology
CPU	Central Processing Unit
CR	Claims Receipt
CRNA	Certified Registered Nurse Anesthesiologist
CTI	Computer Telephony Integration
DAS	Department of Administration Services
DDE	Direct Data Entry
DDI	Design, Development, and Implementation
DDM	Division of Data Management
DEA	Drug Enforcement Administration
DED	Data Element Dictionary
DESI	Drug Efficacy Study Implementation
DHHS	Department of Health and Human Services (Federal)
DHS	Department of Human Services
DIP	Document Import Processor
DME	Durable Medical Equipment
DQ	Data Quality
DRG	Diagnosis-related Groups
DRP	Disaster Recovery Plan
DSD	Detailed System Design

Acronym and Terms	Definition
DSM	Diagnostic and Statistical Manual
DUR	Drug Utilization Review
DVD	Digital Versatile Disc
DW/DSS	Data Warehouse/Decision Support System
EAC	Estimated Acquisition Cost
EAI	Enterprise Application Integration
ECM	Enterprise Content Management
ED	Electronic Data
EDB	Enrollment Database
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EHR	Electronic Health Records
ELVS	Eligibility Verification System
EMC	Electronic Media Claim
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid Benefits
ePHI	Electronic Protected Health Information
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ESB	Enterprise Service Bus
EV	Environment Requirements
EVIC	Employer Verification of Insurance Coverage
FACS	Family and Children's Services
FFP	Federal Financial Participation
FFS	Fee for Service
FIPS	Federal Information Processing Standards
FMAC	Federal Maximum Allowable Cost
FMAP	Federal Medical Assistance Percentage
FMSA	Financial Management Service Agencies
FQHC	Federally Qualified Health Center
FR	Federal Reporting
FTE	Full Time Equivalent
FUL	Federal Upper Limit
GAAP	Generally Accepted Accounting Principle
GAAS	Generally Accepted Auditing Standards

Acronym and Terms	Definition
GAGAS	Generally Accepted Government Auditing Standards
GUI	Graphical User Interface
HCBS	Home and Community Based Services
HCERA	Health Care and Education Reconciliation Act
HCFA CMS	Health Care Financing Administration (now know as Centers for Medicare and Medicaid Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPP	Health Insurance Premium Payment
HIT	Healthcare Information Technology
HMO	Health Maintenance Organization
HP	HIPAA Transaction Requirements
HRSA	Health Resources Service Administration
HTTP	Hypertext Transfer Protocol
IA	Iowa
IABC	Iowa Automated Benefit Calculation
IAPD	Implementation Advance Planning Document
ICAR	Iowa Collection and Reporting
ICD	International Classification of Diseases and Related Health Problems
ICD-CM	International Classification of Diseases Clinical Modification
ICF/MR	Intermediate care facility for the mentally retarded
ICN	Internal Control Number
ICR	Intelligent Character Recognition
ID	Identification
ID&BI	Intellectual Disability and Brain Injury
IDPH	Iowa Department of Public Health
IEC	International Electro technical Commission
IEEE	Standards from the Institute of Electrical and Electronic Engineers
IFADS	Impact Fraud and Abuse Detection System
IHS	Indian Health Services
IL	Informational Letter
IME	Iowa Medicaid Enterprise
I-MERS	Iowa Medicaid Electronic Records System

Acronym and Terms	Definition
IMPA	Iowa Medicaid Portal Application
IMW	Income Maintenance Worker
IPIA	Improper Payments Information Act
IRS	Internal Revenue Service
ISDM	Information Systems Development Methodology
ISIS	Individualized Services Information System
ISO	International Organization for Standardization
ISUR	Impact Surveillance Utilization Review
IT	Information Technology
ITE	Information Technology Enterprise
ITF	Integrated Testing Facility
IV&V	Independent Verification and Validation
IVR	Interactive Voice Response
JAD	Joint Application Design Session
LAN	Local Area Network
LAN/WAN	Local Area Network/Wide Area Network
LIS	Low-Income Subsidy
LOC	Level of Care
LT	Lieutenant
LTC	Long-term Care
MAC	Maximum Allowable Cost
MAIT	Medical Assistance Income Trust
MAR	Management and Administrative Reporting Subsystem
MCO	Managed Care Organization (which the Department uses to describe HMOs and MediPASS providers)
MDC	Multiple Description Coding
MDS	Minimum Data Set
MediPASS	Medicaid Patient Access to Service System
MEPD	Medicaid for Employed People with Disabilities
MFCU	Medicaid Fraud Control Unit (which is the Iowa business unit responsible for conducting federally required Medicaid Provider Fraud Control Unit (MPFCU) activities as well as state-sponsored member fraud control activities)
MFP	Money Follows the Person
MHC	Managed Health Care
MHI	Mental Health Institutes

Acronym and Terms	Definition
MIG	Medicaid Integrity Group
MIPS	Medicaid IowaCare Premium System
MITA	Medicaid Information Technology Architecture
MITS	Medicare IT Supplement
MMCR	Medicaid and Medicare Mainframe Database
MMIS	Medicaid Management Information System
MPFCU	Medicaid Provider Fraud Control Unit
MPR	Medication Possession Ratios
MQUIDS	Medicaid Quality Utilization and Improvement Data System
MSIS	Medicaid Statistical Information System
MTOM	Message Transmission Optimization Mechanism
NABP	National Association of Boards of Pharmacy
NCPDP	National Council for Prescription Drug Program
NCPDP DUR	National Council for Prescription Drug Program Drug Utilization Review
NDC	National Drug Code
NF	Nursing Facility
NFMI	Nursing Facility for the Mentally Ill
NHIN	National Health Information Network
NIPS	Non-inpatient Programs
NMEH	National Medicaid EDI Healthcare
NOD	Notice of Decision
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OBRA	Omnibus Budget Reconciliation Act
OCR	Optical Character Recognition
OCRA	Online Card Replacement Application
OIG	Office of Inspector General
OMR	Optical Mark Recognition
ORT	Operational Readiness Testing
OTC	Over-the-counter
OWA.SS	Optional Waiver Facility and Enhanced State Plan Services Management
PA	Prior Authorization

Acronym and Terms	Definition
PACE	Program for the All-inclusive Care of the Elderly
PASARR	Preadmissions Screening and Resident Review
PBM	Pharmacy Benefit Manager
PC	Personnel Computer
PCA	Provider Cost Audit
PCCM	Primary Care Case Manager
PCP	Primary Care Provider
PDF	Portable Data File
PDL	Preferred Drug List
PDL-PA	Preferred Drug List Prior Authorization
PERM	Payment Error Rate Measurement
PERT	Program Evaluation Review Techniques
PG	Pregnancy
PHC	Primary Health Care
PHI	Protected Health Information
PHS	Public Health Services
PI	Program Integrity
PL	Program Language
PMBOK	Project Management Body of Knowledge
PMF	Provider Master File
PMI	Project Management Institute
PMIC	Psychiatric Medical Institution for Children
PMO	Project Management Office
PMPM	Payment per-member-per-month
POA	Present on Admission
POC	Plan of Care
POS	Point of Sale
PPA	Prior Period Adjustment
PPACA	Patient Protection and Affordable Care Act
PQA	Prior Quarter Adjustment
PQAS	Prior Quarter Adjustment Statement
PUB	Publication
PWP	Project Work Plan
QA	Quality Assurance

Acronym and Terms	Definition
QDWP	Qualified Disabled Working Person
QI-1	Qualified Individual 1
QIO	Quality Improvement Organization
QMB	Qualified Medicaid Beneficiary
RA	Remittance Advice
RBRVS	Resource Based Relative Value Scale
RCF	Residential Care Facility
RE	Rules Engine System Requirements
REST	Representational State Transfer
RF	Reference Data Management
RFI	Request for Information
RFP	Request for Proposal
RHC	Rural Health Clinic
ROSI	Reconciliation of State Invoice
RSD	Requirements Specification Document
RTM	Requirements Traceability Matrix
RUG	Resource Utilization Group
RVS	Relative Value Scale
SC	Statistical Contractor
SCHIP	State Children's Health Insurance Program (See also CHIP)
SDLC	System Development Life Cycle
SDX	State Data Exchange
SFY	State Fiscal Year
SID	State Identification Number
SL	Software License
SLMB	Specified low-income Medicare beneficiary
SM	System Modification
SMAC	State Maximum Allowable Cost
SMM	State Medicaid Manual
SNF	Skilled Nursing Facility
SNIP	Strategic National Implementation Process
SOA	Service Oriented Architecture
SOAP	Simple Object Access Protocol
SOU	Statement of Understanding

Acronym and Terms	Definition
SP	Security and Privacy Requirements
Spenddown	The portion of medical expenses that individuals must pay if they meet the categorical but not the financial criteria for Medicaid eligibility
SPMP	Software Project Management Plans
SSA	Social Security Administration
SSBI	Social Security Buy-In
SSI	Supplemental Security Income
SSN	Social Security Number
SURS	Surveillance and Utilization Review Subsystem
SWG	Sub Working Group
TAD	Turn Around Document
TCM	Targeted Case Management
TCN	Transaction Control Number (that is used to uniquely identify documents)
TCS	Transactions and Code Sets
TIN	Tax Identification Number
TP	Third Party Liability Management
TPA	Third Party Administrator
TPL	Third Party Liability
Turnover phase	The final phase of a contract in which the incumbent contractor turns over operations to a new contractor
TXIX	Title Nineteen
UAT	User Acceptance Test or Testing
UDDI	Universal Description, Discovery, and Integration
UML	Unified Modeling Language
UPIN	Unique Physician Identification Number
UPS	Uninterruptable Power Source
UR	Utilization Review
USPS	United States Postal Services
Usual and Customary	The amount that a provider typically bills for a particular drug or service
VSAM	Virtual Storage Access Method
WA	Waiver, Facility, and Enhanced State Plan Services Management
WAN	Wide Area Network
WBS	Work Breakdown Structure
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infant, Children

Acronym and Terms	Definition
WM	Workflow Management
WP	Web Portal
WS	Web Services
WSDL	Web Services Description Language
WS-I	Web Services Interoperability
XIX	Title XIX
XMI	Metadata Interchange
XML	Extensible Markup Language
XSD	Schema Definitions
XSLT	Extensible Style Sheet Language Transformation
XVIII	Title Eighteen

ATTACHMENT B: BID PROPOSAL CERTIFICATION

By signing below, Bidder certifies that:

Bidder accepts and will comply with all Contract Terms and Conditions contained in the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail Form & Certification.

Bidder has reviewed the additional certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein.

Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, political affiliation, national origin, or handicap;

No cost or pricing information has been included in the Bidder's Technical Proposal;

Bidder has received any amendments to this RFP issued by the Department;

Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP;

The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive agreements outlined above;

Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail Form & Certification. Objections or responses shall not materially alter the RFP. All changes to proposed contract language, including deletions, additions, and substitutions of language, must be addressed in the Bid Proposal;

Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Department to substitute staff;

Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Department in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Department and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract.

Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier; and,

Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms

are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Department may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: *http://www.state.ia.us/tax/business/business.html.*

BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that I have the authority to bind the bidder indicated below to the specific terms, conditions and technical specifications required in the Department's Request for Proposal (RFP) and offered in the bidder's proposal. I understand that by submitting this bid proposal, the bidder indicated below agrees to provide services described in the Iowa Medicaid Enterprise System Services Procurement RFP which meet or exceed the requirements of the Department's RFP unless noted in the bid proposal and at the prices quoted by the bidder.

I certify that the contents of the bid proposal are true and accurate and that the bidder has not made any knowingly false statements in the bid proposal.

_____

Name Date

_____

Title

ATTACHMENT C: CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

By submission of a bid proposal, the bidder certifies (and in the case of a joint proposal, each party thereto certifies) that:

a. the bid proposal has been developed independently, without consultation, communication or agreement with any employee or consultant of the Department who has worked on the development of this RFP, or with any person serving as a member of the evaluation committee;

b. the bid proposal has been developed independently, without consultation, communication or agreement with any other bidder or parties for the purpose of restricting competition;

c. unless otherwise required by law, the information in the bid proposal has not been knowingly disclosed by the bidder and will not knowingly be disclosed prior to the award of the contract, directly or indirectly, to any other bidder;

d. no attempt has been made or will be made by the bidder to induce any other bidder to submit or not to submit a bid proposal for the purpose of restricting competition;

e. no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT D: CERTIFICATION REGARDING DEBARMENT SUSPENSION INELIGIBILITY AND VOLUNTARY EXCLUSION

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION -- LOWER TIER COVERED TRANSACTIONS

By signing and submitting this Proposal, the bidder is providing the certification set out below:

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the bidder knowingly rendered an erroneous certification, in addition to other remedies available to the federal government the Department or agency with which this transaction originated may pursue available remedies, including suspension and or debarment.
2. The bidder shall provide immediate written notice to the person to whom this Proposal is submitted if at any time the bidder learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
3. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this Proposal is submitted for assistance in obtaining a copy of those regulations.
4. The bidder agrees by submitting this Proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department or agency with which this transaction originated.
5. The bidder further agrees by submitting this Proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The

knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Department or agency with which this transaction originated may pursue available remedies, including suspension and or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND OR VOLUNTARY EXCLUSION--LOWER TIER COVERED TRANSACTIONS

(1) The bidder certifies, by submission of this Proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

(2) Where the bidder is unable to certify to any of the statements in this certification, such bidder shall attach an explanation to this Proposal.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT E: AUTHORIZATION TO RELEASE INFORMATION

AUTHORIZATION TO RELEASE INFORMATION

_____ (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Department.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Department or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Department, and the Department of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

The bidder agrees to release all persons, entities, the Department, and the Department of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT F: CERTIFICATION REGARDING REGISTRATION, COLLECTION AND REMISSION OF STATE SALES AND USE TAXES

CERTIFICATION REGARDING REGISTRATION, COLLECTION, AND REMISSION OF STATE SALES AND USE TAX

By submitting a proposal in response to this Request for Proposal (RFP), the undersigned certifies the following: (check the applicable box):

☐ _____ [name of vendor] is registered or agrees to become registered if awarded the contract, with the Iowa Department of Revenue, and will collect and remit Iowa Sales and use taxes as required by Iowa Code chapter 423; or

☐ _____ [name of vendor] is not a "retailer" or a "retailer maintaining a place of business in the state" as those terms are defined in Iowa Code §§ 423.1(42) & (43) (2005).

_____ [name of vendor] also acknowledges that the Department may declare the Vendor's bid or resulting contract void if the above certification is false. The Vendor also understands that fraudulent certification may result in the Department or its representative filing for damages for breach of contract.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT G: CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1000 per day.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT H: CERTIFICATION REGARDING LOBBYING

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

a. No federal appropriated funds have been paid or will be paid on behalf of the Sub-Grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT I: BUSINESS ASSOCIATE AGREEMENT

The following pages provide the Business Associate Agreement.

ADDENDUM: Business Associate Agreement

THIS ADDENDUM supplements and is made a part of the Iowa Department of Human Services ("Agency") Contract (hereinafter, the "Underlying Agreement") between the Agency and the Contractor ("the Business Associate").

1. **Purpose.**
   The Business Associate performs certain services on behalf of or for the Agency pursuant to the Underlying Agreement that require the exchange of information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act") and the federal regulations published at 45 C.F.R. parts 160 and 164 (collectively "HIPAA"). The Agency is a hybrid "Covered Entity" as that term is defined in HIPAA. For purposes of this agreement, the portion of the Agency that fall under the purview of HIPAA shall be referred to as the "Covered Entity". The parties to the Underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding Protected Health Information and to bring the Underlying Agreement into compliance with HIPAA.

2. **Definitions.**
   Unless otherwise provided in this Addendum, capitalized terms have the same meanings as set forth in HIPAA.

3. **Obligations of Business Associate.**
   a. Security Obligations. Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations, apply to the Business Associate in the same manner that such sections apply to the Covered Entity. The Business Associate's obligations include but are not limited to the following:
   - Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Business Associate creates, receives, maintains, or transmits on behalf of the Covered Entity as required by HIPAA;
   - Ensuring that any agent, including a subcontractor, to whom the Business Associate provides such information agrees to implement reasonable and appropriate safeguards to protect the data; and
   - Reporting to the Covered Entity any security incident of which it becomes aware.

   b. Privacy Obligations. To comply with the privacy obligations imposed by HIPAA, Business Associate agrees to:
   - Not use or further disclose information other than as permitted or required by the Underlying Agreement, this Addendum, or as required by law;
   - Abide by any Individual's request to restrict the disclosure of Protected Health Information consistent with the requirements of Section 13405(a) of the HITECH Act;

- Use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by the Underlying Agreement and this Addendum;
- Report to the Covered Entity any use or disclosure of Protected Health Information not provided for by the Underlying Agreement of which the Business Associates becomes aware;
- Ensure that any agents, including a subcontractor, to whom the Business Associate provides Protected Health Information received from the Agency or created or received by the Business Associate on behalf of the Covered Entity agrees to the same restrictions and conditions that apply to the Business Associate with respect to such information;
- Make available to the Covered Entity within thirty (30) days Protected Health Information to comply with an Individual's right of access to their Protected Health Information in compliance with 45 C.F.R. § 164.524 and Section 13405(f) of the HITECH Act;
- Make available to the Covered Entity within thirty (30) days Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;
- Make available to the Covered Entity within fifteen (15) days the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of the HITECH Act;
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Covered Entity, or created or received by the Business Associate on behalf of the Covered Entity, available to the Secretary for purposes of determining the Covered Entity's compliance with HIPAA;
- To the extent practicable, mitigate any harmful effects that are known to the Business Associate of a use or disclosure of Protected Health Information in violation of this Addendum;
- Use and disclose an Individual's Protected Health Information only if such use or disclosure is in compliance with each and every applicable requirement of 45 C.F.R. § 164.504(e);
- Refrain from exchanging any Protected Health Information with any entity of which the Business Associate knows of a pattern of activity or practice that constitutes a material breach or violation of HIPAA;
- To comply with Section 13405(b) of the HITECH Act when using, disclosing, or requesting Protected Health Information in relation to this Addendum by limiting disclosures as required by HIPAA;
- Refrain from receiving any remuneration in exchange for any Individual's Protected Health Information unless (1) that exchange is pursuant to a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that Individual, or (2) satisfies one of the exceptions enumerated in Section 13405(e)(2) of the HITECH Act or HIPAA regulations; and
- Refrain from marketing activities that would violate HIPAA, specifically Section 13406 of the HITECH Act.

c. *Permissive Uses*. The Business Associate may use or disclose Protected Health Information that is disclosed to it by the Covered Entity under the following circumstances:
   - Business Associate may use the information for its own management and administration and to carry out the legal responsibilities of the Business Associate.
   - Business Associate may disclose the information for its own management and administration and to carry the legal responsibilities of the Business Associate if (1) the

disclosure is required by law, or (2) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. *Breach Notification.* In the event that the Business Associate discovers a Breach of Unsecured Protected Health Information, the Business Associate agrees to take the following measures within 30 calendar days after the Business Associate first discovers the incident:

- To notify the Covered Entity of any Breach. Such notice by the Business Associate shall be provided without unreasonable delay, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of this Addendum, the Business Associate is deemed to have discovered the Breach as of the first day on which such Breach is known to the Business Associate or by exercising reasonable diligence, would have been known to the Business Associate, including any person, other than the individual committing the Breach, that is a workforce member or agent of the Business Associate;
- To include to the extent possible the identification of the Individuals whose Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach;
- To complete and submit the Breach Notice form to the Covered Entity (see Exhibit A); and
- To include a draft letter for the Covered Entity to utilize to notify the Individuals that their Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach. The draft letter must include, to the extent possible:
    1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
    2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as full name, Social Security Number, date of birth, home address, account number, disability code, or other types of information that were involved);
    3. Any steps the Individuals should take to protect themselves from potential harm resulting from the Breach;
    4. A brief description of what the Covered Entity and the Business Associate are doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches; and
    5. Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

4. Addendum Administration.

a. *Termination.* The Covered Entity may terminate this Addendum for cause if the Covered Entity determines that the Business Associate or any of its subcontractors or agents has breached a material term of this Addendum. Termination of either the Underlying Agreement or this Addendum shall constituted termination of the corresponding agreement.

b. *Effect of Termination.* At termination of the Underlying Agreement or this Addendum, the Business Associate shall return or destroy all Protected Health Information received or created in connection with this Underlying Agreement, if feasible. If such return or destruction is not feasible, the Business Associate will extend the protections of this

Addendum to the Protected Health Information and limit any further uses or disclosures. The Business Associate will provide the Covered Entity in writing a description of why return or destruction of the information is not feasible.

c. *Compliance with Confidentiality Laws*. Business Associate acknowledges that it must comply with all laws that may protect the Protected Health Information received and will comply with all such laws, which include but are not limited to the following:

- *Medicaid applicants and recipients*: 42 U.S.C. § 1396a(a)(7); 42 C.F.R. §§ 431.300 - .307; Iowa Code § 217.30;
- *Mental health treatment*: Iowa Code chapters 228, 229;
- *HIV/AIDS diagnosis and treatment*: Iowa Code § 141A.9; and
- *Substance abuse treatment:* 42 U.S.C. § 290dd-3; 42 U.S.C. § 290ee-3; 42 C.F.R. part 2; Iowa Code §§ 125.37, 125.93.

d. *Indemnification for Breach Notification.* Business Associate shall indemnify the Covered Entity for costs of an action required to be taken under any law or regulation as a result of any Breach by the Business Associate or any subcontractor in a manner not permitted under 45 C.F.R. part E.

e. *Amendment.* The Covered Entity may amend the Addendum from time to time by posting an updated version of the Addendum on the Agency's website at : *http://www.dhs.state.ia.us/Consumers/Health/HIPAA/Home.html*, and providing the Business Associate electronic notice of the amended Addendum. The Business Associate shall be deemed to have accepted the amendment unless the Business Associate notifies the Covered Entity of its non-acceptance in accordance with the Notice provisions of the Contract within 30 days of the Covered Entity's notice referenced herein. Any agreed alteration of the then current Covered Entity Addendum shall have no force or effect until the agreed alteration is reduced to a Contract amendment and signed by the Contractor, Agency Director, and the Agency Security and Privacy Officer.

f. *Survival.* The obligations of the Business Associate shall survive this Addendum's termination.

g. *No Third Party Beneficiaries.* There are no third party beneficiaries to this agreement between the parties. The Underlying Agreement and this Addendum are intended to only benefit the parties to the agreement.

h. *Effective Date*. This Addendum is effective as of the Underlying Agreement's Effective Date.

EXHIBIT A: NOTIFICATION TO THE AGENCY OF BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

NOTE: The Business Associate must use this form to notify the Covered Entity of any Breach of Unsecured Protected Health Information. Immediately provide a copy of this completed form to (1) the Contract Manager, in compliance with the Notice Requirements of the Underlying Agreement, and (2) the Agency Security and Privacy Officer at:

Iowa Department of Human Services
Attn: Security & Privacy Officer
1305 E. Walnut, 1st Floor, DDM
Des Moines, IA 50319

Contract Information	
Contract Number	**Contract Title**
Contractor Contact Information	
Contact Person for this Incident:	
Contact Person's Title:	
Contact's Address:	
Contact's E-mail:	
Contact's Telephone No.:	

Business Associate hereby notifies the Covered Entity that there has been a Breach of Unsecured (unencrypted) Protected Health Information that Business Associate has used or has had access to under the terms of the Business Associate Agreement, as described in detail below:

Breach Details	
Date of Breach	Date of Discovery of Breach
Detailed Description of the Breach	
Types of Unsecured Protected Health Information involved in the Breach (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc).	
What steps are being taken to investigate the breach, mitigate losses, and protect against any further breaches?	
Number of Individuals Impacted	**If over 500, do individuals live in multiple states?**
	YES | NO

Signature: _____ **Date:** _____

ATTACHMENT J-1: BID PROPOSAL CERTIFICATION OF AVAILABLE RESOURCES

CERTIFICATION OF AVAILABLE RESOURCES

I certify that the bidder organization indicated below has sufficient personnel resources available to provide all services proposed by this Bid Proposal. I duly certify that these personnel resources for the contract awarded will be available on and after November 28, 2011.

In the event that we, the bidder, have bid more than one contract specified by this RFP, my signature below also certifies that the personnel bid for this Bid Proposal are not personnel for any other Bid Proposal. If my organization is awarded more than one contract, I understand that the State may agree to shared resource allocation if the bidder can prove feasibility of shared resource.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT J-2: BID PROPOSAL DRUG FREE WORKPLACE CERTIFICATION

CERTIFICATION OF DRUG FREE WORKPLACE

1. **Requirements for Contractors Who are Not Individuals.** If the bidder is not an individual, by signing below bidder agrees to provide a drug-free workplace by:
   a. publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
   b. establishing a drug-free awareness program to inform employees about:
      (1) the dangers of drug abuse in the workplace;
      (2) the person's policy of maintaining a drug- free workplace;
      (3) any available drug counseling, rehabilitation and employee assistance programs; and
      (4) the penalties that may be imposed upon employees for drug abuse violations;
   c. making it a requirement that each employee to be engaged in the performance of such contract be given a copy of the statement required by subparagraph (a);
   d. notifying the employee in the statement required by subparagraph (a), that as a condition of employment on such contract, the employee will:
      (1) abide by the terms of the statement; and
      (2) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than 5 days after such conviction;
   e. notifying the contracting agency within 10 days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;
   f. imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by 41 U.S.C. § 703; and
   g. making a good faith effort to continue to maintain a drug-free workplace through implementation of subparagraphs (a), (b), (c), (d), (e) and (f).
2. **Requirement for Individuals.** If the bidder is an individual, by signing below the bidder agrees to not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the contract.
3. **Notification Requirement.** The bidder shall, within 30 days after receiving notice from an employee of a conviction pursuant to 41 U.S.C. § 701(a)(1)(D)(ii) or 41 U.S.C. § 702(a)(1)(D)(ii):
   a. take appropriate personnel action against such employee up to and including termination; or
   b. require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

I certify that I have the authority to bind the bidder indicated below to the terms and conditions related to the Drug Free Workplace requirements.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

ATTACHMENT J-3: PRIMARY BIDDER DETAIL FORM & CERTIFICATION

PRIMARY DETAIL FORM AND CERTIFICATION

(Return this completed form behind Tab 5 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	
Address:	
Tel:	
Fax:	
E-mail:	

Primary Bidder Detail	
Business Legal Name ("Bidder"):	
"Doing Business As" names, assumed names, or other operating names:	
Parent Corporation, if any:	
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	
State of Incorporation/organization:	
Primary Address:	
Tel:	
Fax:	
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	
Number of Employees:	
Number of Years in Business:	
Primary Focus of Business:	
Federal Tax ID:	
Bidder's Accounting Firm:	
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	(YES/NO)

Signature:	

Printed Name/Title:	
Date:	

ATTACHMENT J-4: SUBCONTRACTOR DISCLOSURE FORM

*(Return this completed form behind Tab 5 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.*)

Primary Bidder ("Primary Bidder"):	
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	
Address:	
Tel:	
Fax:	
E-mail:	

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	
"Doing Business As" names, assumed names, or other operating names:	
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	
State of Incorporation/organization:	
Primary Address:	
Tel:	
Fax:	
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	
Number of Employees:	
Number of Years in Business:	
Primary Focus of Business:	
Federal Tax ID:	
Subcontractor's Accounting Firm:	
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	
General Scope of Work to be performed by this Subcontractor	

Detail the Subcontractor's qualifications for performing this scope of work

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	
Date:	

ATTACHMENT K: RESOURCE LIBRARY CONTENT

IME Resource Library Web Site Content

The documents listed below are available in the Iowa Medicaid Enterprise resource library located at www.ime.state.ia.us.

a. RFP MED 04-015 Systems and Professional Services for the Iowa Medicaid Enterprise
b. RFP MED 04-034 Medical Services with Preferred Drug List
c. RFP MED 04-037 Implementation and Support Services
d. Pharmacy POS-(MED-04-084)
e. RFP MED 04-085 Medicaid Claims Payment Support Services
f. RFP MED 09-010 Iowa Plan for Behavioral Health
g. RFP MED 09-006 Technical Assistance and Support for Iowa Medicaid Enterprise Services Procurement
h. RFP MED 09-016 Claims Editing and Correct Coding Initiative (CCI)
i. RFP MED 09-017 HIPPA & ICH-10 Technical Assistance & Support
j. RFP MED 10-001 IME Professional Services
k. RFP MED 10-011 Non-Emergency Medical Transportation Brokerage
l. RFP MED 10-013 IME Program Integrity Services
m. IME Operational Procedures
    1. Provider Services
    2. Member Services
    3. Pharmacy Medical Services
    4. Medical Services
    5. Pharmacy POS
    6. Revenue Collections (includes Estate Recovery)
    7. Data Warehouse and Decision Support (DW/DS)
    8. Core MMIS
    9. Program Integrity (formerly SURS)
    10. Provider Cost Audits and Rate Setting (PCA)
n. IME Operational Tools:
    1. OnBase and Mailroom-verification and scanning
    2. MQUIDS
    3. MMIS Valid Values Booklet (Iowa Medicaid Guide)
o. IME Quarterly Reports

1. SFY 2006
2. SFY 2007
3. SFY 2008
4. SFY 2009
5. SFY 2010

p. Other

1. IME Table of Organization
2. MITA SS-A-2009
3. Data Warehouse Overview
4. Encounters Table
5. PDCLAIMN CPY
6. ELIGMSTR CPY
7. MHCNRLMT CPY
8. PDDMSTER CPY
9. PRIRAUTH CPY
10. PROVMAST CPY
11. TPLMSTR CPY
12. MVM 2009 Report Final
13. MVM 2008 Report
14. Sample GAX (contractor invoice form)
15. Medicare Part A and Part V Buy-In Statistics
16. MediPASS Appointment Survey
17. Provider Type Summary
18. Provider Letters
19. Provider Manuals
20. Provider Information Releases
21. Workflow Process Maps
22. System Interface Diagram
23. Consumer Directed Attendant Care (CDAC) Memorandum of Understanding

q. ISIS

1. ISIS Reports
    i. Waiver Workflows
    ii. Change Flows
    iii. Facility Workflows
    iv. Enhances Services Workflows

v. Provider Incident Workflow

vi. Prior Authorization Workflows

2. ISIS Edits

r. Revenue Collections Quarterly Summary Reports

1. SFY 06
2. SFY 07
3. SFY 08
4. SFY 09
5. SFY 10

ATTACHMENT L: BID PROPOSAL REQUIREMENTS CHECKLIST

The Department has provided the following template to submit with the Technical Proposal. Bidders are required to confirm compliance by marking the "Yes" box in the "Bidder Check" column. Upon receipt of bid proposals, the Department will confirm compliance by marking "Yes" in the "Department Check" column. Bidders' failure to complete the requirements will result in the bidders' disqualification for this procurement as described in RFP Section 2.15 Disqualification.

Table 15: Proposed Requirements Checklist

Bidder Check	Requirement	Confirmed by the Department
☐ Yes ☐ No	1. Did the issuing officer receive the bid proposal by 3:00 p.m., Central Time, on the date specified in RFP Section 2.1 Procurement Timetable?	☐ Yes ☐ No
☐ Yes ☐ No	2. Does each bid proposal consist of three distinct parts? a. Technical Proposal b. Cost Proposal c. Company Financial Information	☐ Yes ☐ No
☐ Yes ☐ No	3. Is each bid proposal sealed in a box (or boxes), with the Cost Proposal and Company Financial Information volumes sealed in separate, labeled envelopes inside the same box or boxes?	☐ Yes ☐ No
☐ Yes ☐ No	4. Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4 and so forth for each bid proposal that consists of multiple boxes?	☐ Yes ☐ No
☐ Yes ☐ No	5. Are all boxes containing bids labeled with the following information? a. Bidder's name and address b. Issuing officer name and delivery address as identified by RFP Section 9.1.d.2 c. RFP title (Iowa Medicaid Enterprise System Services Procurement) and RFP reference number (MED-12-001) d. RFP for which the bid proposal is being submitted for consideration whether for the MMIS or POS	☐ Yes ☐ No
☐ Yes ☐ No	6. Are separate boxes utilized for each bid proposal if submitting bid proposals for more than one of the individual contract awards?	☐ Yes ☐ No
☐ Yes ☐ No	7. Are all bid proposal materials printed on 8.5" x 11" paper (two-sided)?	☐ Yes ☐ No
☐ Yes ☐ No	8. Is Technical Proposal presented in a spiral, comb, or pasteboard binder separate from the sealed Cost Proposal and Company Financial Information volumes? (Note: Technical Proposals in 3-ring binders will not be accepted.)	☐ Yes ☐ No
☐ Yes ☐ No	9. Is each Cost Proposal in a spiral, comb or pasteboard binder separate from the sealed Technical Proposal and Company Financial Information volumes? (Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated. 3-ring binders will not be accepted.)	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by the Department
☐ Yes ☐ No	10. Is each Company Financial Information in a spiral binder, or comb or pasteboard binder separate from the sealed Technical Proposal and Cost Proposal volumes? (Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening. 3-ring binders will not be accepted.)	☐ Yes ☐ No
☐ Yes ☐ No	11. Is one sanitized copy of the proposal volumes and Company Financial Information included if any bid proposal information is designated as confidential? (Note: Bidders cannot designate their entire proposal as confidential or proprietary.)	☐ Yes ☐ No
☐ Yes ☐ No	12. Does each Technical Proposal package include: a. One original b. Ten copies c. One sanitized copy (if applicable) in a separate binder (or set of binders) d. Are the original, copies and sanitized copy correctly marked?	☐ Yes ☐ No
☐ Yes ☐ No	13. Does each Cost Proposal package include: a. One original b. Ten copies c. One sanitized copy of Cost Proposal in separate, sealed envelope d. Are the original, copies and sanitized copy correctly marked?	☐ Yes ☐ No
☐ Yes ☐ No	14. Does each Company Financial Information package contain one original and three copies of Company Financial Information (in a separate sealed envelope)? (Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening.)	☐ Yes ☐ No
☐ Yes ☐ No	15. Are all bid proposals also submitted on CD-ROM or DVD?	☐ Yes ☐ No
☐ Yes ☐ No	16. Does one submitted CD-ROM or DVD contain one full version of the Technical Proposal and Cost Proposal and the other submitted CD-ROM or DVD contain one sanitized version of the Technical Proposal?	☐ Yes ☐ No
☐ Yes ☐ No	17. Are all electronic files in PDF format?	☐ Yes ☐ No
☐ Yes ☐ No	18. Are all electronic files individually identified by: a. Component name b. Bid proposal volume title (technical or cost) c. Status (original, copy or sanitized)	☐ Yes ☐ No

	Technical Proposal Content	
Bidder Check	**Requirement**	**Confirmed by the Department**
☐ Yes ☐ No	19. Does each Technical Proposal consist of the following sections separated by tabs with associated documents and responses presented in the following order? a. Table of Contents (Tab 1) b. Transmittal Letter (Tab 2) c. Checklists and Cross-References (Tab 3) d. Executive Summary (Tab 4) e. Corporate Qualifications (Tab 5) f. Project Management (Tab 6) g. General Requirements(Tab 7) h. Start-Up and Implementation Phases (Tab8) i.. MMIS and POS System Requirements (Tab 9) j. MMIS and POS Operational Requirements (Tab 10) k. Certification Phase (Tab 11) l. Turnover Phase (Tab 12)	☐ Yes ☐ No
☐ Yes ☐ No	20. Does the Table of Contents in Tab 1 of the Technical Proposal identify all sections, subsections and corresponding page numbers?	☐ Yes ☐ No
☐ Yes ☐ No	21. Does the Transmittal Letter in Tab 2 include the following? a. The bidder's mailing address b. Electronic mail address, fax number and telephone number for both the authorized signer and the point of contact designated by the bidder c. A statement indicating that the bidder is a corporation or other legal entity d. Identification of all subcontractors and a statement included that indicates the exact amount of work to be done by the prime contractor and each subcontractor, as measured by a percentage of the total work e. Technical proposal must not include actual price information f. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed to work in Iowa g. A statement identifying the bidder's federal tax identification number h. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP i. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal j. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, political affiliation, national origin or handicap k. A statement that no cost or pricing information has been included in this letter or the Technical Proposal l. A statement identifying all amendments to the RFP issued by the state and received by	☐ Yes ☐ No

	Technical Proposal Content	
Bidder Check	**Requirement**	**Confirmed by the Department**
	the bidder. (Note: If no amendments have been received, a statement to that effect shall be included.) m. A statement that the bidder certifies in connection with this procurement that: 1. The prices proposed have been arrived at independently, with consultation, communication or agreement, as to any matter relating to such prices with any other bidder or any competitor for the purpose of restricting competition; and 2. Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor 3. A statement that the person signing this proposal certifies that he and or she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he and or she has not participated and will not participate in any action contrary to items 1, 2 and 3 n. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal o. A statement that the bidder acknowledges the acceptance of all terms and conditions stated in the RFP	
☐ Yes ☐ No	22. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating: a. The general scope of work to be performed by the subcontractor b. The subcontractor's willingness to perform the work indicated; and c. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, political affiliation, national origin or handicap	☐ Yes ☐ No
☐ Yes ☐ No	23. Any request for confidential treatment of information shall also be identified in the transmittal letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public	☐ Yes ☐ No
☐ Yes ☐ No	24. The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information (if applicable)	☐ Yes ☐ No
☐ Yes ☐ No	25. Is a completed copy of the Checklist and Cross-References included in Tab 3? a. Requirements Checklist b. General Requirements Cross-Reference c. MMIS and POS System Services Requirements Cross-Reference	☐ Yes ☐ No
☐ Yes ☐ No	26. Is a General Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 5?	☐ Yes ☐ No
☐ Yes ☐ No	27. Is a MMIS or POS System Services Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration?	☐ Yes ☐ No
☐ Yes ☐ No	28. Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in?	☐ Yes ☐ No

	Technical Proposal Content	
Bidder Check	**Requirement**	**Confirmed by the Department**
☐ Yes ☐ No	29. Does information in Corporate Qualifications (Tab 5) include the following? a. Description of the Corporate Organization (section 9.2.51) b. Description of the Corporate Experience (section 9.2.5.2) c. Corporate References (section 9.2.5.3) d. A signed copy of each of Attachments B through J inclusive with signature from an individual authorized to bind the company (section 9.2.5.5) e. Felony Disclosure (section 9.2.5.4)	☐ Yes ☐ No
☐ Yes ☐ No	30. Does information in MMIS and POS System Requirements (Tab 9) include the following from Section 7: a. Is each contract function addressed as referenced in section 7 b. Indication if each capability is an existing capability of the system being proposed c. Indication if a requirement will be met with system modification (SM) or COTS solution. (Required entry for any Requirement with a "No" in Column B) d. Estimated number of hours required to develop capability. (Required entry for any Requirement with a "No" in Column B)	☐ Yes ☐ No

	Cost Proposal Content	
Bidder Check	**Requirement**	**Confirmed by the Department**
☐ Yes ☐ No	31. Does the Cost Proposal include the following sections: a. Table of Contents (Tab 1) b. Bid Proposal Security (Tab 2) c. Pricing Schedules (Tab 3)	☐ Yes ☐ No
☐ Yes ☐ No	32. Does Tab 1 include a Table of Contents of the Cost Proposal?	☐ Yes ☐ No
☐ Yes ☐ No	33. Does the Table of Contents identify all sections, subsections and corresponding page numbers?	☐ Yes ☐ No
☐ Yes ☐ No	34. Is a proposal bid bond or proposal guarantee in the form of a cashier's check, certified check, bank draft, treasurer's check, bond or a original letter of credit payable to the Department in an amount equal to five percent of the total implementation and operations costs identified by Pricing Schedule N of the Cost Proposal included in Tab 2?	☐ Yes ☐ No
☐ Yes ☐ No	35. Are copies of the proposal bid bond included in Tab 2 in all other copies of the Cost Proposal submitted by the bidder?	☐ Yes ☐ No
☐ Yes ☐ No	36. If a bond is used, is it issued by a surety licensed to do business in Iowa?	☐ Yes ☐ No
☐ Yes ☐ No	37. Are pricing schedules as specified in the RFP included in Tab 3?	☐ Yes ☐ No

	COMPANY FINANCIAL INFORMATION	
Bidder Check	**Requirement**	**Confirmed by the Department**
☐ Yes ☐ No	38. Does the Company Financial Information include audited financial statements (annual reports) for the last 3 years?	☐ Yes ☐ No
☐ Yes ☐ No	39. Does the Company Financial Information include at least three financial references (such as letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports)?	☐ Yes ☐ No
☐ Yes ☐ No	40. Does the Company Financial Information include a description of other contracts or projects currently undertaken by the bidder?	☐ Yes ☐ No
☐ Yes ☐ No	41. Does the Company Financial Information include a summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services?	☐ Yes ☐ No
☐ Yes ☐ No	42. Does the Company Financial Information include a disclosure of any contracts during the preceding five year period, in which the bidder or any subcontractor identified in the bid proposal has defaulted? Does it list all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract?	☐ Yes ☐ No
☐ Yes ☐ No	43. Does the Company Financial Information include a disclosure of any contracts during the preceding five-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term.?	☐ Yes ☐ No
☐ Yes ☐ No	44. Does the Company Financial Information include the company's five-year business plan that would include the award of the state's contract as part of the work plan?	☐ Yes ☐ No

ATTACHMENT M: SAMPLE CROSS-REFERENCE

The following table provides a sample of the necessary cross-reference for General and System Services requirements. The bidder is required to produce a similar table with the same column headings.

Table 16: RFP Cross-Reference

RFP Requirement	Location of Response in Bid Proposal
5.2.1, item a	Section 5.x, pg. yyy
6.2.2.3.2, item a	Section 6.y, pg. zzz

ATTACHMENT N: PRICING SCHEDULES

This section includes the following pricing schedules for this procurement.

Table 17: Pricing Schedule Attachments

Identifier	Title of Pricing Schedule
N-1	Pricing Schedule for MMIS Implementation
N-1A	Pricing Schedule for MMIS Implementation for Optional SUR Component
N-2	Pricing Schedule for MMIS Software Costs
N-3	Pricing Schedule for MMIS Hardware Costs
N-4	Pricing Schedule for MMIS Operational Services
N-5	Pricing Schedule for MMIS Implementation for Optional Waiver, Facility and Enhanced State Plan Services Management
N-6	Pricing Schedule for MMIS Operational for Optional Waiver, Facility and Enhanced State Plan Services Management
N-7	Pricing Schedule for Summary of Total MMIS Proposal
N-8	Pricing Schedule for POS Implementation
N-9	Pricing Schedule for POS Software Costs
N-10	Pricing Schedule for POS Hardware Costs
N-11	Pricing Schedule for POS Operational Services
N-12	Pricing Schedule for Summary of Total POS Proposal

Pricing Schedule N-1

MMIS Implementation

Milestones	Total Phase Price
Project Initiation Activities (5%)	
Requirements Analysis (15%)	
Business and Technical Design (10%)	
Comprehensive Testing Plan (5%)	
Conversion Activities (10%)	
Development Activities (15%)	
System Testing (10%)	
Acceptance Testing (10%)	
MMIS Implementation (15%)	
Certification of MMIS (5%)	
Other Costs (ex: rent)	
Total	

AN AUTHORIZED CORPORATE OFFICIAL OF THE VENDOR MUST SIGN THIS FORM.
THE OFFICIAL'S TITLE AND THE DATE THIS FORM WAS SIGNED MUST BE ENTERED.

Signature of Corporate Official Title Date

Pricing Schedule N-1A

MMIS Implementation for Optional SUR Component

Milestones	Total Phase Price
Project Initiation Activities (5%)	
Requirements Analysis (15%)	
Business and Technical Design (10%)	
Comprehensive Testing Plan (5%)	
Conversion Activities (10%)	
Development Activities (15%)	
System Testing (10%)	
Acceptance Testing (10%)	
MMIS Implementation (15%)	
Certification of MMIS (5%)	
Total	

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Pricing Schedule N-2

MMIS Software Costs

Software Product	Number of Licenses	License Type	COTS or Proprietary	Costs	
		Concurrent, Named or Site		Purchase Price	Annual Maintenance Fee*
Total					

***Enter if applicable**

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Pricing Schedule N-3

MMIS Hardware Costs

Hardware Product	Number of Licenses	COTS or Proprietary	Costs	
			Purchase Price	Annual Maintenance Fee*
Total				

***Enter if applicable**

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Pricing Schedule N-4

MMIS Operational Services

Line Item Description	Year 1	Year 2	Year 3	Year 4	Year 5	Opt 1	Opt 2	Opt 3	Total
Operations									
Salaries and Benefits	$	$	$	$	$	$	$	$	$
Administrative Overhead	$	$	$	$	$	$	$	$	$
Other Costs (itemized in the following rows)	$	$	$	$	$	$	$	$	$
Total	$	$	$	$	$	$	$	$	$

*** Only itemize Hardware and Software operations and maintenance costs for years 2-5 and Option years 1-3.**

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Pricing Schedule N-5

MMIS Implementation for Optional Waiver, Facility and Enhanced State Plan Services Management

Milestones	Total Phase Price
Project Initiation Activities (5%)	
Requirements Analysis (15%)	
Business and Technical Design (10%)	
Comprehensive Testing Plan (5%)	
Conversion Activities (10%)	
Development Activities (15%)	
System Testing (10%)	
Acceptance Testing (10%)	
MMIS Implementation (15%)	
Certification of MMIS (5%)	
Total	

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Pricing Schedule N-6

MMIS Operational Services for Optional Waiver, Facility and Enhanced State Plan Services Management

Line Item Description	Year 1	Year 2	Year 3	Year 4	Year 5	Opt 1	Opt 2	Opt 3	Total
Operations									
Salaries and Benefits	$	$	$	$	$	$	$	$	$
Administrative Overhead	$	$	$	$	$	$	$	$	$
Other Costs (itemized in the following rows)	$	$	$	$	$	$	$	$	$
Total	$	$	$	$	$	$	$	$	$

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Pricing Schedule N-7

SUMMARY OF TOTAL MMIS PROPOSAL

Component	Implementation Price	Base Operational Price	Extension (36 Months) Operational Price	Total
MMIS				

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Pricing Schedule N-8

POS Implementation

Milestones	Total Phase Price
Project Initiation Activities (5%)	
Requirements Analysis (15%)	
Business and Technical Design (10%)	
Comprehensive Testing Plan (5%)	
Conversion Activities (10%)	
Development Activities (15%)	
System Testing (10%)	
Acceptance Testing (10%)	
POS Implementation (15%)	
Certification of POS (5%)	
Other Costs (ex: rent)	
Total	

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Pricing Schedule N-9

POS Software Costs

Software Product	Number of Licenses	License Type	COTS or Proprietary	Costs	
		Concurrent, Named or Site		Purchase Price	Annual Maintenance Fee*
Total					

***Enter if applicable**

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Pricing Schedule N-10

POS Hardware Costs

Hardware Product	Number of Licenses	COTS or Proprietary	Costs	
			Purchase Price	Annual Maintenance Fee*
Total				

***Enter if applicable**

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Pricing Schedule N-11

POS Operational Services

Line Item Description	Year 1	Year 2	Year 3	Year 4	Year 5	Opt 1	Opt 2	Opt 3	Total
Operations									
Salaries and Benefits	$	$	$	$	$	$	$	$	$
Administrative Overhead	$	$	$	$	$	$	$	$	$
Other Costs (itemized in the following rows)	$	$	$	$	$	$	$	$	$
Total	$	$	$	$	$	$	$	$	$

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Pricing Schedule N-12

SUMMARY OF TOTAL POS PROPOSAL

Component	Implementation Price	Base Operational Price	Extension (36 Months) Operational Price	Total
POS				

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Signature of Corporate Official Title Date

ATTACHMENT O: SAMPLE CONTRACT

The following pages provide a sample of the actual contract that the Department will use with the successful bidder(s).