Technical Specifications Matrix - Attachment K Instructions

The requirements in three worksheets in this workbook include the functional, infrastructure and interface requirements for MMIS.

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).

System Functional Requirements Worksheet: Use the instructions below for responsing to this worksheet, which describes the functional specifications with an identifer (per the numering scheme above) for the following areas:

Identifier	Requirements Area
BE	Member Management
PR	Provider Management
CR	Claims Receipt
CA	Claims Adjudication
CA5	Prior Authorization
RF	Reference Data Management
TP	Third Party Liability (TPL)
HP	Health Insurance Premium Payment (HIPP)
PM	Program Management Reporting
FR	Federal Reporting
FI	Financial Management
PI	Program Integrity Management
MG	Managed Care Enrollment
MC	Managed Care Organization
ME	Primary Care Case Management (PCCM) and Medical Home/Managed Care Gatekeeper
RI	Immunization Registry Interface
WPP	Web Portal for Providers
WPM	Web Portal for Members
WA	Waiver Requirements

Infrastructure Requirements Worksheet: Use the instructions below for responsing to this worksheet, which describes the infrastructure specifications with an identifer (per the numering scheme above) for the following areas:

Identifier	Requirements Area
RE	Rules Engine
AR	General Architectural
HP	HIPAA
MT	MITA Technical Requirements
SOA	Service Oriented Architecture
PL	Programming Language
SP	Security and Privacy
SL	Software Licenses and
DQ	Data Quality Control
EV	Environment
WPI	Web Portal Infrastructure
WM	Workflow
ED	Electronic Document Management System (EDMS)
OG	Other General Requirements

Current External Interfaces Worksheet: Describes the current interfaces that are maintained within the Core MMIS.
NOTE: This last worksheet titled "Current External Interfaces" does NOT require that bidders comply with the instructions for response. Rather, bidders should address the interface requirements as outlined in RFP Section 2.

INSTRUCTIONS FOR SYSTEM FUNCTIONAL REQUIREMENTS AND INTFRASTRUCTURE REQUIREMENTS WORKSHEETS:

Column	A	B	C	D
Description	Agree to meet the requirement	Existing Capability	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)	Reference to Proposal Section for proposed solution
Value	Y or N	Y or N	SM or COTS	Proposal Reference

The proposal description referenced by Column D 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 requirement ID in each table 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.

As result of the system requirements, it is the Agency's intention to replace the following current ancillary systems which will become part of the new MMIS: Buy-In, HIPP, MEPD, IMPA and Title XIX

Requirement #		Agree to meet Y or N	[redacted]	SM or COTS	Reference to proposal section for proposed solution.
SCORING: 1 point for each Yes in column C ("Agree to meet") and 1 point for each Yes in column D ("Existing capability), .7 point for COTS in column E, and .4 point for System Mod. In column E.					
BE	**Member Management Requirements**	**A**	[redacted]	**C**	**D**
BE1.01	Support a member data set that contains all required data elements.	Y	[redacted]	COTS	4B.3.1.a.1
	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.				
BE1.01.02	v. Telephone numbers such as home, cell, work, guardian and individual ownership of phone) – must store multiple numbers.	Y	[redacted]	COTS	4B.3.1.a.1

	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. ab. Foster care for Early and Periodic Screening Diagnosis and Treatment (EPSDT) mailing indicator. ac. Immunization Registry data received and displayed in the Medicaid Management Information System (MMIS). ad. Social Security Number. ae. State ID from the eligibility system. af. Multiple indicators of disability, chronic or other condition as identified by Iowa Medicaid Enterprise (IME). ag. Member name, legal and preferred. ah. Eligibility span. ai. Case Number. aj. Medically Frail indicator Others as defined by the department		[redacted]		
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.	Y		COTS	4B.3.1.a.1
BE1.02.01	Provide controls to assure that records received from the eligibility system were properly applied.	Y		COTS	4B.3.1.a.1

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.	Y	[redacted]	COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE1.03	Support management of member information, including archives, reports, transaction and transaction error tracking.	Y		COTS	4B.3.1.a.1
BE1.04	Generate notification when member information is received from external sources to update member records.	Y		COTS	4B.3.1.a.1
BE1.05	Receive and process member eligibility information from external sources such as, the Iowa DHS 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.	Y		COTS	4B.3.1.a.1
BE1.06	Archive member data sets and update transactions according to IME provided parameters.	Y		COTS	4B.3.1.a.1
BE1.07	Provide member data to support case identification, tracking and reporting for the EPSDT services covered under Medicaid.	Y		COTS	4B.3.1.a.1
BE1.07.01	Provide the capability to meet the business requirements of EPSDT.	Y		COTS	4B.3.1.a.1

BE1.07.02	Provide the capability to track screenings, referrals and treatments for EPSDT members.	Y	[redacted]	COTS	4B.3.1.a.1
BE1.07.03	Identify all members eligible for EPSDT services within the benefit plan administration rules engine.	Y		COTS	4B.3.1.a.1
BE1.07.04	Provide the capability for recording all case activity including, but not limited to: a. Logs of notices. b. Recommended dates of service from the periodicity table. c. Actual dates of services. d. IME and contractor contacts. e. Case notes.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE1.08	Provide an indicator to suppress generation of documents containing member identification for confidential services or other reasons.	Y		COTS	4B.3.1.a.1

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.	Y	[redacted]	COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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).	Y		COTS	4B.3.1.a.1
BE1.11	Maintain record and audit trail of errors during update processes, accounting for originating source and user.	Y		COTS	4B.3.1.a.1
BE1.11.01	Provide the capability to produce daily audit trail reports and allow inquiries showing all member data updates applied to the member management module.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE1.12	Allow authorized users to update member records online.	Y		COTS	4B.3.1.a.1

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.	Y	[redacted]	COTS	4B.3.1.a.1
BE1.13	Support and track the identification of duplicate recipient records based on state-defined criteria.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE1.SS.02	Provide the capability to generate an alert when a member gives birth or when a pregnancy is terminated.	Y		COTS	4B.3.1.a.1
BE1.SS.03	Eligibility segments must be date driven and provide accurate eligibility information at any point in history.	Y		COTS	4B.3.1.a.1
BE1.SS.04	Provide an online change-correction process, which allows the database record to be modified according to users' security access levels.	Y		COTS	4B.3.1.a.1
BE1.SS.05	Provide links between all modules, such that the user can easily navigate with one "click" according to users' security access levels.	Y		COTS	4B.3.1.a.1
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:	Y		COTS	4B.3.1.a.1
	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.	Y	[redacted]	COTS	4B.3.1.a.1
BE1.SS.09	Provide the capability to periodically archive member records using criteria approved by IME.	Y		COTS	4B.3.1.a.1
BE1.SS.10	Provide the capability to void and retain member information as determined by IME.	Y		COTS	4B.3.1.a.1
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 schedule to be determined by IME.	Y		COTS	4B.3.1.a.1
BE1.SS.12	Provide the capability to generate Medicare eligibility files for the Medicare claims processor to use in processing crossover claims.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1

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.	Y	[redacted]	COTS	4B.3.1.a.1
BE1.SS.18	Provide the capability to identify the name(s) of the provider(s) to which the member is locked-in.	Y		COTS	4B.3.1.a.1
BE2.01	Provide data storage and retrieval for TPL information; support TPL processing and update of the information.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
	Provide the capability to maintain insurance coverage data in the member management module including, but not limited to:				
	a. Carrier.				
	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).				

BE2.01.05	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.	Y	[redacted]	COTS	4B.3.1.a.1
BE2.02	Supports the assignment of members to Medicaid benefits and benefit packages based on federal and or IME-specific eligibility criteria.	Y		COTS	4B.3.1.a.1
BE2.02.01	Provide the capability to maintain a historical record of benefit assignment(s) for a member, including identifying dual-eligibility spans.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE2.02.03	Provide the capability to create new benefit plans by a business analyst without involvement of programmers.	Y		COTS	4B.3.1.a.1
BE2.02.04	Provide the capability to maintain a historical record of benefit assignment(s) for a member, including identifying dual-eligibility spans.	Y		COTS	4B.3.1.a.1
BE2.02.05	Track member relationships to multiple managed care options during a specific enrollment period, including HMO, Health Home, Integrated Health Home, and ACO	Y		COTS	4B.3.1.a.1
BE2.02.06	Provide the capability for member to be enrolled in multiple health plans, such as a QHP for medical coverage, a dental plan, and a behavioral health plan.	Y		COTS	4B.3.1.a.1
BE2.03	Apply appropriate benefit limitations for members based on federal and or IME-specific criteria.	Y		COTS	4B.3.1.a.1
BE2.04	Maintain record of member benefit limitation information.	Y		COTS	4B.3.1.a.1

BE2.05	Calculate and apply member cost-sharing, including premiums and co-pays, for particular benefits based on federal and or IME-specific criteria.	Y	[redacted]	COTS	4B.3.1.a.1
BE2.05.01	Track cost sharing across family members to ensure cost sharing does not exceed federal limits based upon federal poverty level.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE2.SS.01	Provide the capability of real time updates to the member module as directed by IME.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE2.SS.03	Provide the capability to maintain a real time interface with the POS to verify member eligibility as directed by IME.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE2.SS.09	Provide the capability to lock-in a member to a certain physician, hospital, pharmacy or all.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE3.03	Provide notice of participation in a managed care program in response to an eligibility inquiry made through the MMIS.	Y		COTS	4B.3.1.a.1

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.	Y	[redacted]	COTS	4B.3.1.a.1
BE3.05	Maintain record and audit trail of responses to eligibility inquiries.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE4.02	Support production of X12N 270 transactions to query other payer eligibility files and ability to process responses.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE4.SS.02	Provide the capability to produce HIPAA privacy notices on a scheduled and ad hoc basis.	Y		COTS	4B.3.1.a.1
BE4.SS.03	Track disclosure of protected health Information (PHI) and have the capability to indicate persons authorized to discuss PHI for a member.	Y		COTS	4B.3.1.a.1
BE5.01	Identify and track potential Medicare buy-in members according to IME and CMS-defined criteria.	Y		COTS	4B.3.1.a.1
BE5.02	Transmit IME-identified buy-in member information for matching against CMS-specified federal Medicare member database(s).	Y		COTS	4B.3.1.a.1
BE5.03	Accept buy-in member response information from CMS-specified federal Medicare member database(s).	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1

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.	Y	[redacted]	COTS	4B.3.1.a.1
BE5.06	Track buy-in exceptions for those members who are identified as eligible, but whose premiums have not been paid.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE5.SS.02	Provide the capability to generate buy-in premiums and provide the information required to support IME payment of premiums.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE.SS.01	Maintain historical date-specific spenddown information.	Y		COTS	4B.3.1.a.1
BE.SS.02	Allow for providers to submit claims electronically for spenddown application for the member and family of the members.	Y		COTS	4B.3.1.a.1

BE.SS.03	Allow for providers to submit inquiries concerning spenddown requirements for a member.	Y		COTS	4B.3.1.a.1
BE.SS.04	Allow members to view spenddown information on the web portal including claims that were submitted and used toward spenddown.	Y		COTS	4B.3.1.a.1
BE.SS.05	Generate notice to provider and member of claims that were applied to spenddown and amount of unmet spenddown.	Y		COTS	4B.3.1.a.1
BE.SS.06	Apply the amount of claims that are denied for unmet spenddown to the spenddown balance.	Y		COTS	4B.3.1.a.1
BE.SS.07	Provide the capability to prevent duplicate use of claims for spenddown.	Y		COTS	4B.3.1.a.1
BE.SS.08	Provide capability to manually deduct claims originally applied to unmet spenddown as directed by IME.	Y		COTS	4B.3.1.a.1
BE.SS.9	Support edits which prevent payment of claims that were applied to spenddown in whole or part.	Y		COTS	4B.3.1.a.1
BE.SS.10	Return spenddown met indicator (fund code) to eligibility system once the spenddown amount is met.	Y		COTS	4B.3.1.a.1
BE.SS.11	Ensure claims are applied to spenddown in the Medically Needy file on a first in, first used basis.	Y		COTS	4B.3.1.a.1
BE.SS.12	Allow claims for household members and or relatives of the member, to be applied against the spenddown amount per Iowa rules.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
BE.SS.14	Provide a summary screen of the member's certification history.	Y		COTS	4B.3.1.a.1
BE.SS.15	Apply the unpaid portion of Medicare Crossover Claims to the Medically Needy spenddown amount if the amount is greater than zero.	Y		COTS	4B.3.1.a.1
	Transmit the following information to the IME each time MMIS loads file transfers from the external systems:				

BE.SS.16	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.	Y	[redacted]	COTS	4B.3.1.a.1
BE.SS.17	Reversals of claims should automatically adjust spenddown.	Y		COTS	4B.3.1.a.1
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.	Y		COTS	4B.3.1.a.1
	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.				

BE.SS.19	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 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 (T-MSIS), Payment Error Rate Measurement (PERM) and Office of Inspector General (OIG) audits or any federal or state audits.	Y	[redacted]	COTS	4B.3.1.a.1
BE.SS.20	A member may be eligible for multiple limited benefit eligibility groups. The system must be able to track when a member is eligible for multiple concurrent benefits plans and use the appropriate benefit plan when adjudicating claims.	Y		COTS	4B.3.1.a.1
BE.SS.21	Assign federal and program reporting codes to the member enrollment span using basis of eligibility, benefit plan, and other member indicators.	Y		COTS	4B.3.1.a.1
BE.SS.22	Eligibility verification should be a service that can be called by other services	Y		COTS	4B.3.1.a.1
BE.SS.23	The system must have the capability to verify eligiblity from health plan cards that are digitized to check the verification systems.	Y		COTS	4B.3.1.a.1

PR	Provider Management Requirements	A		C	D
PR1.01	Provide secure access to provider applications.	Y		COTS	4B.3.1.a.2
PR1.01.01	Have security to maintain control over all data pertaining to provider enrollment.	Y		COTS	4B.3.1.a.2
PR1.01.02	Provide authorized IME and contractor user inquiry access to provider data stored within the system.	Y		COTS	4B.3.1.a.2
PR1.01.03	Provide update access only to authorized IME and contractor staff to make updates to the provider data.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR1.01.05	The provider module must process provider data in an online, real-time mode and produce audit trails of all updates.	Y		COTS	4B.3.1.a.2
PR1.02	Provide capability to route provider applications, collect and processes provider enrollment and status information.	Y		COTS	4B.3.1.a.2
PR1.02.01	Provide edits, in the provider enrollment and update process, to track and identify errors and inconsistencies.	Y		COTS	4B.3.1.a.2
PR1.02.02	Accept electronic signature on enrollment without hard copy as allowed by IME, state and federal regulations.	Y		COTS	4B.3.1.a.2
PR1.02.03	Provide capability to upload provider enrollment files electronically and create electronic audit trail with ability to review applications.	Y		COTS	4B.3.1.a.2
PR1.02.04	Edit appropriate provider applications and existing providers against the CMS excluded provider list.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR1.02.06	Provide the capability to suspend a provider application in pending status, until additional information is received from the provider.	Y		COTS	4B.3.1.a.2

PR1.02.07	Assign a unique tracking number to each provider enrollment application or correspondence document.	Y	[redacted]	COTS	4B.3.1.a.2
PR1.02.08	Provide the capability to tie provider correspondence documents to appropriate enrollment application when applicable.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR1.02.10	Provide the capability to identify sanctioned providers and facilities to prevent the enrollment of members in sanctioned facilities.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR1.03.01	Automatically generate notices to providers including but not limited to status change, approvals, denials and license expiration as determined by IME.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR1.04.01	Perform an automated duplicate checking process prior to adding applications to the file.	Y		COTS	4B.3.1.a.2
PR1.05	Flag and route for action if multiple internal provider numbers are assigned to a single provider.	Y		COTS	4B.3.1.a.2
PR1.06	Support communications to and from providers. Track and monitor responses of communications.	Y		COTS	4B.3.1.a.2

PR1.06.01	Support mailings to multiple provider addresses as requested by the provider electronically or as directed by IME.	Y	[redacted]	COTS	4B.3.1.a.2
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).	Y		COTS	4B.3.1.a.2
PR1.07	Support a provider appeals process in compliance with federal guidelines contained in 42 CFR 431.105.	Y		COTS	4B.3.1.a.2
PR1.08	Provide for date-specific provider enrollment and demographic data.	Y		COTS	4B.3.1.a.2
PR1.08.01	Enable provider application processing statistics by type, month, year and processor.	Y		COTS	4B.3.1.a.2
PR1.08.02	Provide the capability to track all provider enrollment denials in the provider tracking database.	Y		COTS	4B.3.1.a.2
PR1.09	Generate information requests, correspondence or notifications based on the status of the application for enrollment.	Y		COTS	4B.3.1.a.2
PR1.10	Track the sending of IME furnished information to enrolled providers.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR1.SS.01	Support editing for address standardization, according to United States Postal Service (USPS) standardization.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2

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.	Y	[redacted]	COTS	4B.3.1.a.2
PR2.02	Track and support any established provider review schedule to ensure providers continue to meet program eligibility requirements.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR2.03	Verify provider eligibility in support of other system processes (e.g., payment of claims).	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR2.04.02	Use CLIA information from the national data site in the enrollment process.	Y		COTS	4B.3.1.a.2
PR2.05	Cross-reference license and sanction information with other state or federal agencies.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR2.06	Generate notices to providers of expiring Medicaid agreements and or state licenses.	Y		COTS	4B.3.1.a.2

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.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR2.06.03	Have the capability to edit the provider master file for license end date.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR2.07.01	Provide the capability to store and maintain provider rates including historical rates and date changes.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR2.SS.02	Provide data elements to capture provider contact information.	Y		COTS	4B.3.1.a.2
PR2.SS.03	Provide online view of all provider specific rates.	Y		COTS	4B.3.1.a.2
PR2.SS.04	A data element must exist to capture the facility bed size.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR2.SS.06	Provide a mechanism to identify provider types not required to have a license.	Y		COTS	4B.3.1.a.2

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.	Y		COTS	4B.3.1.a.2
PR2.SS.08	Support automated criminal background checks for all providers as specified by IME.	Y		COTS	4B.3.1.a.2
PR2.SS.09	Store geographic codes for provider locations.	Y		COTS	4B.3.1.a.2
PR2.SS.10	Enable different provider enrollment rule definitions by provider, provider type, program, geographic area and other areas, as defined by IME.	Y		COTS	4B.3.1.a.2
PR3.01	Accept, validate and process transactions or user entries to update and maintain provider information.	Y		COTS	4B.3.1.a.2
PR3.01.01	Provide for the collection and maintenance of additional data in the provider database, including, but not limited to:	Y		COTS	4B.3.1.a.2
	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.	Y	[redacted]	COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR3.03	Track and control the process of reconciliation of errors in transactions that are intended to update provider information.	Y		COTS	4B.3.1.a.2
PR3.04	Maintain current and historical multiple address capabilities for providers.	Y		COTS	4B.3.1.a.2
PR3.05	Maintain an audit trail of all updates to the provider data for a time period as specified by IME.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR3.07	Update and maintain financial data and all necessary information to track consolidate and report 1099 information including current and prior year 1099 reported amounts.	Y		COTS	4B.3.1.a.2
PR3.08	Maintain links from providers to other entities such as groups, Managed Care Organizations (MCO), chains, networks, ownerships and partnerships.	Y		COTS	4B.3.1.a.2

PR3.09	Provide capability to do mass updates to provider information based on flexible selection criteria.	Y		COTS	4B.3.1.a.2
PR3.09.01	Maintain the capability to apply mass updates to provider-specific rates based on IME's specified criteria.	Y		COTS	4B.3.1.a.2
PR3.10	Maintain indicators to identify providers that are Fee-for-Service (FFS), MCO network only and other state health care program participants.	Y		COTS	4B.3.1.a.2
PR3.11	Maintain a flag for providers who are eligible to use EFT and electronic claims submission.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR3.SS.02	Provide the capability to reactivate a previously enrolled provider without complete reenrollment.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR3.SS.04	Enable a process to suspend, terminate or withhold payments from providers under investigation.	Y		COTS	4B.3.1.a.2
PR3.SS.05	Provide the capability for automated disenrollment procedures according to IME defined criteria.	Y		COTS	4B.3.1.a.2
PR3.SS.06	Ability to identify if the provider uses electronic health records (EHR) and the CMS certification number of the EHR system.	Y		COTS	4B.3.1.a.2
PR4.01	Require (when appropriate), capture and maintain the ten digit NPI.	Y		COTS	4B.3.1.a.2
PR4.02	Accept the NPI in all standard transactions mandated under HIPAA.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2

PR4.04	Do not allow atypical provider to be assigned numbers that duplicate any number assigned by the NPPES.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR4.SS.01	Provide the capability to process an NPI, taxonomy and other fields as specified by IME including secondary NPI.	Y		COTS	4B.3.1.a.2
PR4.SS.02	Be capable of producing a random sample of providers for audit purposes based on IME established selection criteria.	Y		COTS	4B.3.1.a.2
PR4.SS.03	Send alert if multiple provider numbers are assigned to a single atypical provider.	Y		COTS	4B.3.1.a.2
PR4.SS.04	Process actions and responses to B Notices from Internal Revenue Service (IRS) as determined by IME.	Y		COTS	4B.3.1.a.2
PR.SS.01	Provide online inquiry to summary information regarding provider year-to-date claims submittal and payment data.	Y		COTS	4B.3.1.a.2
PR.SS.02	Maintain the flexibility to change provider type categories and convert history records to reflect new provider type categories.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR.SS.04	Capture and maintain vendor code field in MMIS for HMO or MediPASS providers.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2

PR.SS.06	Provide the capability to support periodic provider re-enrollment.	Y	[redacted]	COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR.SS.08	Produce provider mailing labels based on specific provider attributes and merge with letters as directed by the IME.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
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.	Y		COTS	4B.3.1.a.2
PR.SS.11	Provide capability to provide data required for rate setting.	Y		COTS	4B.3.1.a.2
PR.SS.12	Provide the capability to update licensure data based on electronic files from occupational licensing entities.	Y		COTS	4B.3.1.a.2
PR.SS.13	Synchronize data with statewide provider directory Health Information Exchange (HIE) and licensing boards.	Y		COTS	4B.3.1.a.2
PR.SS.14	Accept and upload enrollment information, including NPI if required on providers from external source.	Y		COTS	4B.3.1.a.2

PR.SS.15	Accept and upload rate information from external sources including excel spreadsheets.	Y	[redacted]	COTS	4B.3.1.a.2
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.	Y	[redacted]	COTS	4B.3.1.a.2
PR.SS.17	Perform automated checks of national databases and bulletin boards for exclusions, sanctions or license revocation in other states or by CMS.	Y	[redacted]	COTS	4B.3.1.a.2
PR.SS.18	Identify providers that have a foreign mailing address and provide the capability to not send payment to a foreign mailing address.	Y	[redacted]	COTS	4B.3.1.a.2
PR.SS.19	Provide the functionality to allow multiple provider status codes to be valid for the same or overlapping timeframes.	Y	[redacted]	COTS	4B.3.1.a.2
	Process and maintain inputs and outputs including but not limited to the following:		[redacted]		
	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.				

PR.SS.20	**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.	Y	[redacted]	COTS	4B.3.1.a.2
PR.SS.21	Track the relationship between ACO organization and primary care provider.	Y		COTS	4B.3.1.a.2
CR	**Claims Receipt Requirements**	**A**		**C**	**D**
CR1.01	Capture accurately all input into the system in the timeframe required by IME.	Y		COTS	4B.3.1.a.3
CR1.02	Provide and maintain interfaces with designated entities as required by IME.	Y		COTS	4B.3.1.a.3
CR1.02.01	Assign each claim a unique identifier upon its entering the system.	Y		COTS	4B.3.1.a.3

CR1.03	Accept and use the hospital paper billing form developed by the National Uniform Billing Committee (NUBC) for non-electronic claims. Use the most current form based upon IME policy.	Y	[redacted]	COTS	4B.3.1.a.3
CR1.04	Accept and use the non-institutional paper claim form developed by the National Uniform Claim Committee (NUCC) for non-electronic claims. Use the most current form based upon IME policy.	Y		COTS	4B.3.1.a.3
CR1.05	Accept and use the dental paper billing form developed by the American Dental Association (ADA) for non-electronic claims. Use the most current form based upon IME policy.	Y		COTS	4B.3.1.a.3
CR1.06	Control, track and reconcile captured claims to validate that all claims received are processed.	Y		COTS	4B.3.1.a.3
CR1.07	Provide the ability to identify claims input for control and balancing hardcopy and electronic media.	Y		COTS	4B.3.1.a.3
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. Return to Provider (RTP) for missing or invalid provider NPI. b. If member ID number is invalid or missing send to adjucation to process. c. If procedure codes are invalid or missing send to adjudication to process. d. If diagnosis codes are invalid or missing send to adjudication to process.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3

CR1.11	Log each batch into an automated batch control system.	Y	[redacted]	COTS	4B.3.1.a.3
CR1.12	Provide the ability to identify claim entry statistics to assess performance compliance.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
CR1.14.01	Provide the ability to tie the electronic claim to all related paper claim images, attachments and adjustments that are submitted for the claim.	Y		COTS	4B.3.1.a.3
CR1.14.02	Receive and process electronic attachments and apply them to one or more claims based on IME rules.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
CR1.17	Identify any incomplete claim batches that fail to balance to control counts.	Y		COTS	4B.3.1.a.3
CR1.17.01	Provide a return transmission that verifies the number of claims received and accepted.	Y		COTS	4B.3.1.a.3
CR1.17.02	Maintain electronic data interchange (EDI) transmission logs of all transactions (i.e., successful or failed).	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
CR1.SS.01	Accept pharmacy claims from the POS.	Y		COTS	4B.3.1.a.3
CR1.SS.02	Provide the capability for authorized IME users to directly enter a claim online when IME deems necessary.	Y		COTS	4B.3.1.a.3

CR1.SS.03	Record time and date and user in the record for any online updates.	Y		COTS	4B.3.1.a.3
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).	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
CR1.SS.06	Provide the capability to edit for potential duplicate services across all claim types as defined by IME.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
CR1.SS.08	Provide the ability to process all claims real-time.	Y		COTS	4B.3.1.a.3
CR1.SS.09	Support a customized (reduced data requirements) online claim submission feature for waivered services, and other entities not covered by HIPAA.	Y		COTS	4B.3.1.a.3
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. e. Prior authorization required. f. Modifiers. g. Place of service. h. Co-payment indicators (overrides). i. Eligibility aid category.	Y		COTS	4B.3.1.a.3

	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.	Y		COTS	4B.3.1.a.3
CR1.SS.12	Provide the capability to respond with appropriate acknowledgement transactions such as the TA1, 997, 999 and 277CA as directed by IME.	Y		COTS	4B.3.1.a.3
CR2.01	Accept, record, store and retrieve documents submitted with, or in reference to, claim submission activity including but not limited to the following:	Y		COTS	4B.3.1.a.3
	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.	Y		COTS	4B.3.1.a.3
CR2.03	Accept Medicare crossover claims for Medicare coinsurance and deductible or Medicare Explanation of Benefits (EOB) claims attachments.	Y		COTS	4B.3.1.a.3
CR2.03.01	Provide the capability to accept and process Medicare and other carrier crossovers electronically at the claim and line level.	Y		COTS	4B.3.1.a.3

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.	Y	[redacted]	COTS	4B.3.1.a.3
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. d. Electronic cost reports. e. Disproportionate share reports. f. Any other inputs required for services under the state's approved plan.	Y	[redacted]	COTS	4B.3.1.a.3
CR2.05.01	Accept and process all standard data that can be submitted on any claim or claim type.	Y	[redacted]	COTS	4B.3.1.a.3
	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:		[redacted]		

CR3.01	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.	Y	[redacted]	COTS	4B.3.1.a.3
CR3.01.01	Receive standardized managed care encounters in 837 formats.	Y		COTS	4B.3.1.a.3
CR3.02	Provide secure HIPAA compliant software and documentation for use by providers to submit electronic claims.	Y		COTS	4B.3.1.a.3
CR3.03	Process batch 837 claims rejecting only individual bad claims and accepting all others.	Y		COTS	4B.3.1.a.3
CR3.04	Employ an electronic tracking mechanism to locate archived source documents or to purge source documents in accordance with HIPAA security provisions.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3

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.	Y		COTS	4B.3.1.a.3
CR3.SS.03	Provide the capability to track and document all changes to system edits.	Y		COTS	4B.3.1.a.3
CR3.SS.04	Provide the capability to produce a claim in hardcopy and electronic format.	Y		COTS	4B.3.1.a.3
CR.SS.01	Provide an Enterprise Application Integration (EAI) translator and EDI integrated mapping software that:	Y		COTS	4B.3.1.a.3
	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.	Y	[redacted]	COTS	4B.3.1.a.3
CR.SS.03	Accept and use the state targeted medical care paper billing form for non-electronic claims.	Y		COTS	4B.3.1.a.3
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.	Y		COTS	4B.3.1.a.3
CR.SS.05	The system must accept and generate all HIPAA, ASC X12 , and CORE operating rule standards to electronically exchange data with providers. The contractor is responsible for implementing and supporting any future standards adopted under federal regulation. Including but not limited to 837 (P, I, D), 270/271, 276/277, 834, 835, and 278.	Y		COTS	4B.3.1.a.3
CR.SS.06	The system must support administration simplification and all rules authorized by the Affordable Care Act.	Y		COTS	4B.3.1.a.3
CA	**Claims Adjudication Requirements**	**A**		**C**	**D**
CA1.01	Track all claims within the processing period paid, suspended, pending or denied.	Y		COTS	4B.3.1.a.4
CA1.01.01	Reconcile prepaid services with actual expenses for Consumer Choice Option (CCO) and automatically generate adjustment claim.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4

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.	Y		COTS	4B.3.1.a.4
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).	Y		COTS	4B.3.1.a.4
CA1.03	Verify that suspended transactions have valid error and or exception codes.	Y		COTS	4B.3.1.a.4
CA1.04	Track claims flagged for investigative follow-up because of third party discrepancies.	Y		COTS	4B.3.1.a.4
CA1.05	Generate audit trails for all claims and maintain audit trail history.	Y		COTS	4B.3.1.a.4
CA1.05.01	Generate and maintain audit trails for all claims activity including add, update, inquiry and or delete.	Y		COTS	4B.3.1.a.4
CA1.06	Verify that all claims for services approved or disallowed are properly flagged as paid or denied.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA1.09	Provide claims history for use by Program Management and Program Integrity.	Y		COTS	4B.3.1.a.4
CA1.10	Assign claim status (i.e., approved, denied, pended, rejected) based on the state's criteria.	Y		COTS	4B.3.1.a.4
CA1.11	Verify that claim correction activities have entered only valid override code(s) or manual prices.	Y		COTS	4B.3.1.a.4

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.	Y		COTS	4B.3.1.a.4
CA1.11.02	Provide the ability to accumulate and report statistics on why claims edits are overridden.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA1.13	Identify and track all edits and audits posted to the claim in a processing period.	Y		COTS	4B.3.1.a.4
CA1.13.01	Provide the capability to configure and apply all edits and audits with a rules engine.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA1.SS.01	Provide the ability to process a claims payment file daily, weekly and as specified by IME.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA1.SS.04	Provide the ability to process a corrected claim through all edits and audits after corrections are applied to a rejected claim.	Y		COTS	4B.3.1.a.4
CA1.SS.05	Provide the ability to store in the MMIS claims processed through the POS.	Y		COTS	4B.3.1.a.4

CA2.01	Verify all fields defined as numeric contain only numeric data.	Y		COTS	4B.3.1.a.4
CA2.01.01	Support claim adjudication based on HIPAA standard code sets in effect on the date of service.	Y		COTS	4B.3.1.a.4
CA2.02	Verify all fields defined as alphabetic contain only alphabetic data.	Y		COTS	4B.3.1.a.4
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).	Y		COTS	4B.3.1.a.4
CA2.03	Verify all dates are valid and reasonable.	Y		COTS	4B.3.1.a.4
CA2.04	Verify all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.06	Verify any data item that contains self-checking digits (e.g., member ID number, NPI number) passes the specified check-digit test.	Y		COTS	4B.3.1.a.4
CA2.07	Verify numeric items with definitive upper and or lower bounds are within the proper range.	Y		COTS	4B.3.1.a.4
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).	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.09	Verify the date of service is within the allowable time frame for payment.	Y		COTS	4B.3.1.a.4
CA2.10	Verify the procedure is consistent with the diagnosis.	Y		COTS	4B.3.1.a.4
CA2.11	Verify the procedure is consistent with the member's age.	Y		COTS	4B.3.1.a.4
CA2.12	Verify the procedure is consistent with the member's gender.	Y		COTS	4B.3.1.a.4

CA2.13	Verify the procedure is consistent with the place of service.	Y		COTS	4B.3.1.a.4
CA2.14	Verify the procedure is consistent with the category of service.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.17	Verify the claim is not a duplicate of a previously adjudicated claim including a prior one in the current processing period.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.20	Utilize data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.21	Flag for review claims from a single provider for multiple visits on the same day to a single member.	Y		COTS	4B.3.1.a.4
CA2.22	Verify the provider type is consistent with the procedure(s).	Y		COTS	4B.3.1.a.4

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.	Y	[redacted]	COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.25	Have the capability to pay claims per capita from encounter data or FFS.	Y		COTS	4B.3.1.a.4
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 and routes for manual pricing).	Y		COTS	4B.3.1.a.4
CA2.27	Record and edit that all required attachments, per the reference records or edits have been received and maintained for audit purposes.	Y		COTS	4B.3.1.a.4
CA2.28	Price claims according to pricing data and reimbursement methodologies applicable on the date(s) of service on the claim.	Y		COTS	4B.3.1.a.4
CA2.29	Deduct TPL paid amounts and Medicare paid amount as defined in the state plan when pricing claims.	Y		COTS	4B.3.1.a.4
CA2.29.01	Provide the capability to account for cost recovery at either the claim or line level as specified by IME.	Y		COTS	4B.3.1.a.4
CA2.29.02	Ensure that the claims payment process accurately reads the TPL resource file including the benefit coverage.	Y		COTS	4B.3.1.a.4
CA2.30	Deduct member co-payment amounts as appropriate when pricing claims.	Y		COTS	4B.3.1.a.4
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).	Y		COTS	4B.3.1.a.4
CA2.31	Price Medicare coinsurance or deductible for crossover claims depending on IME policy at the lower of the Medicaid or Medicare allowed amount.	Y		COTS	4B.3.1.a.4

CA2.32	Price services billed with procedure codes with multiple modifiers. The system must have the capability to price based on a modifier hierarchy as well as pricing modifier combinations.	Y	[redacted]	COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.35	Provide and maintain test claim processing capabilities including testing with providers.	Y		COTS	4B.3.1.a.4
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).	Y		COTS	4B.3.1.a.4
CA2.35.02	Produce each output of ITF including files, reports, data files and images separate from the corresponding routine MMIS output and identify as a test output.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4

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.	Y	[redacted]	COTS	4B.3.1.a.4
CA2.SS.02	Provide the capability to set maximum payment amounts for specified revenue and procedure codes and apply this to payment methodologies.	Y		COTS	4B.3.1.a.4
CA2.SS.03	Provide for automatic bundling and unbundling of claim lines based on rules established by IME.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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).	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.SS.10	Provide the capability to accumulate and report statistics on why claims are denied.	Y		COTS	4B.3.1.a.4

CA2.SS.11	Support claims edits, using a rules engine that are date sensitive and retain the date parameters for historical reference.	Y		COTS	4B.3.1.a.4
CA2.SS.12	Provide the ability to replace or add codes and have existing edits apply to the new codes, using a rules engine.	Y		COTS	4B.3.1.a.4
CA2.SS.13	Determine the deductible, coinsurance allowed and adjusted amounts applied, for each line on a claim.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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 defined by IME.	Y		COTS	4B.3.1.a.4
CA2.SS.16	Use the Clinical Laboratory Improvement Amendments (CLIA) data in claims processing.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA2.SS.18	Provide the ability to inquire on payment status of claim lines, associated voids, adjustments and payments (by provider and authorized user).	Y		COTS	4B.3.1.a.4
CA2.SS.19	Provide the ability to process for outlier payments.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4

CA3.01	Verify the provider is eligible to render service(s) during the period covered by the claim.	Y		COTS	4B.3.1.a.4
CA3.02	Verify the provider is eligible to render the specific service covered by the claim.	Y		COTS	4B.3.1.a.4
CA3.02.01	Provide the capability to perform prepayment reviews on providers, as defined by IME.	Y		COTS	4B.3.1.a.4
CA3.02.02	Verify the referring provider is not excluded for the period covered by the claim.	Y		COTS	4B.3.1.a.4
CA3.03	Verify the provider is eligible to provide the specific service covered by the plan to the specific member.	Y		COTS	4B.3.1.a.4
CA4.01	Verify the member was eligible for the particular category of service, at the time it was rendered.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA4.03	Identify, by member, the screening and related diagnosis and treatment services the member receives for EPSDT.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA4.07	Provide and maintain the capability to edit claims for members LTC facilities to ensure that services included in the LTC payment rate are not billed separately by individual practitioners or other providers.	Y		COTS	4B.3.1.a.4

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.	Y		COTS	4B.3.1.a.4
CA4.09	Edit claims for newborns' eligibility based upon state-defined newborn enrollment policies and procedures.	Y		COTS	4B.3.1.a.4
CA4.10	Edit for member participation in special programs (i.e., waivers) against program services and restrictions.	Y		COTS	4B.3.1.a.4
CA4.11	Limit benefits payable by member eligibility category or other member groupings.	Y		COTS	4B.3.1.a.4
CA4.SS.01	Update service limits for members when claims are voided or replaced and allow online access to member service limit data.	Y		COTS	4B.3.1.a.4
CA4.SS.02	Process claims when members have multiple benefit plans, according to the hierarchy determined by IME.	Y		COTS	4B.3.1.a.4
CA4.SS.03	Provide the capability to enable a bed hold payment process for members in facilities according to rules established by IME.	Y		COTS	4B.3.1.a.4
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.	Y		COTS	4B.3.1.a.4
CA4.SS.05	Support claims edits by benefit plan, age limitations, gender limitations and service limitations.	Y		COTS	4B.3.1.a.4
CA4.SS.06	Provide the capability to generate payments on demand outside of normal payment cycles.	Y		COTS	4B.3.1.a.4
CA4.SS.07	Provide MMIS inquiry and reporting capabilities to authorized IME staff.	Y		COTS	4B.3.1.a.4

CA5	Prior Authorization Requirements	A		C	D
CA5.01	System will process and retain all prior authorization request data.	Y		COTS	4B.3.1.a.5
CA5.01.01	Provide the ability to edit claims against prior authorization data and track activity against approved prior authorizations.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
CA5.02	Ensure there is a field for authorization or identification when an override indicator (force code) is used.	Y		COTS	4B.3.1.a.5
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:	Y		COTS	4B.3.1.a.5
	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.	Y		COTS	4B.3.1.a.5
CA5.04	Support the prior authorization staff's ability to send requests for additional information on paper or electronically.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5

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.	Y	[redacted]	COTS	4B.3.1.a.5
CA5.06	Support entry of retroactive prior authorization requests.	Y		COTS	4B.3.1.a.5
CA5.07	Assign a unique prior authorization number as an identifier to each prior authorization request.	Y		COTS	4B.3.1.a.5
CA5.08	Edit prior authorization requests with edits that mirror the applicable claims processing edits.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5

CA5.11	Capture and maintain both the requested amount and authorized amount on the prior authorization record.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
CA5.13	Accept update from claim processing that “draw down” or decrement authorized services.	Y		COTS	4B.3.1.a.5
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).	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
CA.SS.5.01	Support a prior authorization process that is flexible across numerous programs, benefit plans and claim types.	Y		COTS	4B.3.1.a.5
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).	Y		COTS	4B.3.1.a.5
CA.SS.5.03	Allow a cutback on payment amounts instead of a denial once the prior authorized limit is reached.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5

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.	Y	[redacted]	COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
CA.SS.5.08	Support manual entry of prior authorization approvals.	Y		COTS	4B.3.1.a.5
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.	Y		COTS	4B.3.1.a.5
CA.SS.5.10	Provide ability to process X12n 278 transaction real time using the rules engine for decision where applicable.	Y		COTS	4B.3.1.a.5
CA.SS.5.11	Provide capability to relate prior authorizations to subsequent claims requiring such authorization.	Y		COTS	4B.3.1.a.5
CA.SS.5.12	Produce statistical reports on prior authorization requests (e.g., received, approved, approved with modifications and denied).	Y		COTS	4B.3.1.a.5
CA.SS.5.13	Produce statistical reports on utilization of prior authorized services.	Y		COTS	4B.3.1.a.5
CA.SS.5.14	Produce statistical reports on the data source (e.g., X12n 278, electronic file, manually entered) of prior authorization requests.	Y		COTS	4B.3.1.a.5 4B.3.1.a.5

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.	Y	[redacted]	COTS	4B.3.1.a.5
CA.SS.5.16	Accept prior authorization transactions through the Health Information Network allowing providers to request the authorization from the EHR system.	Y		COTS	4B.3.1.a.5
CA	**Claims Adjudication State Specific**				
CA.SS.01	Provide for ad hoc reporting, as appropriate, based on data needs.	Y		COTS	4B.3.1.a.6
CA.SS.02	Provide the capability to download data for statistical data manipulation. This refers to report data, file extract data and billing information.	Y		COTS	4B.3.1.a.6
CA.SS.03	Provide help screens, help tabs or drop down help windows, for all modules of the system, including COTS products.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
CA.SS.05	Reference any void and replacements (paper or electronic) to original claims.	Y		COTS	4B.3.1.a.6
CA.SS.06	Provide the ability to allow voids and replacements to update an accounts receivable (AR).	Y		COTS	4B.3.1.a.6

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.	Y	[redacted]	COTS	4B.3.1.a.6
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. Category of service i. Condition codes j. Prior Authorization k. Claim Type l. Other criteria, as defined by IME.	Y		COTS	4B.3.1.a.6
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).	Y		COTS	4B.3.1.a.6
CA.SS.10	Provide the capability to void claims using the mass functionality (i.e., not replace the voids).	Y		COTS	4B.3.1.a.6
					4B.3.1.a.6
CA.SS.12	Support online void and replacements to previously adjudicated claims.	Y		COTS	4B.3.1.a.6
CA.SS.13	Allow history only claims adjustments.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6

CA.SS.15	Provide the ability to identify uncollectable credit balances and flag all related financial balances as uncollectable.	Y		COTS	4B.3.1.a.6
CA.SS.16	Accept non-claim payment for the flagged uncollectable balances.	Y		COTS	4B.3.1.a.6
CA.SS.14	Provide the ability to indicate whether the recovery is to be offset against claims or gross adjustments payments.	Y		COTS	4B.3.1.a.6
CA.SS.17	Provide a summary screen that presents for each provider previous year, current year month-to-date, year-to-date and most recent payment information and number of pended claims.	Y		COTS	4B.3.1.a.6
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).	Y		COTS	4B.3.1.a.6
CA.SS.19	Provide the capability to process institutional claims for PMIC at the line level in accordance with IME rules.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
CA.SS.21	Receive and store non-emergency medical transportation and other managed care contractor encounter data.	Y		COTS	4B.3.1.a.6
CA.SS.22	Provide capability to retrieve electronic images by control number, date of service, member number or provider number.	Y		COTS	4B.3.1.a.6
CA.SS.23	Identify any inactivated claims or batches on daily control logs.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6

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.	Y		COTS	4B.3.1.a.6
CA.SS.26	Support multiple methodologies for pricing claims, as established by the IME.	Y		COTS	4B.3.1.a.6
CA.SS.27	Edit billed charges for reasonableness and flag any exceptions (high or low variance).	Y		COTS	4B.3.1.a.6
CA.SS.28	Provide online inquiry access to the status of any related limitations for which the member has had services.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
CA.SS.30	Provide security reports.	Y		COTS	4B.3.1.a.6
CA.SS.31	Edit each data element of the claim record for required presence, format, consistency, reasonableness and or allowable values. Allowable values include ICD9 or ICD10 codes based upon date of service (DOS).	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
CA.SS.33	Update the prior authorization record to reflect the service paid and to update the number of services or dollars remaining to be used on the record.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
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).	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6

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.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
CA.SS.40	Support program management and utilization review by editing claims against the prior authorization file to ensure that payment is made accurately.	Y		COTS	4B.3.1.a.6
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.	Y		COTS	4B.3.1.a.6
CA.SS.42	Provide capability to produce a file of paid claims that include HCPCS J codes.	Y		COTS	4B.3.1.a.6

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 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.	Y	[redacted]	COTS	4B.3.1.a.6
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 transmitted and input into the 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. System performance analysis for real-time, and batch claims adjudication and payment cycles j. Report of specially handled or manually processed claims. k. Report of claims withheld from payment processing.	Y	[redacted]	COTS	4B.3.1.a.6

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.	Y	[redacted]	COTS	4B.3.1.a.6
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.	Y	[redacted]	COTS	4B.3.1.a.6
CA.SS.47	Provide the ability to hold providers harmless for assessment fee expenses. Be able to issue and collect fee payments and/or recoupments (AR or Cash Receipt) from lump sum payments and/or claims payment offsets.	Y	[redacted]	COTS	4B.3.1.a.6
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).	Y	[redacted]	COTS	4B.3.1.a.6

	Outputs:		[redacted]		
	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.	Y		COTS	4B.3.1.a.6
CA.SS.50	System must have the ability to apply edits that support program integrity and correct claim editing prior to adjudication. [1]	Y		COTS	4B.3.1.a.6
CA.SS.51	System must have the ability to apply the CCI edits to the adjusted claim.	Y		COTS	4B.3.1.a.6
CA.SS.52	System must support all current and future national standards for code sets recognized by CMS.	Y		COTS	4B.3.1.a.6
CA.SS.53	System must have capability to provide and display all edits that result it claim denial or cutback of payment	Y		COTS	4B.3.1.a.6
CA.SS.54	The system must have the ability to apply cost sharing rules.	Y		COTS	4B.3.1.a.6
CA.SS.55	Total cost sharing must be tracked by household unit. Including premiums and co-payments or deductibles.	Y		COTS	4B.3.1.a.6
CA.SS.56	When a house hold unit has exceed maximum cost sharing allowed by law, the system must stop all co-payments and cost sharing until the annual period restarts.	Y		COTS	4B.3.1.a.6

CA.SS.57	System must share with other administration systems when cost sharing maximum has been met.	Y		COTS	4B.3.1.a.6
CA.SS.58	The system must have the ability to generate payments to Qualified Health Plans.	Y		COTS	4B.3.1.a.6
CA.SS.59	The system must have the ability to generate payments for Health Home care coordination fees.	Y		COTS	4B.3.1.a.6
CA.SS.60	The system must have the ability to generate bonus payments to Health Home and ACO providers.	Y		COTS	4B.3.1.a.6
[1] See section 4241 (C) (5) of the Small Business Jobs Act of 2010					
RF	**Reference Data Management Requirements**	**A**		**C**	**D**
RF1.01	Maintain reasonable and customary charge 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	Y		COTS	4B.3.1.a.7

	c. Acquisition cost less % reduction plus a dispensing fee.		[redacted]		
	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.	Y		COTS	4B.3.1.a.7
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.	Y		COTS	4B.3.1.a.7
RF1.01.03	Provide for the capability to apply the following pricing methodologies, including, but not limited to:	Y		COTS	4B.3.1.a.7
	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. 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 file formats including but not limited to: Excel, Text or Access.	Y		COTS	4B.3.1.a.7
RF1.02	Support Payment for Services by providing reference data including procedure, diagnostic and formulary codes 42 CFR 447.	Y		COTS	4B.3.1.a.7
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).	Y		COTS	4B.3.1.a.7
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.	Y		COTS	4B.3.1.a.7
RF1.03	Process change transactions to procedure, diagnosis, formulary codes and other data. Ability to respond to queries and report requests.	Y		COTS	4B.3.1.a.7
RF1.03.01	Produce a report of any codes that failed to update as part of a batch file load. The report must be stored in the report repository and displayed to the user submitting the batch file.	Y		COTS	4B.3.1.a.7
RF1.04	Archive all versions of reference information and files used to load reference information.	Y		COTS	4B.3.1.a.7

RF1.05	Fee schedules available for Usual and Customary Rate (UCR). Must have the ability to load them into the fee schedule location and query and report on them.	Y	[redacted]	COTS	4B.3.1.a.7
RF1.05.01	Provide capability to generate upon request hard copy listings on all data elements used in the reference management.	Y		COTS	4B.3.1.a.7
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.	Y		COTS	4B.3.1.a.7
RF1.06	Retrieve as needed archived reference data for processing of outdated claims or for duplicate claims detection.	Y		COTS	4B.3.1.a.7
RF1.07	Reference data reports needed: a. Production history of a given reference code with effective and terminate dates. b. Complete audit trail for a given reference code. c. Audit trails for all reference codes of a certain type for a given date range.	Y		COTS	4B.3.1.a.7
RF1.08	Maintain current and historical reference data used in claims processing.	Y		COTS	4B.3.1.a.7
RF1.08.01	Accommodate retroactive rate changes.	Y		COTS	4B.3.1.a.7
RF1.09	Maintain online access to all reference tables with inquiry by the appropriate code.	Y		COTS	4B.3.1.a.7
RF1.09.01	Provide the capability to maintain and display online multiple pricing segments, status and effective dates for unlimited history segments.	Y		COTS	4B.3.1.a.7
RF1.09.02	Provide for role-based security to limit update access to reference tables to IME specified staff.	Y		COTS	4B.3.1.a.7
RF1.10	Maintain an audit trail of all information changes including errors in changes and suspended changes.	Y		COTS	4B.3.1.a.7
	Provide and maintain the following data fields for all reference data elements:				

RF1.10.01	a. Effective date. b. End date. c. Date when last changed. d. Who changed it. e. Source of change f. A notes field to hold additional supporting documentation of a change	Y	[redacted]	COTS	4B.3.1.a.7
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.	Y	[redacted]	COTS	4B.3.1.a.7
RF1.12	Maintain date sensitive parameters for all Reference Data Management data.	Y	[redacted]	COTS	4B.3.1.a.7
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.	Y	[redacted]	COTS	4B.3.1.a.7
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.	Y	[redacted]	COTS	4B.3.1.a.7
RF1.14	Support code sets for the payment of Medicaid-covered non-health care services (e.g., waiver services).	Y	[redacted]	COTS	4B.3.1.a.7
RF1.16	Maintain a grouping of trauma-related codes to be used to identify TPL cases.	Y	[redacted]	COTS	4B.3.1.a.7
RF1.17	Maintain diagnosis and procedure code narrative descriptions of each code contained in the files.	Y	[redacted]	COTS	4B.3.1.a.7
RF1.18	Any update made to the reference data prior must be available for use during real-time adjudication and payment cycles.	Y	[redacted]	COTS	4B.3.1.a.7

RF1.SS.01	Maintain and update the service frequency limitations for each procedure or for range of procedure codes contained on the edit.	Y	[redacted]	COTS	4B.3.1.a.7
RF1.SS.02	Maintain relationship edits on procedure and diagnosis codes.	Y		COTS	4B.3.1.a.7
RF1.SS.03	Provide capability to link from the claim detail line to the pricing table.	Y		COTS	4B.3.1.a.7
RF1.SS.04	Maintain current and historical coverage status for physician administered drugs.	Y		COTS	4B.3.1.a.7
RF1.SS.05	Maintain current and historical coverage status for biologic drugs.	Y		COTS	4B.3.1.a.7
RF2.01	Manage all HIPAA-required external data sets (e.g., ICD-9, ICD-10, HCPCS and CPT).	Y		COTS	4B.3.1.a.7
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).	Y		COTS	4B.3.1.a.7
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. Ability to group codes for purposes of determining coverage. b. Ability to group codes for the purposes of applying edits. c. Ability to group codes for purposes of applying maximum amounts of services that can be received over a certain period of time (ie.one in a lifetime limitations or maximum number of visits per month).	Y		COTS	4B.3.1.a.7

	d. Ability to create and manage EOB and other messages.				
	e. Fee schedules.				
	f. Effective and terminate dates.				
	g. Ability to group codes for purposes of creating benefit plans.				
	h. Ability to group codes for purposes of prior authorization required.				
	i. Ability to group codes to suspend for manual manual review.				
	j. Ability to identify codes and code groups that are only payable by exception to policy				
	k. Other as defined by IME.				
RF2.02.02	Provide capability to have an IME specific value for all indicators on any NDC code.	Y		COTS	4B.3.1.a.7
RF2.02.03	Provide the capability to capture the NPPES information file received from CMS to be easily extractable and reportable.	Y		COTS	4B.3.1.a.7
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:	Y		COTS	4B.3.1.a.7
	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.	Y		COTS	4B.3.1.a.7
RF2.02.06	Provide capability to add new procedures requiring prior authorization as part of routine rules engine maintenance.	Y		COTS	4B.3.1.a.7

RF2.02.07	Process and maintain inputs and outputs including, but not limited to the following: **Inputs:** 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.	Y	[redacted]	COTS	4B.3.1.a.7
TP	**Third-Party Liability (TPL) Requirements**	**A**		**C**	**D**
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. n. National Health Plan Identifier o. File source code	Y		COTS	4B.3.1.a.8
TP1.01.01	Accept file updates of carrier information from electronic files, excel spreadsheets and manually.	Y		COTS	4B.3.1.a.8

TP1.01.02	Provide the capability to identify the type of TPL recovery in the MMIS.	Y	[redacted]	COTS	4B.3.1.a.8
TP1.01.03	Allow for mass update of TPL information on carrier plans.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP1.01.05	Provide online notes capability for narrative about each TPL information data field.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP1.01.07	Automatically identify previously paid claims when TPL resources are identified or verified retroactively.	Y		COTS	4B.3.1.a.8
TP1.01.08	Provide the capability to adjust claims history to reflect TPL recoveries that are claim-specific.	Y		COTS	4B.3.1.a.8
TP1.01.09	Provide the capability to account for TPL recoveries that are non-claim-specific at the provider and member level.	Y		COTS	4B.3.1.a.8
TP1.01.10	Adjust previously reported cost-avoided payments for subsequent resubmission and payment amounts.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
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).	Y		COTS	4B.3.1.a.8
TP1.07.01	Accept and process verification data from long term care insurance - nursing home.	Y		COTS	4B.3.1.a.8
TP1.08	Maintain all TPL resource information at the member-specific level.	Y		COTS	4B.3.1.a.8
TP1.08.01	Identify TPL resources that are liable for some, or all, of the member's medical claim by member, including absent parent.	Y		COTS	4B.3.1.a.8

TP1.09	Maintain multiple TPL coverage information for individual members for all of their periods of eligibility.	Y	[redacted]	COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP1.10.01	Generate eligibility matches with other payers using the HIPAA 270/271 transactions or proprietary format, if needed.	Y		COTS	4B.3.1.a.8
TP1.10.02	Support the use of the 270/271 transaction between entities.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP1.11	Edit TPL data updates for validity and for consistency with existing TPL data.	Y		COTS	4B.3.1.a.8
TP1.12	Edit additions and updates to the member insurance information to prevent the addition of duplicates.	Y		COTS	4B.3.1.a.8
TP1.13	Provide a mechanism to correct outdated TPL information.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP1.14.02	Contain an audit trail for all records and track the time, date and person who made the update to the record.	Y		COTS	4B.3.1.a.8
TP1.15	Cross-reference the health insurance carriers to the employers.	Y		COTS	4B.3.1.a.8
TP1.15.01	Maintain employer data that identifies employers and the health care plans they provide to employees.	Y		COTS	4B.3.1.a.8

TP1.16	Allow only authorized staff members to do manual deletes and overrides of alerts and or edits.	Y	[redacted]	COTS	4B.3.1.a.8
TP1.16.01	Allow authorized users to adjust claims and enter settlements against claims as needed to account for TPL recoveries.	Y		COTS	4B.3.1.a.8
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).	Y		COTS	4B.3.1.a.8
TP1.SS.01	Provide IME with the capability to update member TPL Resource by batch interface or online real-time.	Y		COTS	4B.3.1.a.8
TP1.SS.02	Produce a file of all paid claims monthly for revenue collections contractor.	Y		COTS	4B.3.1.a.8
TP1.SS.03	Accept automated updates to the TPL Management module.	Y		COTS	4B.3.1.a.8
TP1.SS.04	Generate accurate user defined TPL reports in the format and media determined by IME.	Y		COTS	4B.3.1.a.8
TP1.SS.05	Produce appropriate TPL reports on schedule and in a media as determined by IME.	Y		COTS	4B.3.1.a.8
TP1.SS.06	Generate formatted TPL correspondence with all fields displayed accurately.	Y		COTS	4B.3.1.a.8
TP1.SS.07	Allow authorized users print capability to generate TPL reports in hardcopy.	Y		COTS	4B.3.1.a.8
TP1.SS.08	Report on all TPL recoveries by type of service.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP1.SS.11	Enable the web portal to accurately display TPL information for providers, including carrier addresses.	Y		COTS	4B.3.1.a.8
TP1.SS.12	Maintain accurate reporting to track cost-avoidance by private insurance, Medicare and other TPL resources.	Y		COTS	4B.3.1.a.8

TP1.SS.13	Account for TPL recoveries at the provider and member level for non-claim specific recoveries.	Y		COTS	4B.3.1.a.8
TP1.SS.14	Receive, process and update medical Support information received from child support enforcement agency.	Y		COTS	4B.3.1.a.8
TP1.SS.15	Produce files to send to all eligibility systems for TPL coverage identified by the Revenue Collections contractor.	Y		COTS	4B.3.1.a.8
TP1.SS.16	Allow for online entry of TPL and COB rules by IME staff or contractor staff as defined by IME.	Y		COTS	4B.3.1.a.8
TP1.SS.17	Generate alerts to IME recovery units and others designated by IME when retroactive third party coverage has been identified.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP2.03	Account for TPL payments to providers in determining the appropriate Medicaid payment.	Y		COTS	4B.3.1.a.8
TP2.04	Track and report cost avoidance dollars.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP2.11	Associate third party recoveries to individual claims.	Y		COTS	4B.3.1.a.8
TP2.11.01	Process revenue collection contractor file and update claims history.	Y		COTS	4B.3.1.a.8
TP2.13	Designate portions of claims amounts collected to reimburse CMS and the state. Medicaid will never collect more than the Medicaid amount.	Y		COTS	4B.3.1.a.8

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 ,B, C or D.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
TP2.SS.02	Accept, process and respond to the HIPAA standard 837 TPL segment on a claim transaction.	Y		COTS	4B.3.1.a.8
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.	Y		COTS	4B.3.1.a.8
HP	**Health Insurance Premium Payment (HIPP) Requirements**	**A**		**C**	**D**
HP.SS.01	Receive and process daily incoming transactions that identify members enrolled in HIPP.	Y		COTS	4B.3.1.a.9
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.	Y		COTS	4B.3.1.a.9
HP.SS.03	Calculate or select premium payment amount and generate payments and remittance advices to members, payees, insurers or employers on behalf of HIPP enrollees.	Y		COTS	4B.3.1.a.9

HP.SS.04	Produce state defined reports for premium payments made associated with HIPP.	Y		COTS	4B.3.1.a.9
HP.SS.05	Produce state defined reports for monitoring cost avoidance associated with HIPP coverage based on TPL data.	Y		COTS	4B.3.1.a.9
HP.SS.06	Prevent HIPP enrollees from enrollment in managed care programs.	Y		COTS	4B.3.1.a.9
HP.SS.07	Accept a tax ID number for tracking and distributing HIPP payments.	Y		COTS	4B.3.1.a.9
HP.SS.08	Provide for payment to be made by either check or electronic means.	Y		COTS	4B.3.1.a.9
HP.SS.09	Provide for payments to be made on a daily basis or as directed by IME.	Y		COTS	4B.3.1.a.9
HP.SS.10	Maintain online information related to HIPP cases including HIPP premium payout data and employer data, based on state specifications.	Y		COTS	4B.3.1.a.9
HP.SS.11	Create a member file for HIPP enrollees who are not Medicaid members (i.e., AIDS/HIV HIPP).	Y		COTS	4B.3.1.a.9
PM	**Program Management Reporting Requirements**	**A**		**C**	**D**
PM1.01	Provide capability to support the production of information and or reports to assist management in fiscal planning and control.	Y		COTS	4B.3.1.a.10
PM1.01.01	Provide parameter-driven capability to download data required for management analysis to excel spreadsheet or other format required by IME data.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM1.03	Provide capability to support the production of information and or reports to support the preparation of budget allocations by fiscal years.	Y		COTS	4B.3.1.a.10
PM1.04	Provide capability to support the production of information and or reports for projection of the cost of program services for future periods.	Y		COTS	4B.3.1.a.10
PM1.05	Provide capability to support the production of information and or reports to compare current cost with previous period cost to establish a frame of reference for analyzing current cash flow.	Y		COTS	4B.3.1.a.10

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.	Y	[redacted]	COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
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).	Y		COTS	4B.3.1.a.10
PM1.09	Maintain provider, recipient, claims processing and other data to support agency management reports and analyses.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM1.11	Support online real-time summary information such as but not limited to: number and type of providers, members and services.	Y		COTS	4B.3.1.a.10
PM1.12	Track claims processing financial activities and provide reports on current status of payments.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10

PM1.14	Provide capability to support the production of information and or reports on the utilization and cost of services against benefit limitations.	Y	[redacted]	COTS	4B.3.1.a.10
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.	Y	[redacted]	COTS	4B.3.1.a.10
PM1.16	Provide capability to support the production of information and or reports on hospice services showing a comparison of hospice days versus inpatient days for each enrolled hospice member and for all hospice providers.	Y	[redacted]	COTS	4B.3.1.a.10
PM1.17	Provide capability to support the production of information and or reports to analyze break-even point between Medicare and Medicaid payments.	Y	[redacted]	COTS	4B.3.1.a.10
PM1.18	Provide capability to support the production of information and or reports to analyze cost-effectiveness of managed care programs versus FFS.	Y	[redacted]	COTS	4B.3.1.a.10
PM1.19	Provide capability to support the production of information and or reports to track impact of Medicare drug program.	Y	[redacted]	COTS	4B.3.1.a.10
PM1.20	Provide capability to support the production of information and or reports on any change from baseline for any program or policy change.	Y	[redacted]	COTS	4B.3.1.a.10
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.	Y	[redacted]	COTS	4B.3.1.a.10
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.	Y	[redacted]	COTS	4B.3.1.a.10

PM2.03	Provide capability to support the production of information and or reports to monitor third party avoidance and collections per state plan.	Y		COTS	4B.3.1.a.10
PM2.04	Retain all information necessary to support state and federal initiative reporting requirements.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM2.07	Identify payments by type such as, but not limited to, abortions and sterilizations.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM2.10	Automatically alerts administration when significant change occurs in daily, weekly or other time period payments.	Y		COTS	4B.3.1.a.10
PM3.01	Provide capability to support the production of information and or reports to review provider performance to determine the adequacy and extent of participation and service delivery.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10

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.	Y	[redacted]	COTS	4B.3.1.a.10
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	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM3.08	Provide capability to support the production of information and or reports to monitor individual provider payments.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM4.02	Provide capability to support the production of information and or reports to analyze progress in accreting eligible Medicare buy-in members.	Y		COTS	4B.3.1.a.10
PM4.03	Provide capability to support the production of information and or reports to analyze data on individual drug usage.	Y		COTS	4B.3.1.a.10
PM4.04	Provide capability to support the production of information and or reports for geographic analysis of expenditures and member participation.	Y		COTS	4B.3.1.a.10

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.	Y		COTS	4B.3.1.a.10
PM4.06	Provide capability to support the production of information and or reports summarizing expenditures, based on type of federal expenditure and the eligibility and program of the member.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM4.09	Provide the ability to request information online and to properly categorize services based on benefit plan structure.	Y		COTS	4B.3.1.a.10
PM4.10	Provide capability to support the production of information and or reports on dual eligible's pre and post Medicare Part D implementation.	Y		COTS	4B.3.1.a.10
PM5.01	Support report balancing and verification procedures.	Y		COTS	4B.3.1.a.10
PM5.02	Maintain a comprehensive list of standard program management reports and their intended use (business area supported).	Y		COTS	4B.3.1.a.10
PM5.03	Provide reports or access to reports for users designated by the IME.	Y		COTS	4B.3.1.a.10
PM5.04	Maintain online access to at least four (4) years of selected management reports and five (5) years of annual reports.	Y		COTS	4B.3.1.a.10
PM5.05	Meet state defined time frames and priorities for processing user requests.	Y		COTS	4B.3.1.a.10
PM5.SS.01	Provide the capability to store and retrieve all reports per IME requirements.	Y		COTS	4B.3.1.a.10

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.	Y	[redacted]	COTS	4B.3.1.a.10
PM5.SS.03	Provide the capability to archive all MMIS production reports for permanent storage in electronic media approved by IME.	Y		COTS	4B.3.1.a.10
PM5.SS.04	Provide the capability to run any report at any time.	Y		COTS	4B.3.1.a.10
PM5.SS.05	Maintain the uniformity and comparability of data through reports including reconciliation between comparable reports and reconciliation of all financial reports with claims processing reports.	Y		COTS	4B.3.1.a.10
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.	Y		COTS	4B.3.1.a.10
PM5.SS.07	Provide capability to report on the timely delivery of all scheduled reports.	Y		COTS	4B.3.1.a.10

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.	Y	[redacted]	COTS	4B.3.1.a.10
FR	**Federal Reporting Requirements**	**A**		**C**	**D**
FR1.01	Maintain data sets forTransformed Medical Statistical Information System (T-MSIS) reporting as required.	Y		COTS	4B.3.1.a.11
FR1.02	Merge intoT-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.	Y		COTS	4B.3.1.a.11
FR1.03	Provide and maintainT-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.	Y		COTS	4B.3.1.a.11
FR1.04	Provide and maintain encounter data in appropriate claim(s) file.	Y		COTS	4B.3.1.a.11
FR1.05	Follow the eligibility reporting guidelines of theT-MSIS file specifications and data dictionary documents from CMS.	Y		COTS	4B.3.1.a.11
FR1.06	MeetT-MSIS reporting timeliness, providingT-MSIS data files in accordance with the CMS required schedules and delivery methods	Y		COTS	4B.3.1.a.11

FR1.SS.01	Provide data to support the production of the SF425 for the Money Follows the Person. The report is based upon services only.	Y		COTS	4B.3.1.a.11
FR1.SS.02	Support Payment Error Rate Measurement (PERM) processing in compliance with CMS quarterly claims sample frequency requirements as directed by IME.	Y		COTS	4B.3.1.a.11
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.	Y		COTS	4B.3.1.a.11
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.	Y		COTS	4B.3.1.a.11
FR4.01	Provide data to support the production of CMS-37 and CMS-64 quarterly estimates and expenditure reports.	Y		COTS	4B.3.1.a.11
FR4.01.01	Report drug rebate collections on the CMS-64 and CMS-21, as applicable. This may require a data interface with the POS system to receive the data.	Y		COTS	4B.3.1.a.11
FR4.01.02	Report the top ten manufacturers with outstanding drug rebate invoices on quarterly CMS-64 data.	Y		COTS	4B.3.1.a.11
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.	Y		COTS	4B.3.1.a.11

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.	Y	[redacted]	COTS	4B.3.1.a.11
FR4.SS.02	The system must be able to report all the claims and financial transaction detail that supports each federal report line.	Y		COTS	4B.3.1.a.11
FR4.SS.03	Incorporate TPL information including collections and cost avoidance (w/Medicare) on the CMS-64.	Y		COTS	4B.3.1.a.11
FR4.SS.04	Provide the capability to create a Quarterly Report of Abortions (CMS 64.9b) based on IME rules.	Y		COTS	4B.3.1.a.11
FR4.SS.05	Provide the capability to create a quarterly report on expenditures under the Money Follows the Person program based on IME rules.	Y		COTS	4B.3.1.a.11
FR4.SS.06	Provide the capability to create a quarterly report on HIPP premium payments and refunds based on IME rules.	Y		COTS	4B.3.1.a.11
FR4.SS.07	Incorporate information concerning member premium payments and refunds on the CMS-64.	Y		COTS	4B.3.1.a.11
FR4.SS.08	Include the following data in the reports to support the 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.	Y		COTS	4B.3.1.a.11
FR.SS.01	T-MSISProvide the ability to regenerate retroactive federal reports and T-MSIS based upon changes to the federal report code.	Y		COTS	4B.3.1.a.11

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. T-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.	Y	[redacted]	COTS	4B.3.1.a.11
FI	**Financial Management Requirements**	**A**	[redacted]	**C**	**D**
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.	Y	[redacted]	COTS	4B.3.1.a.12
FI1.01.01	Provide EOB notices on the web portal in multiple languages, as defined by IME.	Y	[redacted]	COTS	4B.3.1.a.12
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.	Y	[redacted]	COTS	4B.3.1.a.12
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.	Y	[redacted]	COTS	4B.3.1.a.12
FI2.02	Maintain garnishments and tax levies and assignment information to be used in directing or splitting payments to the provider and garnishor.	Y	[redacted]	COTS	4B.3.1.a.12
FI2.03	Maintain financial transactions in sufficient detail to support 1099.	Y	[redacted]	COTS	4B.3.1.a.12
FI2.04	Account for recovery payment adjustments received from third parties that do not affect the provider's 1099.	Y	[redacted]	COTS	4B.3.1.a.12

FI2.05	Provide a full audit trail to the source of general ledger transactions generated by the MMIS or other supporting financial packages.	Y		COTS	4B.3.1.a.12
FI2.05.01	Link financial data back to the source claim line or system generated payment transaction.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI2.05.03	Provide financial audit controls meeting Generally Accepted Accounting Principles (GAAP).	Y		COTS	4B.3.1.a.12
FI2.06	Provide reports in electronic format for performing periodic bank account or fund allocation reconciliations.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI2.08	Maintain a history of refunds.	Y		COTS	4B.3.1.a.12
FI2.09	Withhold the federal share of payments to Medicaid providers to recover Medicare overpayments. The system must allow a threshold (A/R) to be set up and continue to withhold the federal share of claims until the Medicare overpayment amount is reached.	Y		COTS	4B.3.1.a.12
FI2.SS.01	Provide an accounts payable module to manage payments to providers, members and other entities.	Y		COTS	4B.3.1.a.12
FI2.SS.02	Provide an AR module to manage receivables from providers, members and other entities.	Y		COTS	4B.3.1.a.12
FI2.SS.03	Provide a follow-up process to ensure that required changes to account coding and financial management business rules are applied.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12

FI2.SS.05	Provide the ability to easily navigate between accounts payable and AR.	Y	[redacted]	COTS	4B.3.1.a.12
FI2.SS.06	Produce the 1099 file, as directed by IME, using AR data to appropriately adjust providers' earnings for recoupment.	Y		COTS	4B.3.1.a.12
FI2.SS.07	Process voids and replacements for incorrect payments and create AR where appropriate.	Y		COTS	4B.3.1.a.12
FI2.SS.08	Generate payments at the Financial Account level.	Y		COTS	4B.3.1.a.12
FI2.SS.09	Provide the ability to record debts and process accurate and timely cash receipts from debtors.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI2.SS.11	Provide the capability to manually create a receivable and stamp account code and federal report code, based on direction from IME.	Y		COTS	4B.3.1.a.12
FI2.SS.12	Provide the ability to create a payment plan for manually and automatically created AR.	Y		COTS	4B.3.1.a.12
FI2.SS.13	Provide online viewing of all transactions and provider balances.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12

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.	Y	[redacted]	COTS	4B.3.1.a.12

FI3.01	Track Medicare deductibles and coinsurance paid by Medicaid for all crossover claims, by member and program type.	Y		COTS	4B.3.1.a.12
FI3.02	Process and retain all data from provider credit and adjustment transactions.	Y		COTS	4B.3.1.a.12
FI3.03	Produce payment information to the payment issuing system.	Y		COTS	4B.3.1.a.12
FI3.04	Issue an electronic remittance advice detailing claims processing activity at the same time as the payment or payment information transfer.	Y		COTS	4B.3.1.a.12
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 162.	Y		COTS	4B.3.1.a.12
FI3.05.01	Report on the remittance advice and the ASC X12N 835 any payment amounts applied to an AR or interest debt.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI3.05.04	Provide ability to populate multiple message fields on the RA.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI3.05.06	Produce a RA that can be downloaded as a Portable Data File (PDF) version from the web portal.	Y		COTS	4B.3.1.a.12
FI3.05.07	Provide the capability to capture denial path of claims, including edits, showing all of the denial reasons on the RA.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12

FI3.06	Net provider payments against credit balance or AR amounts due in the payment cycle in determining the payment due the provider.	Y		COTS	4B.3.1.a.12
FI3.07.01	Provide the ability to apply claim payments to satisfy an outstanding AR balance, including payment of interest.	Y		COTS	4B.3.1.a.12
FI3.07.02	Provide the ability to apply cash receipts against AR and interest, based on business rules provided by IME.	Y		COTS	4B.3.1.a.12
FI3.08	Process voids and replacements for incorrect payments or returned warrants, crediting fund source accounts and creating AR or credit balances where appropriate.	Y		COTS	4B.3.1.a.12
FI3.09	Support stop payment processes.	Y		COTS	4B.3.1.a.12
FI3.10	Allow online access to AR or provider credit balances to authorized individuals.	Y		COTS	4B.3.1.a.12
FI3.11	Allow online access to remittance advice through a web-based browser.	Y		COTS	4B.3.1.a.12
FI3.12	Provide support for identification and application of recovery funds and lump-sum payments.	Y		COTS	4B.3.1.a.12
FI3.13	Identify providers with credit balances and no claim activity during a state-specified number of months.	Y		COTS	4B.3.1.a.12
FI3.14	Notify providers when a credit balance or AR has been established.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI3.15	Display adjustment and or void in a separate section of the remittance advice.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI3.SS.01	Provide the ability to identify interest that is applied through settlements (e.g., liens, settlements and sanctions).	Y		COTS	4B.3.1.a.12

FI3.SS.02	Remittance advices must be generated at a financial account level.	Y	[redacted]	COTS	4B.3.1.a.12
FI3.SS.03	Allow for the creation of multiple categories of AR (audit, overpayments, fraud) at the claim line level.	Y		COTS	4B.3.1.a.12
FI3.SS.04	Automatically create a receivable collectable whenever a provider advance is created, unless instructed by IME.	Y		COTS	4B.3.1.a.12
FI3.SS.05	Provide the ability to continue to report an outstanding receivable balance even if IME suspends collection.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI3.SS.08	Be able to transfer credit balances between associated financial accounts.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI3.SS.10	Provide the ability to allow uncollectable credit balances to be set as directed by IME.	Y		COTS	4B.3.1.a.12
FI4.01	Provide a financial transaction application for processing non-claim specific financial transactions including payouts, AR, refund checks and returned warrants.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12

	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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI4.03.01	Update and track information necessary to support a reconciliation of cancelled, outdated and or replaced warrants.	Y		COTS	4B.3.1.a.12
FI4.04	Process payments from providers for refunds and update records as needed. Capability to adjust 1099 reporting.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI4.04.02	Process and track requests for duplicates and provider change requests for 1099 in accordance with IME business rules.	Y		COTS	4B.3.1.a.12
FI4.04.03	Process the annual IRS “no match” provider file and generate a report, as defined by IME.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI4.04.05	Provide capability for providers to securely access and print their 1099 from the web portal.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI4.05	Provide the capability to pay the desiginated financial account for electronic health record incentive payments made to eligible providers. The 1099 for the EHR incentive payment must be sent to the eligible provider, not the designated payee.	Y		COTS	4B.3.1.a.12

FI.SS.01	Provide the ability to manually update an account receivable transaction	Y		COTS	4B.3.1.a.12
FI.SS.03	Provide remittance processing capabilities to account for both payment offsets and cash receipts.	Y		COTS	4B.3.1.a.12
FI.SS.04	Accumulate payments for multiple benefit plans by provider and include on same remittance advice.	Y		COTS	4B.3.1.a.12
FI.SS.05	Summarize payment cycle transactions by account coding.	Y		COTS	4B.3.1.a.12
FI.SS.06	Create a payment processing summary file for upload to state accounting system.	Y		COTS	4B.3.1.a.12
FI.SS.07	Balance all payment cycle processing, including balancing a Claims Payment Summary Report to a Remittance Advice Report.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI.SS.09	Support the calculation of disproportionate share payments, per business rules provided by IME.	Y		COTS	4B.3.1.a.12
FI.SS.10	Allow for limiting payment amounts, per IME business rules.	Y		COTS	4B.3.1.a.12
FI.SS.12	Support multiple AR for a given provider to include a prioritization of satisfaction of the outstanding balances that may be overridden.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI.SS.14	Update MMIS financial claims history to reflect cash receipts.	Y		COTS	4B.3.1.a.12
FI.SS.15	Support drill down capability for AR and cash receipts.	Y		COTS	4B.3.1.a.12
FI.SS.16	Produce reports and notices and letters in Microsoft Office compatible files, for use in spreadsheets and emailing of reports.	Y		COTS	4B.3.1.a.12
FI.SS.17	Allow for export of financial management reports to Excel, based on user-defined parameters.	Y		COTS	4B.3.1.a.12

FI.SS.18	Include beginning and end dates on reports, if applicable.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI.SS.20	Identify the type of TPL recovery on each AR.	Y		COTS	4B.3.1.a.12
FI.SS.21	Provide a link for related AR correspondence.	Y		COTS	4B.3.1.a.12

FI.SS.22	Provide the capability to maintain reason codes for all receipts of money (i.e., recoupment payments).	Y		COTS	4B.3.1.a.12
FI.SS.23	Provide the capability to assign a financial control number to any cash transaction.	Y		COTS	4B.3.1.a.12
FI.SS.24	Provide the capability to track and store federal financial participation (FFP) amounts.	Y		COTS	4B.3.1.a.12
FI.SS.25	Provide the capability to maintain complete audit trails of AR processing and all transactions must be reflected in subsequent financial reporting.	Y		COTS	4B.3.1.a.12
FI.SS.26	Provide the capability to automatically transfer credit balances when a provider changes ownership as determined by IME.	Y		COTS	4B.3.1.a.12
FI.SS.27	Provide the capability to send payment file as directed by IME for EFT.	Y		COTS	4B.3.1.a.12
FI.SS.28	Track all county and school based billing payments and adjustments. (AEA and LEA)	Y		COTS	4B.3.1.a.12
FI.SS.29	Note the disputed amount of the AR for county and school based ARs, provide the capability to record the dispute reason, resolution, and link an image of supporting documentation.	Y		COTS	4B.3.1.a.12
FI.SS.30	Provide the capability to adjust a County and School billing AR at the claim level.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI.SS.33	Provide the capability to generate a monthly report of Medicare premium and crossover payments.	Y		COTS	4B.3.1.a.12
FI.SS.34	Calculate and provide electronic record of the total dollars of assessment fees that are to be repaid to the state.	Y		COTS	4B.3.1.a.12
FI.SS.35	Provide the ability to hold providers harmless for assessment fee expenses. Be able to issue and collect assessment fee payments and/or recoupments (AR or Cash Receipt)	Y		COTS	4B.3.1.a.12

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.	Y	[redacted]	COTS	4B.3.1.a.12
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) and provider type, on a monthly basis.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
FI.SS1.42	Accept and process the Department of Administrative Services Offset Program file received monthly from the Department.	Y		COTS	4B.3.1.a.12
FI.SS.43	Provide the capability to refund overpayments on AR.	Y		COTS	4B.3.1.a.12
FI.SS.44	Provide a method to link payments from providers to the specific claim line affected.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12
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.	Y		COTS	4B.3.1.a.12

FI.SS.47	Provide the capability for recoveries to be made from provider payments at the Department user-defined percentage from 0 to 100.	Y	[redacted]	COTS	4B.3.1.a.12
FI.SS.48	Provide the capability to produce a summary report of all payments for each payment cycle.	Y		COTS	4B.3.1.a.12
FI.SS.49	Provide the capability to drill down to the claim line from any provider payment.	Y		COTS	4B.3.1.a.12
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. c. File of paid claims and encounter data to Medical Services contractor.	Y		COTS	4B.3.1.a.12
FI.SS.51	The system must have ability to transfer money from the HRA to a Healthy Rewards debit card 60 days after a member's anniversary if requested by the member.	Y		COTS	4B.3.1.a.12
FI.SS.52	The system must have the ability to make payments to the Healthy Rewards debit card if the member achieves specific milestones of an incentive program. Milestones include but are not limited to : Completion of Risk Assessment, Annual Physicial, Completion of Prevention Services	Y		COTS	4B.3.1.a.12
FI.SS.53	Electronic EFT payments must meet the CAHQ/CORE operating rules.	Y		COTS	4B.3.1.a.12

FI.SS.54	The system must support ACO payment models and pay for performance initiatives.	Y		COTS	4B.3.1.a.12
FI.SS.55	The system must maintain a health responsibility account (HRA) for selected benefit plans.	Y		COTS	4B.3.1.a.12
FI.SS.56	System must accept state and member contributions to a health responsibility account.	Y		COTS	4B.3.1.a.12
FI.SS.57	If a member has an health responsibility account, the system must apply deductibles as a debit against the account up to the maximum deductible per member anniversary year.	Y		COTS	4B.3.1.a.12
PI	**Program Integrity Management Requirements**	**A**		**C**	**D**
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	Y		COTS	4B.3.1.a.13
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.	Y		COTS	4B.3.1.a.13

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.	Y	[redacted]	COTS	4B.3.1.a.13
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.	Y		COTS	4B.3.1.a.13
PI.SS.05	Generate annual ranking by dollars for utilizing members and providers, by program, including listings of the top 100 for each category.	Y		COTS	4B.3.1.a.13
PI.SS.06	Provide the lock-in contractor with a file of member Program Integrity claim details from the MMIS to support their review and investigation of inappropriate utilization of services in the member population.	Y		COTS	4B.3.1.a.13
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.	Y		COTS	4B.3.1.a.13

PI.SS.08	Provide access to the Program Integrity contractor all reports produced for the Program Integrity module.	Y		COTS	4B.3.1.a.13
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.	Y		COTS	4B.3.1.a.13
MG	**Managed Care Enrollment Requirements**	**A**		**C**	**D**
MG1.01	Capture enrollee choice of PCCM on beneficiary record.	Y		COTS	4B.3.1.a.14
MG1.02	Auto-assign enrollees to a PCCM who fail to choose a PCCM and complete provider lock-in process.	Y		COTS	4B.3.1.a.14
MG1.03	Display enrollees associated with PCCM.	Y		COTS	4B.3.1.a.14
MG1.04	Disenroll member from PCCM.	Y		COTS	4B.3.1.a.14
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.	Y		COTS	4B.3.1.a.14
MG1.06	Automatically disenroll enrollees from a terminated PCCM provider and places the beneficiary in regular FFS status.	Y		COTS	4B.3.1.a.14
MG1.06.01	If a provider is terminated from participation in the Medicaid program, automatically disenroll the provider from the PCCM program and generate report of disenrollment action.	Y		COTS	4B.3.1.a.14

MG1.07	Perform mass reassignment of enrollees if contract with PCCM is terminated or beneficiary disenrolls for any reason other than ineligibility for Medicaid.	Y	[redacted]	COTS	4B.3.1.a.14
MG1.08	Generate notices to members of enrollment or disenrollment from PCCM.	Y		COTS	4B.3.1.a.14
MG1.10	Identify members excluded from enrollment, subject to mandatory enrollment or free to voluntarily enroll in PCCM.	Y		COTS	4B.3.1.a.14
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.	Y		COTS	4B.3.1.a.14
MG1.12	Provide a default enrollment process for those members who do not choose a PCCM.	Y		COTS	4B.3.1.a.14
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.	Y		COTS	4B.3.1.a.14
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.	Y		COTS	4B.3.1.a.14
MG1.14	Support ANSI X12N 834 transaction, as required by HIPAA.	Y		COTS	4B.3.1.a.14
MG2.01	Identify PCCMs who have agreed to provide gatekeeper services, geographic location(s), number of assigned members and capacity to accept additional patients.	Y		COTS	4B.3.1.a.14
MG2.02	Accept and processes updates information about the PCCM as changes are reported.	Y		COTS	4B.3.1.a.14
MG2.03	Capture termination information when a PCCM provider contract is cancelled.	Y		COTS	4B.3.1.a.14
MG2.03.01	Automatically disenroll PCCM from managed care program.	Y		COTS	4B.3.1.a.14
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).	Y		COTS	4B.3.1.a.14

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.	Y	[redacted]	COTS	4B.3.1.a.14
MG3.01	Calculate administrative payment per-member-per-month (PMPM) for primary care gatekeeper services.	Y		COTS	4B.3.1.a.14
MG3.01.01	Calculate and issues performance incentive payment for qualifying medical homes.	Y		COTS	4B.3.1.a.14
MG3.02	Support ANSI X12N 837 transactions, as required by HIPAA.	Y		COTS	4B.3.1.a.14
MG3.03	Support ANSI X12N 835 transaction, as required by HIPAA.	Y		COTS	4B.3.1.a.14
MG4.01	Edit and deny payment to FFS providers for services without PCCM referral and or prior authorization.	Y		COTS	4B.3.1.a.14
MG4.02	Allow payment to providers for services carved out of the PCCM benefit package (e.g., family planning, women health specialist).	Y		COTS	4B.3.1.a.14
MG4.03	Allow payment for emergency medical condition without authorization from PCCM.	Y		COTS	4B.3.1.a.14
MG4.04	Edit and deny payment to referral providers (pharmacy, lab, radiology, specialty physician, etc.) if service is not authorized by a PCCM gatekeeper.	Y		COTS	4B.3.1.a.14
MG4.05	Allow payment to FFS providers for services rendered in pre-enrollment periods or other periods of transition.	Y		COTS	4B.3.1.a.14
MG5.01	Generate as required by IME reports for monitoring enrollee access to medical services.	Y		COTS	4B.3.1.a.14
MG5.01.01	Generate data extract of all paid claims and encounter for use by actuarial contract.	Y		COTS	4B.3.1.a.14
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.	Y		COTS	4B.3.1.a.14
MG5.03	Generate as required by IME reports to monitor PCCM referrals to specialty care.	Y		COTS	4B.3.1.a.14

MG5.04	Produce report for each PCCM identifying the PCCM's enrollees and the total payment per month per enrollee.	Y	[redacted]	COTS	4B.3.1.a.14
MG.SS.01	Generate a capitation payment for clients enrolled in the PACE benefit plan. Payments are currently made based upon the PACE Provider, the member age and dual eligibility status.	Y		COTS	4B.3.1.a.14
MG.SS.02	Produce a report of all members enrolled with a PACE provider. Frequency should be configurable. Current frequency is monthly.	Y		COTS	4B.3.1.a.14
MG.SS.03	Edit and deny all FFS payments after enrollment in PACE.	Y		COTS	4B.3.1.a.14
MG.SS.04	Provide a "PACE" indicator on client file when a client is enrolled in the PACE benefit plan.	Y		COTS	4B.3.1.a.14
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.	Y		COTS	4B.3.1.a.14
MG.SS.06	Provide capability to adjust the PACE payment for client participation.	Y		COTS	4B.3.1.a.14
MG.SS.07	Provide capability to assure the PACE program does not co-exist with any other benefit plan.	Y		COTS	4B.3.1.a.14
MG.SS.08	Allow access to the member contact data through link on any screen.	Y		COTS	4B.3.1.a.14
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. 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.	Y		COTS	4B.3.1.a.14

MG.SS.10	Manage dual enrollment in Iowa benefit plans based on IME hierarchy enrollment rules.	Y		COTS	4B.3.1.a.14
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.	Y		COTS	4B.3.1.a.14
MC	**Managed Care Organization Requirements**	**A**		**C**	**D**
MC1.01	Capture information on contracted MCOs, including geographic locations, capitation rates and organization type.	Y		COTS	4B.3.1.a.15
MC1.02	Capture information identifying contracted providers within MCO network, including Primary Care Providers (PCPs).	Y		COTS	4B.3.1.a.15
MC1.03	Capture information identifying providers who have agreed to provide gatekeeper services, number of members assigned and capacity to accept additional patients.	Y		COTS	4B.3.1.a.15
MC1.04	Accept and process update information as changes are reported.	Y		COTS	4B.3.1.a.15
MC1.05	Capture termination information when an MCO contract is cancelled.	Y		COTS	4B.3.1.a.15
MC1.06	Remove and end-date PCP status from MCO (optional if states require MCO to identify PCPs).	Y		COTS	4B.3.1.a.15

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.	Y	[redacted]	COTS	4B.3.1.a.15
MC1.08	Provide information to support review of new enrollments and to prohibit affiliations with individuals debarred by federal agencies.	Y		COTS	4B.3.1.a.15
MC2.01	Calculate per-member per-month (PMPM) capitation payment based on state-defined rate factors such as age, gender, category of eligibility, health status, geographic location and other.	Y		COTS	4B.3.1.a.15
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).	Y		COTS	4B.3.1.a.15
MC2.03	Identify individuals and enrollees who have terminated enrollment, disenrolled or are deceased and excludes those individuals from the monthly MCO capitation payment.	Y		COTS	4B.3.1.a.15
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.	Y		COTS	4B.3.1.a.15
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).	Y		COTS	4B.3.1.a.15
MC2.06	Perform mass adjustment to rates according to state policy (e.g., annual adjustment, negotiated rate change, court settlement).	Y		COTS	4B.3.1.a.15
MC2.07	Perform periodic reconciliations of state member records with MCO, PCP enrollment records.	Y		COTS	4B.3.1.a.15
MC2.08	Verify correct transfer of capitation payment when member disenrolls from one MCO and enrolls in another plan.	Y		COTS	4B.3.1.a.15
MC2.09	Support ANSI X12N 820 Premium Payment transaction as required by HIPAA.	Y		COTS	4B.3.1.a.15
MC3.01	Collect and store encounter data on a periodic basis.	Y		COTS	4B.3.1.a.15

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.	Y	[redacted]	COTS	4B.3.1.a.15
MC3.03	Return erroneous encounter data for correction.	Y		COTS	4B.3.1.a.15
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.	Y		COTS	4B.3.1.a.15
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.	Y		COTS	4B.3.1.a.15
MC3.07	Accept and process encounter claims in formats, as mandated by HIPAA (e.g., X12N 837).	Y		COTS	4B.3.1.a.15
MC4.04	Collect and sort encounter data for use in completing Medicaid Statistical Information System (MSIS) reports.	Y		COTS	4B.3.1.a.15
MC4.05	Collects and sorts encounter data for use in determining capitation rates.	Y		COTS	4B.3.1.a.15
MC4.09	Access encounter data to identify persons with special health care needs as specified by IME.	Y		COTS	4B.3.1.a.15
MC4.10	Produce reports to identify network providers and assess enrollee access to services.	Y		COTS	4B.3.1.a.15
MC4.11	Produce managed care program reports by category of service, category of eligibility and by provider type.	Y		COTS	4B.3.1.a.15
MC5.01	Block payment to FFS providers for services included in the MCO benefit package, with the exceptions stated per the state plan.	Y		COTS	4B.3.1.a.15
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).	Y		COTS	4B.3.1.a.15
MC5.03	Allow payment to FFS providers for services rendered in pre-enrollment periods or other periods of transition.	Y		COTS	4B.3.1.a.15
MC6.01	Generate monthly or as required by IME reports of capitation payment by various categories (e.g., by eligibility group, rate cell).	Y		COTS	4B.3.1.a.15

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).	Y	[redacted]	COTS	4B.3.1.a.15
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.	Y		COTS	4B.3.1.a.15
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.	Y		COTS	4B.3.1.a.15
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).	Y		COTS	4B.3.1.a.15
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.	Y		COTS	4B.3.1.a.15

ME	Primary Care Case Manager (PCCM) and Medical Home and Managed Care Gatekeeper Requirements	A	[redacted]	C	D
ME1.01	Capture enrollee choice of MCO or PCP and enter into member record.	Y		COTS	4B.3.1.a.16
ME1.03	Assign enrollee to MCO or PCP based on factors such as member age, gender, geographic location; and MCO capitation rate, location.	Y		COTS	4B.3.1.a.16
ME1.05	Display enrollees associated with MCO.	Y		COTS	4B.3.1.a.16
ME1.06	Disenroll member from MCO.	Y		COTS	4B.3.1.a.16
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.	Y		COTS	4B.3.1.a.16
ME1.08	Automatically disenroll and re-enroll members in new plans during periods of open enrollment or when an MCO leaves the program.	Y		COTS	4B.3.1.a.16
ME1.09	Automatically disenroll member from a terminated MCO and places in regular FFS status.	Y		COTS	4B.3.1.a.16
ME1.10	Generate notices to member of assignment to or disenrollment from MCO.	Y		COTS	4B.3.1.a.16
ME1.11	Identify members excluded from enrollment, subject to mandatory enrollment or free to voluntarily enroll in MCO.	Y		COTS	4B.3.1.a.16
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.	Y		COTS	4B.3.1.a.16
ME1.13	Provide a default enrollment process for those members who do not choose a MCO.	Y		COTS	4B.3.1.a.16
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).	Y		COTS	4B.3.1.a.16
ME1.15	Support ANSI X12N 834 transaction, as required by HIPAA.	Y		COTS	4B.3.1.a.16
ME2.01	Receive and process eligibility data from state's eligibility source system.	Y		COTS	4B.3.1.a.16

ME2.02	Receive MCO contract information from contract data store (e.g., address, covered services, rates).	Y		COTS	4B.3.1.a.16
ME2.03	Receive and process provider eligibility data from MMIS or data repository for PCP program.	Y		COTS	4B.3.1.a.16
ME2.05	Calculate or select premium payment amount and generate PMPM payment (e.g.capitation, case management fee).	Y		COTS	4B.3.1.a.16
ME2.06	Support ANSI X12N 820 transaction for PMPM premium payment as required by HIPAA.	Y		COTS	4B.3.1.a.16
ME2.07	Transmit enrollment and PMPM payment data to MMIS or data repository.	Y		COTS	4B.3.1.a.16
ME2.08	Transmit enrollment records and PMPM payments to MCOs.	Y		COTS	4B.3.1.a.16
ME3.01	Calculate and generate premium notices to members.	Y		COTS	4B.3.1.a.16
ME3.02	Process premium receipts from members.	Y		COTS	4B.3.1.a.16
ME3.02.01	Identify outstanding premium payments due from members and reports for debt collection accordance with IME policy.	Y		COTS	4B.3.1.a.16
ME3.03	Support inquiries regarding premium collections.	Y		COTS	4B.3.1.a.16
ME3.03.01	Member premium rules must be configurable to accommodate program rules.	Y		COTS	4B.3.1.a.16
ME3.03.02	Automatically extend or terminate eligibility for premium based eligibility programs in accordance with rules for each program.	Y		COTS	4B.3.1.a.16
ME3.03.03	Accept data file from lock box for premium payments.	Y		COTS	4B.3.1.a.16
ME3.04	Produce premium collection reports.	Y		COTS	4B.3.1.a.16
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.	Y		COTS	4B.3.1.a.16

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.	Y	[redacted]	COTS	4B.3.1.a.16
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.	Y		COTS	4B.3.1.a.16
ME.SS.03	System must be able to enroll, disenroll, maintain, track and produce reports for Medical Home as directed by IME.	Y		COTS	4B.3.1.a.16
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.	Y		COTS	4B.3.1.a.16
ME.SS.05	Allow the capability for a member to be in a medical home and on lock-in.	Y		COTS	4B.3.1.a.16

RI	Immunization Registry (MMIS Interfaced to Registry)	A		C	D
RI1.1	Collect and maintain claims history for vaccinations at the Member-specific level.	Y		COTS	4B.3.1.a.17
RI1.2	Interface with a statewide automated immunization registry and allow regularly scheduled data exchanges.	Y		COTS	4B.3.1.a.17
	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:	Y		COTS	4B.3.1.a.17
	a. Medicaid identifier.				
	b. Demographic information.				
	c. CPT billing procedure code.				
	d. Identify rendering service provider.				
	e. Reminder and recall notice dates.				
RI1.4	Edit data for data validity, duplicate records and perform quality checks; sends error message if appropriate.	Y		COTS	4B.3.1.a.17
RI3.2	Measure immunization coverage for the Medicaid population using current Advisory Committee on Immunization Practices (ACIP) schedule and update as necessary.	Y		COTS	4B.3.1.a.17
RI3.3	Select and send data weekly or as directed by IME to the registry at least on a weekly basis.	Y		COTS	4B.3.1.a.17
RI3.5	Generate results of surveillance of vaccine-preventable diseases.	Y		COTS	4B.3.1.a.17
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.	Y		COTS	4B.3.1.a.17
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.	Y		COTS	4B.3.1.a.17

WPP	Web Portal for Providers	A		C	D
WPPSS1.01	Support distributed security to allow provider organizations to identify staff members and assign roles to their staff.	Y		COTS	4B.3.1.a.18
WPPSS1.02	Allow providers 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.	Y		COTS	4B.3.1.a.18
WPPSS1.03	Allow providers to enter, submit, update and inquire all claim types through direct entry on the provider portal. Accept attachments. Reject claims that fail front end edits.	Y		COTS	4B.3.1.a.18
WPPSS1.04	Provide smart link navigation to all provider activities on the web portal, guiding a provider through specific tasks.	Y		COTS	4B.3.1.a.18
WPPSS1.05	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.	Y		COTS	4B.3.1.a.18
WPPSS1.06	Provide the capability to provide HIPAA response transactions via the web portal.	Y		COTS	4B.3.1.a.18
WPPSS1.07	Provide audit trail and history of all transactions conducted on the web portal.	Y		COTS	4B.3.1.a.18
WPPSS1.08	Provide ability for general public to report suspected fraud and abuse via web portal.	Y		COTS	4B.3.1.a.18
WPPSS1.09	Provide the ability to post announcements and alerts (general 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.	Y		COTS	4B.3.1.a.18
WPPSS1.10	Provide multiple level role-based securities as designated by IME.	Y		COTS	4B.3.1.a.18
WPPSS1.11	Provide low bandwidth versions of IME-specified pages for easy access by providers mobile devices.	Y		COTS	4B.3.1.a.18
WPPSS1.12	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.	Y		COTS	4B.3.1.a.18

WPPSS1.13	Provide the functionality to display informational Messages in descending date order (most recent to oldest).	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1.14	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.	Y		COTS	4B.3.1.a.18
WPPSS1.15	Support the ability to receive and respond to secure messaging and HIPAA compliant transactions from providers.	Y		COTS	4B.3.1.a.18
WPPSS1.16	Provide the ability for providers to upload attachments to submit to the IME, including claims attachments, provider enrollment, prior authorization support, pre-admission screening applications and others as defined by the IME. Auto log all file uploads and route to the appropriate work queue within IME	Y		COTS	4B.3.1.a.18
WPPSS1.17	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.	Y		COTS	4B.3.1.a.18
WPPSS1.18	Support ability to utilize electronic and/or digital signatures in compliance with IME, state and federal policies.	Y		COTS	4B.3.1.a.18
WPPSS1.19	Support the Provider enrollment process with a trigger mechanism to identify provider applications for which required paper documents have not been received. Auto-generate a resolution letter to the applicant.	Y		COTS	4B.3.1.a.18
WPPSS1.20	Allow a provider to check the status of their Medicaid provider enrollment application, regardless of the method used to submit the application.	Y		COTS	4B.3.1.a.18

WPPSS1.21	Provide the capability for providers to verify their current information and update as needed.	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1.22	Provide authorized users web access to forms for direct data entry as directed by IME. Examples are: a. TPL entry or update b. Fraud and Abuse c. Enrollment and Re-enrollment d. Demographic changes e. Hospital and therapeutic leave bed hold days f. Complaints g. Status of Accepting new members h. Prior Authorization i. Email correspondence. j. Discharge and disenrollment information.	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1.23	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.	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1.24	Allow authorized trading partners to enroll for standard HIPAA EDI exchange with the IME.	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1.25	Support the submission of HIPAA transaction files.	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1.26	Allow authorized trading partners to submit EDI file for immediate processing and retrieval of the corresponding response acknowledgement.	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1.27	Allow authorized trading partners to retrieve EDI response records.	Y	[redacted]	COTS	4B.3.1.a.18

WPPSS1.28	Allow providers to view claim status information, payment history, member eligibility, benefit information, rate information, and prior authorization status.	Y	[redacted]	COTS	4B.3.1.a.18
WPPSS1..29	Support provider access to a complete fee schedule that is downloadable via PDF or CSV formats.	Y		COTS	4B.3.1.a.18
WPPSS1.30	Provide access to interactive fee schedule functionality to allow providers to look up rates.	Y		COTS	4B.3.1.a.18
WPPSS1.31	Process direct data entry claims real-time. Reject claims that fail front-end edits and can not be adjudicated.	Y		COTS	4B.3.1.a.18
WPPSS1.32	Allow providers to submit member insurance coverage information via the web and attach to the correct member record.	Y		COTS	4B.3.1.a.18
WPPSS1.33	Enable the web portal to accurately display TPL information and carrier information to providers and other authorized users.	Y		COTS	4B.3.1.a.18
WPPSS1.34	Allow authorized providers to directly data enter and submit prior authorization requests, prior authorization addendums and updates to prior authorizations on the web portal.	Y		COTS	4B.3.1.a.18
WPPSS1.35	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.	Y		COTS	4B.3.1.a.18
WPPSS1.36	Notify initiator of prior authorization decision immediately when appropriate or by another method if decision is delayed.	Y		COTS	4B.3.1.a.18
WPPSS1.37	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.	Y		COTS	4B.3.1.a.18
WPPSS1.38	Provide provider specific online report retrieval capabilities including printing of the provider's 1099.	Y		COTS	4B.3.1.a.18
WPPSS1.39	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.	Y		COTS	4B.3.1.a.18

WPPSS1.40	Provide support for online registration for provider knowledge transfer seminars.	Y		COTS	4B.3.1.a.18
WPPSS1.41	Allow providers to submit incident reports. Store data points and route communication through defined workflow processes to ensure the case manager has responded to the incident.	Y		COTS	4B.3.1.a.18
WPPSS1.42	Using role based security allow a provider to review authorized services for case management and home and community based services. The information is intended to support transitions of care and discharge planning.	Y		COTS	4B.3.1.a.18
WPPSS1.43	Allow providers to identify members who enroll in their health home. Enrollment includes the start date, tier status, assessment date, and supporting diagnosis codes.	Y		COTS	4B.3.1.a.18
WPPSS1.44	Provide member rosters that can be exported for Health Home members, Medipass members, or other members assigned or attributed to a provider organization.	Y		COTS	4B.3.1.a.18
WPPSS1.45	Provide mechanism for providers to upload batch files with enrollment add, update and removal for health home.	Y		COTS	4B.3.1.a.18
WPPSS1.46	Support qualifying entity attestation and enrollment for the Presumptive Eligibility program.	Y		COTS	4B.3.1.a.18
WPM	**Web Portal – Member Requirements**	**A**		**C**	**D**
WPM.SS.01	Provide integration and linkages between the Medicaid Member portal and the ELIAS eligibility portal.	Y		COTS	4B.3.1.a.19
WPM.SS.02	Provide a web portal navigation that meets reading level needs of Medicaid population.	Y		COTS	4B.3.1.a.19
WPM.SS.03	Allow members to register online for access to the secure areas of the portal based on security rules defined by IME. Registration policies should be consistent with DHS standards and align with other DHS member portals.	Y		COTS	4B.3.1.a.19
WPM.SS.04	Allow interactive online support for members.	Y		COTS	4B.3.1.a.19
	Provide Medicaid program public information for members and their support team. All content must be available in printer friendly formats. Information includes but is not limited to:				

WPM.SS,05	a. Announcements b. Manuals c. Benefit package information d. Newsletters e. Articles f. Privacy and Security Policies g. Appeal Processes h. Complaint Processes i. Frequently Asked Questions	Y	[redacted]	COTS	4B.3.1.a.19
WPM.SS.06	Provide ability for members to report suspected fraud and abuse..	Y		COTS	4B.3.1.a.19
WPM.SS.07	Inform members of privacy and security policies. Provide instructions and forms to submit complaints regarding misuse of their private health care and Medicaid identification information.	Y		COTS	4B.3.1.a.19
WPM.SS.08	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.	Y		COTS	4B.3.1.a.19
WPM.SS.09	Maintain archives of posted announcements and alerts, including the date and message content.	Y		COTS	4B.3.1.a.19
WPM.SS.10	The web portal for members must be functional on mobile devices including smart phones.	Y		COTS	4B.3.1.a.19
WPM.SS.11	Allow members to search for providers near a specific address. Filter by types of service and if the provider is taking new clients.	Y		COTS	4B.3.1.a.19
WPM.SS.12	Allow a member to see their specific benefit plan details.	Y		COTS	4B.3.1.a.19
WPM.SS.13	Allow member to view current and past eligibility.	Y		COTS	4B.3.1.a.19
WPM.SS.14	Provide member with explanation of benefits for all claims.	Y		COTS	4B.3.1.a.19
WPM.SS.15	Allow member to select managed care or health home provider, and to disenroll in optional services such as a health home.	Y		COTS	4B.3.1.a.19
WPM.SS.16	Provide capability to allow members to request replacement ID cards.	Y		COTS	4B.3.1.a.19

WPM.SS.17	Support the ability to receive and respond to secure messaging between the member and IME member services.	Y		COTS	4B.3.1.a.19
WPM.SS.18	Allow members to submit change of address information.	Y		COTS	4B.3.1.a.19
WPM.SS.19	Allow members to submit secondary insurance questionnaires	Y		COTS	4B.3.1.a.19
WPM.SS.20	Allow members to request a physical copy of a publication.	Y		COTS	4B.3.1.a.19
WPM.SS.21	Allow a member to see an audit trail of who has viewed PHI.	Y		COTS	4B.3.1.a.19
WPM.SS.22	Provide personal health record information. Data sources would be the Iowa Health Information Network and claim information.	Y		COTS	4B.3.1.a.19
WPM.SS.23	Capture personal health record information from the member including weight, immunization, allergies, etc.	Y		COTS	4B.3.1.a.19
WPM.SS.24	Allow the member to see the authorized service plan for HCBS waiver programs, the Consumer Choices Option (CCO) budget, and the CCO expenses paid.	Y		COTS	4B.3.1.a.19
WPM.SS.25	Provide member alerts based upon triggers from PHR information.	Y		COTS	4B.3.1.a.19
WPM.SS.26	Apply intelligence to the PHR and present customized links to content based upon members medical status. For example – A article on how to manage Asthma, or Diabetes, etc.	Y		COTS	4B.3.1.a.19
WPM.SS.27	Trigger health alert notices to members for health prevention activities such as annual check-ups, immunizations, etc. Alerts should be sent to member portal account or as a text message.	Y		COTS	4B.3.1.a.19
WPM.SS.28	Allow members to opt in and out of text message communications.	Y		COTS	4B.3.1.a.19
WPM.SS.29	Support incident reporting by or on behalf of a member.	Y		COTS	4B.3.1.a.19
WPM.SS.30	Allow members to view premium payments made and premium payments due.	Y		COTS	4B.3.1.a.19
WPM.SS.31	Show members summary and detail information of all cost sharing for the annual time period.	Y		COTS	4B.3.1.a.19

WPM.SS.32	Allow member to review premium payment history and billing information. Allow member to print billing statement to send with member payment.	Y		COTS	4B.3.1.a.19
WPM.SS.33	Accept electronic payments for premium payments.	Y		COTS	4B.3.1.a.19
WPM.SS.34	Provide features to support consumer engagement in healthy behavior.	Y		COTS	4B.3.1.a.19
WPM.SS.35	Accommodate customer preferences for communications by e-mail, text, mobile devices, or phones	Y		COTS	4B.3.1.a.19
WA	**Waiver Requirements**	**A**		**C**	**D**
WA.SS.01	**For state supplemental program pay payee on the member file rather than provider.**	Y		COTS	4B.3.1.a.20
WA.SS.02	Provide capability to add a waiver program or add services to an existing waiver program through changes to the rules engine.	Y		COTS	4B.3.1.a.20
WA.SS.03	Maintain date-specific Managed Health Care enrollment data spans on the MMIS eligibility file, including:	Y		COTS	4B.3.1.a.20
WA.SS.03.a	a. Enrollment begin and end dates.	Y		COTS	4B.3.1.a.20
WA.SS.03.b	b. Provider ID.	Y		COTS	4B.3.1.a.20
WA.SS.03.c	c. Vendor ID.	Y		COTS	4B.3.1.a.20
WA.SS.03.d	d. Plan type.	Y		COTS	4B.3.1.a.20
WA.SS.03.e	e. State ID.	Y		COTS	4B.3.1.a.20
WA.SS.03.f	f. County of residence.	Y		COTS	4B.3.1.a.20
WA.SS.03.g	g. Zip code.	Y		COTS	4B.3.1.a.20
WA.SS.03.h	h. Aid type.	Y		COTS	4B.3.1.a.20
WA.SS.03.i	i. Birth date.	Y		COTS	4B.3.1.a.20
WA.SS.03.j	j. Medicare eligibility.	Y		COTS	4B.3.1.a.20

WA.SS.03.k	k. Gender.	Y		COTS	4B.3.1.a.20
WA.SS.03.l	l. Case number.	Y		COTS	4B.3.1.a.20
WA.SS.03.m	m. Reason for disenrollment.	Y		COTS	4B.3.1.a.20
WA.SS.04	Generate electronic notice of decisions for approved service plans that the case manager may send to the providers and the members.	Y		COTS	4B.3.1.a.20
WA.SS.05	Services must be authorized by units per month or units within a specified time period.	Y		COTS	4B.3.1.a.20
WA.SS.06	Provide support for CCO to determine amount of funding available per member.	Y		COTS	4B.3.1.a.20
WA.SS.07	Provide appropriate edits for lifetime and annual limits on services such as home and vehicle modification.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
	http://www.ime.state.ia.us/IMEResourceLibrary.html	Y		COTS	4B.3.1.a.20
WA.SS.09	Support waiting lists for the various programs.	Y		COTS	4B.3.1.a.20
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).	Y		COTS	4B.3.1.a.20
WA.SS.11	Workflow between incident reporting and the care plan review.	Y		COTS	4B.3.1.a.20

WA.SS.12	Provide reporting:	Y		COTS	4B.3.1.a.20
	Below is the link to the current ISIS workflow charts located in the IME Resource Library:	Y		COTS	4B.3.1.a.20
	http://www.ime.state.ia.us/IMEResourceLibrary.html	Y		COTS	4B.3.1.a.20
WA.SS.12.a	a. Consumers turning 18.	Y		COTS	4B.3.1.a.20
WA.SS.12.b	b. Verification that a person is on waiver (only for the rent subsidy program).	Y		COTS	4B.3.1.a.20
WA.SS.12.c	c. Audit trails of service plans.	Y		COTS	4B.3.1.a.20
WA.SS.12.d	d. Allow workers to see claims paid for a service plan.	Y		COTS	4B.3.1.a.20
WA.SS.13	Edit the authorized service against claims paid before allowing the case worker to change the service.	Y		COTS	4B.3.1.a.20
WA.SS.14	Capture requests for quality assurance (QA) changes to service plans.	Y		COTS	4B.3.1.a.20
WA.SS.15	Provide workflow to support LOC eligibility determinations and continued stay reviews.	Y		COTS	4B.3.1.a.20
WA.SS.16	Allow case managers to build case plans authorizing services, not to exceed maximums allowed by IME program rules.	Y		COTS	4B.3.1.a.20
WA.SS.17	Provide a workflow process for authorizing exceptions to policies.	Y		COTS	4B.3.1.a.20
WA.SS.18	Provide workflow process to support prior authorization of selected services.	Y		COTS	4B.3.1.a.20
WA.SS.19	Process and maintain inputs and outputs including, but not limited to:	Y		COTS	4B.3.1.a.20
WA.SS.19.i	Inputs:	Y		COTS	4B.3.1.a.20
WA.SS.19.i.a	a. Eligibility System.	Y		COTS	4B.3.1.a.20
WA.SS.19.o	Outputs:	Y		COTS	4B.3.1.a.20
WA.SS.19.o.a	a. None	Y		COTS	4B.3.1.a.20
WA1.01	Identify by waiver unduplicated participants enrolled in 1915c waiver programs.	Y		COTS	4B.3.1.a.20

WA1.01.01	Identify by waiver unduplicated participants enrolled in 1115 waiver programs.	Y		COTS	4B.3.1.a.20
WA1.01.02	Identify unduplicated participants enrolled in Facility and Enhanced State Plan programs.	Y		COTS	4B.3.1.a.20
WA1.01.03	Accept the waiver and Enhanced State Plan indicator from eligibility system.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
WA1.03	Track and report the number of unduplicated participants in the 1915c waiver program.	Y		COTS	4B.3.1.a.20
WA1.03.01	Track and report the number of unduplicated participants in the 1115 waiver program.	Y		COTS	4B.3.1.a.20
WA1.04	Identify the date a participant is assessed to meet the waiver LOC.	Y		COTS	4B.3.1.a.20
WA1.04.01	Identify the date a participant is assessed to meet the assessment criteria for Facility and Enhanced State Plan programs.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20

WA1.SS.03	Provide the ability to identify and extract services approved as exceptions to certain waiver programs or service plan.	Y		COTS	4B.3.1.a.20
WA1.SS.05	Provide the ability to accept real time adds, changes and deletes for Facility eligibility and Enhanced State Plan eligibility and services.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
WA2.01.01	Provide enrollment information, including NPI if required, on providers to external source.	Y		COTS	4B.3.1.a.20
WA2.02	Prevent enrollment of entities and individuals who do not meet the provider qualifications contained in the provider agreement.	Y		COTS	4B.3.1.a.20
WA2.03	Update information as changes are reported.	Y		COTS	4B.3.1.a.20
WA2.04	Capture termination information when a waiver, Facility and Enhanced State Plan provider voluntarily terminates or a provider agreement is cancelled.	Y		COTS	4B.3.1.a.20
WA2.05	Prohibit enrollment of providers affiliated with individuals debarred by state or federal agencies, listed in abuse registries or otherwise unqualified to provide service.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
WA4.01	Process claims for medical services.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
WA4.03	Prevent payments for members who have become ineligible for Medicaid.	Y		COTS	4B.3.1.a.20

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.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
WA4.06	Edit waiver, Facility and Enhanced State Plan services claims for prior authorization, if applicable.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20

WA4.08	Edit waiver, Facility and Enhanced State Plan services claims for member cost share of premium or enrollment fees prior to payment.	Y		COTS	4B.3.1.a.20
WA5.01	Gather data and produce a variety of financial reports to facilitate cost reporting and financial monitoring of waiver programs.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
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.	Y		COTS	4B.3.1.a.20
WA5.04.01	Collect and store data and produce reports in electronic format to support county billing process programs.	Y		COTS	4B.3.1.a.20

WA5.04.02	Collect and store data and produce reports in electronic format to assess waiver performance standards.	Y	[redacted]	COTS	4B.3.1.a.20
WA5.05	Monitor provider capacity and capabilities to provide waiver and Enhanced State Plan services to enrolled participants.	Y		COTS	4B.3.1.a.20
WA5.SS.01	Generate reports on the structure of the benefit plans to help IME set the benefit plan rules more efficiently.	Y		COTS	4B.3.1.a.20
WA5.SS.02	Provide, accept, maintain and process information with designated entities, as required by IME.	Y		COTS	4B.3.1.a.20

Requirement #		Agree to meet Y or N		SM or COTS	Reference to proposal section for proposed solution.
SCORING: 1 point for each Yes in column C ("Agree to meet") and 1 point for each Yes in column D ("Existing capability), .7 point for COTS in column E, and .4 point for System Mod. In column E.					
RE	**Rules Engine System Requirements**	**A**		**C**	**D**
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.	Y		COTS	4B.3.1.b
RE.SS1.02	Provide a rules engine sufficiently scalable to meet rules growth and processing demands.	Y		COTS	4B.3.1.b
RE.SS1.03	Provide role-based security to the rules.	Y		COTS	4B.3.1.b
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.	Y		COTS	4B.3.1.b

RE.SS1.05	Allow for rules to be rapidly implemented in a real-time enterprise environment.	Y	[redacted]	COTS	4B.3.1.b
RE.SS1.06	Support flexibility with respect to customization of the rules to support processing requirements throughout the IME.	Y		COTS	4B.3.1.b
RE.SS1.07	Support adaptability to easily accommodate timely changes in response to federal, legislative or administrative mandates.	Y		COTS	4B.3.1.b
RE.SS1.08	Provide capability for the user to view and model rules for system exceptions online and to trace exception rule dependencies.	Y		COTS	4B.3.1.b
RE.SS1.09	Provide a debugging process that automatically analyzes and identifies logical errors (i.e., conflict, redundancy and incompleteness) across business rules.	Y		COTS	4B.3.1.b
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.	Y		COTS	4B.3.1.b
RE.SS1.11	Produce documentation regarding all business rules in electronic format and make it accessible to the IME.	Y		COTS	4B.3.1.b
RE.SS1.12	Provide the capability to manage implementation timing.	Y		COTS	4B.3.1.b
RE.SS1.13	Allow for rules to be date specific, including date added, date modified, start date, end date and effective date.	Y		COTS	4B.3.1.b
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.	Y		COTS	4B.3.1.b

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.	Y	[redacted]	COTS	4B.3.1.b
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.	Y	[redacted]	COTS	4B.3.1.b
RE.SS1.17	Provide the capability to establish and link notes to rules to explain why the rule was modified, created or inactivated.	Y	[redacted]	COTS	4B.3.1.b
RE.SS1.18	Provide a rules search capability by keyword, data element or other criteria so that staff may search for existing rules.	Y	[redacted]	COTS	4B.3.1.b
AR	**General Architectural Requirements**	**A**	[redacted]	**C**	**D**
AR.SS.01	The contractor must provide an MMIS system that meets the requirements of the Iowa Medicaid Enterprise, meets all CMS certification requirements, and aligns with the MITA standards and meets all Iowa functional and business requirements specified in this RFP.	Y	[redacted]	COTS	4B.3.1.c
AR.SS.02	Must meet Iowa Enterprise Information Technology standards.	Y	[redacted]	COTS	4B.3.1.c
AR.SS.03	Must meet Iowa and federal standards concerning web accessibility.	Y	[redacted]	COTS	4B.3.1.c
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.	Y	[redacted]	COTS	4B.3.1.c

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).	Y	[redacted]	COTS	4B.3.1.c
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.	Y		COTS	4B.3.1.c
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.	Y		COTS	4B.3.1.c

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.	Y	[redacted]	COTS	4B.3.1.c
AR.SS.09	Provide system availability 24/7, other than for scheduled maintenance.	Y		COTS	4B.3.1.c
AR.SS.10	Maintain the most current vendor supported version of the product(s), with the IME's prior approval through the life of the contract at no additional cost to the IME.	Y		COTS	4B.3.1.c
AR.SS.11	Provide Enterprise Application Integration (EAI), to include web services technology and standards to promote Iowa Medicaid Enterprise applications integration.	Y		COTS	4B.3.1.c
AR.SS.12	Ensure full HIPAA compliance through the life of the contract at no additional cost to the IME.	Y		COTS	4B.3.1.c
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.	Y		COTS	4B.3.1.c
AR.SS.14	Align with the Seven Standards and Conditions, including MITA, through the life of the contract at no additional cost to the IME.	Y		COTS	4B.3.1.c
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.	Y		COTS	4B.3.1.c

AR.SS.16	Provide metadata management that is accessible by the IME staff. Provide context-sensitive help from all screens.	Y	[redacted]	COTS	4B.3.1.c
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.	Y		COTS	4B.3.1.c
AR.SS.18	Metadata reports must be able to be generated to for all data extracts T-MSISprovide information on what data is contained and how it was produced. The data item information should include code value tables where appropriate.	Y		COTS	4B.3.1.c
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.	Y		COTS	4B.3.1.c
AR.SS.20	Integrate the call center software and the MMIS system to assist call centers in quickly having the provider or member information readily at hand,	Y		COTS	4B.3.1.c

HP	HIPAA Transaction Requirements	A	[redacted]	C	D
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.	Y		COTS	4B.3.1.d
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.	Y		COTS	4B.3.1.d
HP.SS.03	Ensure that the system receives processes and returns the HIPAA mandated attributes that are utilized to enforce IME policy.	Y		COTS	4B.3.1.d
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.	Y		COTS	4B.3.1.d

HP.SS.05	Ensure that the system maintains data to support EDI transmission logs of all transactions (successful or failed).	Y	[redacted]	COTS	4B.3.1.d
HP.SS.06	The system must support eligibility verification through IVR, Provider Web Portal, or HIPAA 270/271 transactions. Must support use of the Healthy Rewards Debit card for electronic eligibility verification.	Y	[redacted]	COTS	4B.3.1.d
MT	**MITA Technical Requirements**	**A**	[redacted]	**C**	**D**
MT.SS.01	The contractor must propose, implement and operate an Iowa Medicaid Enterprise solution that meets the requirements of the RFP and meets the 7 Standards and Conditions of enhanced federal funding. This includes but is not limited to MITA 3.0 .	Y	[redacted]	COTS	4B.3.1.d
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.	Y	[redacted]	COTS	4B.3.1.d
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.	Y	[redacted]	COTS	4B.3.1.d
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.	Y	[redacted]	COTS	4B.3.1.d

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.	Y		COTS	4B.3.1.d
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.	Y		COTS	4B.3.1.d
MT.SS.07	Integrate Direct Secure between IME and providers through the Iowa Health Information Network.	Y		COTS	4B.3.1.d
SOA	**SOA Requirements**	**A**		**C**	**D**
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.iISCP.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.	Y		COTS	4B.3.1.e
SOA.02	Technology Independence: The service modules must be able to be invoked from multiple platforms and utilize standard protocols.	Y		COTS	4B.3.1.e

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. XDS.b or XCA to connect to Iowa Health Information Network.	Y	[redacted]	COTS	4B.3.1.e
SOA.04	Life-Cycle Independence: Each service module should be able to operate in a separate life-cycle.	Y		COTS	4B.3.1.e
SOA.05	Invoke Interfaces: The Service interfaces must be able to be invoked locally or remotely.	Y		COTS	4B.3.1.e
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.	Y		COTS	4B.3.1.e
SOA.07	Flexibility: The contractor must focus on the business processes that comprise the systems, with the following in mind:	Y		COTS	4B.3.1.e
	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.	Y	[redacted]	COTS	4B.3.1.e
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.	Y	[redacted]	COTS	4B.3.1.e

PL	Programming Language Requirements	A		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.iISCP.gov/wiki/.	Y		COTS	4B.3.1.e
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.	Y		COTS	4B.3.1.e
SP	**Security & Privacy Requirements**	**A**		**C**	**D**
SPSS.01	The system must use state of Iowa Enterprise Authentication and Authorization Service for authentication. Iowa has recently published an updated security standard. Please refer to the bidders library.	Y		COTS	4B.3.1.f
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.	Y		COTS	4B.3.1.f
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.	Y		COTS	4B.3.1.f
SPSS.04	Provide online screens for the maintenance of security management.	Y		COTS	4B.3.1.f
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.	Y		COTS	4B.3.1.f
SPSS.06	Allow authorized users access to all user history activity including logon approvals and disapprovals.	Y		COTS	4B.3.1.f

SPSS.07	Maintain an audit trail of all transactions where PHI is viewed. Provide reports that allow HIPAA review by member (who has seen their information), and by worker (who's information has the worker viewed).	Y		COTS	4B.3.1.f
SPSS.08	Ensure all test data is de-identified.	Y		COTS	4B.3.1.f
SL	**Software Licenses and Maintenance Requirements**	**A**		**C**	**D**
SLSS.01	The contractor must list all proprietary and COTS software, as defined by State Medicaid Manual (SMM), Part 11, in attachment G.	Y		COTS	4B.3.1.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.	Y		COTS	4B.3.1.g
SLSS.03	Prior approved upgrades, new releases and or version 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.	Y		COTS	4B.3.1.g
SLSS.04	Transfer of all software that supports the system.	Y		COTS	4B.3.1.g
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).	Y		COTS	4B.3.1.g
SLSS.06	The contractor will be responsible for operation of the system through CMS certification and life of the contract.	Y		COTS	4B.3.1.g

DQ	Data Quality Control Requirements	A		C	D
DQSS.01	The contractor must apply industry standards for professional principles of data management, data security, data integrity and data quality control.	Y		COTS	4B.3.1.h
DQSS.02	A modern relational database management system must be used.	Y		COTS	4B.3.1.h
DQSS.03	All tables must be properly normalized, de-normalized or dimensionalized for efficient operation.	Y		COTS	4B.3.1.h
DQSS.04	Relations between tables within databases must be properly set and controlled.	Y		COTS	4B.3.1.h
DQSS.05	Database integrity features (such as primary keys, foreign keys, unique constraints) must be used to enforce field and relationship requirements.	Y		COTS	4B.3.1.h
DQSS.06	Control must be in place to prevent duplicate or orphan records.	Y		COTS	4B.3.1.h
DQSS.07	Transactions must provide for error recovery (i.e., if the entire transaction does not process completely, the entire transaction is rolled back).	Y		COTS	4B.3.1.h
DQSS.08	Communication routine must use integrity checks to assure accuracy of a file before it is processed.	Y		COTS	4B.3.1.h
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.	Y		COTS	4B.3.1.h
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.	Y		COTS	4B.3.1.h

EV	Environment Requirements	A		C	D
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.	Y		COTS	4B.3.1.i
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.	Y		COTS	4B.3.1.i
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.	Y		COTS	4B.3.1.i

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 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.	Y	[redacted]	COTS	4B.3.1.i
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.	Y		COTS	4B.3.1.i

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.	Y	[redacted]	COTS	4B.3.1.i
	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.	Y		COTS	4B.3.1.i

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 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.	Y	[redacted]	COTS	4B.3.1.i
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.	Y		COTS	4B.3.1.i

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.	Y		COTS	4B.3.1.i
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.	Y		COTS	4B.3.1.i
WPI	**Web Portal Infrastructure Requirements**	**A**		**C**	**D**
WPISS1.01	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) 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™.	Y		COTS	4B.3.1.j
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.	Y		COTS	4B.3.1.j
WPISS1.04	Provide the capability to link the web portal to any other applications, as defined by IME.	Y		COTS	4B.3.1.j

WPISS1.05	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.	Y	[redacted]	COTS	4B.3.1.j
WPISS1.06	Allow IME to identify items for monitoring. Items may be automated operations on the web portal or manual actions.	Y		COTS	4B.3.1.j
WPISS1.07	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.	Y		COTS	4B.3.1.j
WPISS1.08	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.	Y		COTS	4B.3.1.j
WPISS1.09	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).	Y		COTS	4B.3.1.j
WPISS1.10	Provide the capability for an online tutorial functionality.	Y		COTS	4B.3.1.j
WPISS1.11	Provide capability for web portal information to be searchable by keywords.	Y		COTS	4B.3.1.j
WPISS1.12	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 questions.	Y		COTS	4B.3.1.j
WPISS1.13	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.	Y		COTS	4B.3.1.j
WPISS1.14	Comply with IME usability and content standards (i.e., style guide) and provide a layout that has user-configurable resolution, fonts and color choices.	Y		COTS	4B.3.1.j

WPISS1.15	Provide and display web content in multiple languages as directed by IME.	Y	[redacted]	COTS	4B.3.1.j
WPISS1.16	Provide basic general information about the Medicaid Program that would be of interest to potential providers and members and other collaborating agencies.	Y		COTS	4B.3.1.j
WPISS1.18	Provide audit trail and history of all transactions conducted on the web portal.	Y		COTS	4B.3.1.j
WPISS1.19	Provide ability for general public to report suspected fraud and abuse via web portal.	Y		COTS	4B.3.1.j
WPISS1.21	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.	Y		COTS	4B.3.1.j
WPISS1.22	Maintain archives of posted announcements and non-provider specific alerts, including the date and Message.	Y		COTS	4B.3.1.j
WPISS1.23	Maintain HIPAA compliance and support the access, privacy and security requirements.	Y		COTS	4B.3.1.j
WPISS1.24	Provide multiple level role-based securities as designated by IME.	Y		COTS	4B.3.1.j
WPISS1.25	Provide low bandwidth versions of IME-specified pages for easy access by providers with mobile, wireless web access.	Y		COTS	4B.3.1.j
WPISS1.26	Post Frequently Asked Questions (FAQs) online organized by topic or key word search and update periodically as determined by IME.	Y		COTS	4B.3.1.j
WPISS1.27	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.	Y		COTS	4B.3.1.j
WPISS1.29	Provide the functionality to display informational Messages in descending date order (most recent to oldest).	Y		COTS	4B.3.1.j

WPISS1.30	Allow users to view and print manuals, instructions, bulletins, program descriptions, eligibility criteria and forms for current and prior versions as directed by IME.	Y	[redacted]	COTS	4B.3.1.j
WPISS1.36	Support ability to utilize electronic and/or digital signatures in compliance with IME, state and federal policies.	Y		COTS	4B.3.1.j
WPISS1.39	Allow an administrative user account within the provider practice that can then activate, deactivate and assign varying levels of access to additional practice staff.	Y		COTS	4B.3.1.j
WPISS1.42	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.	Y		COTS	4B.3.1.j
WPISS1.43	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.	Y		COTS	4B.3.1.j
WPISS1.44	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.	Y		COTS	4B.3.1.j
WPISS1.45	Provide capability for outreach where providers, applicants, and members can provide feedback and assesssment of accessibility, ease of use, and accuracy.	Y		COTS	4B.3.1.j
WPISS1.45	Submit and manage web interactions to self-manage and monitor.	Y		COTS	4B.3.1.j

WPISS1.46	Section 508(c) compliance for all software and interfaces	Y		COTS	4B.3.1.j
WPISS1.60	Process and maintain inputs including, but not limited to: a. Updates to content. b. Alert information.	**Y**		COTS	4B.3.1.j
WPISS1.62	Provide support for online registration educational or informational seminars.	**Y**		COTS	4B.3.1.j
WPISS1.68	Provide search capability based on wild cards or any combination of fields. For web portals, provide site-wide search capabilities for all documents within the web portal.	**Y**		COTS	4B.3.1.j
WM	**Workflow Requirements**	**A**		**C**	**D**
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.	Y		COTS	4B.3.1.k
WMSS.02	Provide the ability to split or modify electronic documents for the purpose of indexing while maintaining the original document.	Y		COTS	4B.3.1.k
WMSS.03	Ensure that authorized workflow participants have direct access to perform all their designated roles within the workflow.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.05	Document and maintain definition and modeling of workflow processes and their constituent activities.	Y		COTS	4B.3.1.k
WMSS.06	Provide configurable work distribution rules, using configuration tables.	Y		COTS	4B.3.1.k
WMSS.07	Include a user-friendly graphical user interface GUI for process definition, execution, monitoring and management.	Y		COTS	4B.3.1.k

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.	Y	[redacted]	COTS	4B.3.1.k
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. 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.	Y		COTS	4B.3.1.k
WMSS.10	Provide integrated online workflow management capability to track all Iowa Medicaid Enterprise activities.	Y		COTS	4B.3.1.k

WMSS.11	Store data in a central repository.	Y	[redacted]	COTS	4B.3.1.k
WMSS.12	DHS proposes that the Kofax imaging solution be included in the proposal. Other solutions may be proposed, and will be considered if performance, cost or integration needs demand an alternative. The MMIS solution must include a high-speed imaging solution capable of imaging and automatically routing documents.	Y		COTS	4B.3.1.k
WMSS.13	Capable of simplex and duplex scanning on a user-defined basis, by document type.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
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).	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.17	Provide the capability to convert data contained in images into MMIS data through OCR.	Y		COTS	4B.3.1.k
WMSS.18	Provide the capability to automatically orient forms to landscape or portrait presentation.	Y		COTS	4B.3.1.k
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).	Y		COTS	4B.3.1.k

WMSS.20	Track the status of all activities from receipt through final disposition.	Y	[redacted]	COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.22	Link scanned images to workflow records to provide a view of all related material (e.g., images, letters, interactions and tracking number).	Y		COTS	4B.3.1.k
WMSS.23	Provide the ability to differentiate between forms and attachments and allow the attachment to be grouped with the form to create a single document with individually numbered pages.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.25	Provide the ability to access stored, system-generated member and provider notices, through the use of an index.	Y		COTS	4B.3.1.k
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).	Y		COTS	4B.3.1.k
WMSS.27	Provide for generation of an indicator to identify to whom the work should be distributed.	Y		COTS	4B.3.1.k
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).	Y		COTS	4B.3.1.k

WMSS.29	Provide the ability to recognize and automatically delete blank pages without storing them in the system.	Y	[redacted]	COTS	4B.3.1.k
WMSS.30	Send data from scanned, imaged and released documents to the MMIS in real-time.	Y		COTS	4B.3.1.k
WMSS.31	Provide the real time viewing of imaged documents and all pages within the document, by using a paging function.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.34	Provide the ability to auto set field characters to upper case, lower case or ignore case as defined by the user.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.36	Provide the capability to attach notes, annotations, emails and other documents, to an original scanned document at any time, without rescanning, by direct system access (users) and end users.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k

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).	Y	[redacted]	COTS	4B.3.1.k
WMSS.39	Maintain image retrieval response times at an average of fifteen seconds.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.41	Provide the capability to scan radiographs and diagnostic images.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.43	Allow the user to manually remove, rescan and replace a scanned image or document(s) from a previously scanned group of documents.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.46	Index fields on forms must be user-definable and recognize numeric, alphanumeric, date, currency and special characters as designated by IME.	Y		COTS	4B.3.1.k

WMSS.47	Provide the ability to validate data captured from specific fields on forms electronically read by industry standards, ICR, OMR and OCR.	Y	[redacted]	COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.49	Provide the capability to date-stamp all activity in the record and to identify the person who performed the activity.	Y		COTS	4B.3.1.k
WMSS.50	Provide ability to utilize user-defined templates that support various workflow processes.	Y		COTS	4B.3.1.k
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 requiring technical assistance. Functionality should include:	Y		COTS	4B.3.1.k
	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.	Y	[redacted]	COTS	4B.3.1.k
WMSS.53	Provide the capability to assign and re-assign records to an area, unit or individual.	Y		COTS	4B.3.1.k
WMSS.54	Workflow must be integrated with the imaging system and the electronic document management system. The system must provide the capability for workflow to be initiated as document images are created. The workflow system must have the capability to link to view images pertaining to the workflow.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.56	Provide the capability to prioritize records within type.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
WMSS.59	Support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.	Y		COTS	4B.3.1.k

WMSS.60	Provide workflow management reports to identify inventories of items in each stage of a process, new items and completed items.	Y	[redacted]	COTS	4B.3.1.k
WMSS.61	Provide the ability for a user to view all their workload.	Y		COTS	4B.3.1.k
WMSS.62	Provide the ability for a user to reserve a work item for their exclusive use.	Y		COTS	4B.3.1.k
WMSS.63	Provide the ability for a user to view all their reserved work items.	Y		COTS	4B.3.1.k
WMSS.64	Provide a Workflow Management Module that ensures data security.	Y		COTS	4B.3.1.k
WMSS.65	Provide reports that identify adherence to performance standards for each work flow.	Y		COTS	4B.3.1.k
WMSS.66	Provide supporting supervisory operations for the management of workflow, including, but not limited to:	Y		COTS	4B.3.1.k
	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.	Y		COTS	4B.3.1.k
WMSS.68	Provide a query capability for the workflow process management system database with appropriate security access.	Y		COTS	4B.3.1.k
ED	**Electronic Document Management System Requirements**	**A**		**C**	**D**
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. h. Retrieve images by member ID number.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
EDSS.03	Support drag-and-drop functionality to be used when creating or editing a document.	Y		COTS	4B.3.1.k
EDSS.04	Provide the ability to print or fax one or more selected images from image search.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
EDSS.06	Provide conversion of all documents to a format as defined by IME.	Y		COTS	4B.3.1.k
EDSS.07	Support cataloging and indexing of all imaged documents.	Y		COTS	4B.3.1.k

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.	Y		COTS	4B.3.1.k
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.	Y		COTS	4B.3.1.k
EDSS.10	Allow manual data entry from scanned documents if they cannot be read and transmit electronically from an image to IME Enterprise.	Y		COTS	4B.3.1.k
ED	**Automatic Letter Generation Requirements**	**A**		**C**	**D**
EDSS.11	Provide the capability to create letter templates and forms, including, but not limited to: 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.	Y		COTS	4B.3.1.l

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.	Y	[redacted]	COTS	4B.3.1.l
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.	Y		COTS	4B.3.1.l

EDSS.14	Provide a method of automatically generating letters to providers, members and other stakeholders. The automated letter generator must:	Y	[redacted]	COTS	4B.3.1.l
	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 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.	Y	[redacted]	COTS	4B.3.1.l
EDSS.16	Provide the ability to link a letter image to its appropriate data element (i.e., member, provider, claim, other).	Y		COTS	4B.3.1.l
EDSS.17	Provide the ability to print letter templates to networked, individual or high volume centralized production printers.	Y		COTS	4B.3.1.l
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.	Y		COTS	4B.3.1.l
OG	**OTHER GENERAL REQUIREMENTS**				
***** Items OG 2, OG3, OG14, OG15: "These are draft MECT requirements for the Seven Standards and Conditions that are subject to modifications from CMS."**					
OG-1	The system must utilize privacy and transaction standards	Y		COTS	4B.3.1.m
OG-2 ***	The system must comply with Affordable Care Act Section 1104 Andministrative Simplification, and Section 1561 Health IT Enrollment Standards and Protocols.	Y		COTS	4B.3.1.m
OG-3***	The system must comply with HIPAA .	Y		COTS	4B.3.1.m
OG-4	Section 508(c) compliance for all sofware and interfaces.	Y		COTS	4B.3.1.m
OG-5	Comply with all standards and protocols adopted by Secretary under section 1561 of the Affordable Care Act.	Y		COTS	4B.3.1.m
OG-6	Comply with all Federal Civil Rights Laws	Y		COTS	4B.3.1.m
OG-7	The system must be capable of supporting ICD-9, ICD-10 and all future code sets.	Y		COTS	4B.3.1.m
OG-8	The system must conform to ASC X12 Technical Reports Type 3 (TR3), Version 5010, and must maintain compliance with industry standards going forward.	Y		COTS	4B.3.1.m
OG-9	Use medical code set, for coding diseases, signs and symptoms, abnormal findings, and external causes of injuries/diseases, as stipulated in 45 CFR Part 162.1002	Y		COTS	4B.3.1.m

OG-10	The architecture must preserve the ability to efficiently, effectively and appropirately exchange data with other participants in the health and human services enterprise.	Y	[redacted]	COTS	4B.3.1.m
OG-12	Pursue a service-oriented strategy for systems development.	Y		COTS	4B.3.1.m
OG-13	The solution must minimizes, with justification, need for ground-up or customization solutions.	Y		COTS	4B.3.1.m
OG-14***	Demonstrate consideration of reuse, and promote sharing, leverage, and reuse of Medicaid technologies and systems.	Y		COTS	4B.3.1.m
OG-15***	Defined MMIS modules can be interchanged without major system design.	Y		COTS	4B.3.1.m
OG-16	Uses nationally standardized business rule definitions submitted to the HHS design repository	Y		COTS	4B.3.1.m
OG-17	MMIS modules are adequately defined.	Y		COTS	4B.3.1.m
OG-18	The solution produces transactional data, reports, and performance information that contribute to program evaluation, continuous improvement in business operations, transparency and accountability.	Y		COTS	4B.3.1.m

Current MMIS External Interfaces

Indicated below is a list of current external interfaces as **of May 1, 2013** 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 MMIS Resource Library and should be reviewed by the bidder for any updates.

Partner	Direction	Visio Ref	Source	Destination	Interface Name	Type	Server
3M							
	Out	1.02	3M	MMIS	DRG Grouper		
		1.01	3M	MMIS	APC Grouper		IME FTP COLD
ABC System							
	In	18.01	MMIS	ABC System	Medically NeedyTransmission File	Connect Direct	NDM-MMIS
		46.01	Part A&B BuyIn	ABC System	Medicare A&B Premium Info - Monthly	SM	
		48.03	Title XIX Eligibility	ABC System	Medicare Eligibility	SM	
			Title XIX Eligibility	ABC System	Iowa Care Autoclose file	SM	
			Part A&B Buy-In	ABC System	Medicare Transaction File	SM	
			Title XIX Eligibility	ABC System	IowaCare Auto-Close File	SM	
			Title XIX Eligibility	ABC System	Medicaid Provider File	SM	
			Title XIX Eligibility	ABC System	State Supp $1 Payments File	SM	
	Out	18.05	ABC System	Title XIX Eligibility	Member Medical Eligibility -Monthly	SM	
			ABC System	Title XIX Eligibility	LOG File - Approvals, Denials, and Pends	SM	
			ABC System	Title XIX Eligibility	MEPD Premium File	SM	
			ABC System	Title XIX Eligibility	IowaCare Premium File	SM	
			ABC System	Title XIX Eligibility	IowaCare Premium File	SM	
		18.06	ABC System	TXIX Eligibility	Facility & Waiver Eligibility	SM	
		18.04	ABC System	Title XIX Eligibility	Member Medical Eligibility -Daily	SM	
		18.03	ABC System	MMIS	Medically Needy Worker File	Connect Direct	NDM-Other
		18.02	ABC System	MMIS	Medically Needy Transmission File	Connect Direct	NDM-Other
			ABC System	TXIX Eligibility	Facility & Waiver Eligibility (Forms File)	SM	
Xerox / ACS							
	In	37.1	MMIS	ACS	Debit Card Process - Account Maintenance File	Connect Direct	
	Out	37.2	ACS	MMIS	Debit Card Process - Account Maintenance Status File	Connect Direct	
		37.3	ACS	MMIS	Debit Card Process - Account Maintenance Summary File	Connect Direct	
		37.4	ACS	MMIS	Debit Card Process - Account Maintenance Reject File	Connect Direct	
		37.5	ACS	MMIS	Debit Card Process - ACH Deposit Summary File	Connect Direct	
Advantis							
	In	17.09	MMIS	Advantis	Provider Extract File	Connect Direct	NDM-MMIS
		17.04	MMIS	Advantis	Paid Claims Extract File -Month End	Connect Direct	NDM-MMIS
		4.16	Check Write System	Advantis	Bank ReconciliationFile	Connect Direct	
		17.05	MMIS	Advantis	Eligibility Master File (also called "Recipient Master File")	Connect Direct	NDM-MMIS
		17.07	MMIS	Advantis	Carrier File Extract Data	Connect Direct	NDM-MMIS
	Out	17.11	Advantis	MMIS	Non-Pharmacy Claim Adjustments	Connect Direct	NDM-MMIS
	Out	17.04	Advantis	HMS	Paid Claims Extract File -Month End	Connect Direct	NDM-MMIS
		17.06	Advantis	MMIS	TPL Data Match Update File	Connect Direct	NDM-MMIS
		4.15	Advantis	Wells Fargo	Bank ReconciliationFile	Connect Direct	
AEA							

	In	51	Data Warehouse	AEA	Medicaid Recovery A/R	FTP	
		2.01	MMIS	AEA	Special Education Eligibility - IMS AEA Extract	Connect Direct	
APS							
	In		MMIS	APS	Eligibility Extract	FTP	
		64	Data Warehouse	APS	Claims Data	FTP	
		64.01	Data Warehouse	APS	Provider Data	FTP	
			MMIS	APS	HMO Encounter Data	FTP	IME FTP
BBA							
	Out	52	BBA	Data Warehouse	Medicaid Recovery A/R	FTP	
Bloodhound							
	In		MMIS	Bloodhound	Bloodhound Utilization & Maintenance File	SFTP	IME SFTP
			MMIS	Bloodhound	Bloodhound Claims Extract	SFTP	IME SFTP
	Out		Bloodhound	MMIS	Bloodhound Results File	SFTP	IME SFTP
BMGI							
	In		MMIS	BMGI	CDAC Union Payment File	SFTP	IME SFTP
BSCS							
	Out	53	BSCS	Data Warehouse	Medicaid Recovery A/R	FTP	
Check Write System							
	In	4.04	MMIS	Check Write System	Remittance Advice -Envelope File	Connect Direct	NDM-MMIS
		4.09	MMIS	Check Write System	Remittance Advice Mailing Summary Report	Connect Direct	NDM-MMIS
		4.08	MMIS	Check Write System	Remittance Advice Check Register File	Connect Direct	NDM-MMIS
		4.07	MMIS	Check Write System	Remittance Advice Box Labels File	Connect Direct	NDM-MMIS
		4.06	MMIS	Check Write System	Remittance Advice -Box File	Connect Direct	NDM-MMIS
		4.05	MMIS	Check Write System	Remittance Advice -Flat File	Connect Direct	NDM-MMIS
		4.13	MMIS	Check Write System	RCF Check Balance Report	Connect Direct	NDM-MMIS
		4.12	MMIS	Check Write System	RCF Mailing Summary Report	Connect Direct	NDM-MMIS
		4.11	MMIS	Check Write System	RCF Check Register	Connect Direct	NDM-MMIS
		4.1	MMIS	Check Write System	Remittance Advice Check Balance Report	Connect Direct	NDM-MMIS
		4.01	MMIS	Check Write System	RCF Letter File	Connect Direct	
		4.14	MMIS	Check Write System	Bank Reconciliation File	Connect Direct	NDM-MMIS
	Out	4.16	Check Write System	Advantis	Bank ReconciliationFile	Connect Direct	
		4.03	Check Write System	MMIS	Control File - Trigger File for Electronic RA Process	Connect Direct	
CMS							
	In	6.01	GHS	CMS	64.9R Report Data		
			Title XIX Eligibility	CMS	MMA - Medicare Part D	Connect Direct	
		46	Part A&B BuyIn	CMS	Medicare A&B Enrollment File	Connect Direct	
		7.07	Title XIX Eligibility	CMS	Medicare Enrollment Finder File (EDB)	Connect Direct	
		7.04	Title XIX Eligibility	CMS	MMA - Medicare Part D	Connect Direct	
		6.06	MMIS	CMS	Inpatient Encounter Data - Quarterly	SFTP	IME FTP Server
		6.07	MMIS	CMS	Other Encounter Data - Quarterly	FTP	IME FTP Server
	Out		CMS	Mathematica	Results		
			CMS	Title XIX Eligibility	MMA Part D Response File	Connect Direct	
			CMS	Title XIX Eligibility	MMA - Medicare Part D	Connect Direct	
		7.06	CMS	Title XIX Eligibility	Member Medicare Enrollment (EDB)	Connect Direct	
		7.05	CMS	Title XIX Eligibility	MMA - Medicare Part D		
		6.02	CMS	GHS	Quarterly Drug Rebate Data		
			CMS	Title XIX Eligibility	MMA Part D Response File	Connect Direct	
		40	CMS	Part A&B Buy-In	Medicare A&B Response Billing File	Connect Direct	

COLD/DIP Server							
	In	5.8	MMIS	COLD/DIP Server	IowaCare Remittance Advice Files	FTP	IME FTP COLD
			IMPA	COLD/DIP Server	EHR Application DIP	Web Service	
		5.07	MMIS	COLD/DIP Server	County Billing Files	FTP	IME FTP COLD
		5.6	MMIS	COLD/DIP Server	IDPH License Files	FTP	IME FTP COLD
			MMIS	COLD/DIP Server	Remittance Advice Files	FTP	IME FTP COLD
		29.02	MMIS	COLD/DIP Server	MMIS Report Files	FTP	IME FTP COLD Server
		23.04	MMIS	COLD/DIP Server	Provider Extract	FTP	IME FTP COLD Server
	Out	5.9	COLD/DIP Server	MMIS	IowaCare Extract Files	FTP	Manual
Core Scan Station							
	Out		Core Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
			Core Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
County Billing System							
	In	8.01	MMIS	County Billing System	Combined County Bill -Accounts Receivable File	Connect Direct	NDM-MMIS
Dakota Imaging System							
	Out	9.01	Dakota Imaging System	MMIS	Claim Data Upload - InstXover	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - NEWDental	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - Dental	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - PTAOUT	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - UB92	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - UB04	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - PTAXIN	FTP	DHSIMEMR1
	Out	9.01	Dakota Imaging System	MMIS	Claim Data Upload - PTBX	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - New1500	FTP	DHSIMEMR1
			Dakota Imaging System	OnBase	RTP Claim	DIP	DHSIMEOBCDP
		9.02	Dakota Imaging System	OnBase	Image Transfer	FTP	IME DI
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - 1500	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - ProfXover	FTP	DHSIMEMR1
Data Warehouse							
	In		Title XIX Eligibility	Data Warehouse	IowaCare Billing System Extract File	FTP	
		50.03	Program Integrity	Data Warehouse	Medicaid Recovery A/R	FTP	
			MMIS	Data Warehouse	NDC List Upload to Website	FTP	IME FTP
			MMIS	Data Warehouse	Update for Fee Schedule	FTP	IME FTP
			MMIS	Data Warehouse	Monthly Claim Audit File	Connect Direct	
			OnBase	Data Warehouse	Remit Process	UNC	
			OnBase	Data Warehouse	CHK_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	Data Warehouse	MEM_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	Data Warehouse	PRV_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	Data Warehouse	WV_MEM_ContactLog_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
		59.03	Maximus	Data Warehouse	Hawki Survey	FTP	
			MMIS	Data Warehouse	Mass Adjustment Processor	FTP	IME FTP
		62	Revenue Collections	Data Warehouse	Medicaid Recovery A/R	FTP	
			Title XIX Eligibility	Data Warehouse	Medicaid Eligibility File	FTP	
			MMIS	Data Warehouse	Weekly Quality data for PART A & PART B	Connect Direct	
			MMIS	Data Warehouse	Incarceration Data	FTP	IME FTP
			OnBase	Data Warehouse	WV_PRV_ContactLog_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
		12.04	MMIS	Data Warehouse	Prior Approval Extract	Connect Direct	NDM-MMIS
		12.01	MMIS	Data Warehouse	HMO Encounter Data	FTP	IME FTP

		12.14	MMIS	Data Warehouse	Procedure, Diagnosis & Drug	Connect Direct	NDM-MMIS
		3.28	MMIS	Data Warehouse	Family Planning Terminated Pregnancy File	FTP	IME FTP
		12.03	MMIS	Data Warehouse	Provider Extract	Connect Direct	NDM-MMIS
		59.02	Maximus	Data Warehouse	Hawki Perm Data	FTP	
		12.05	MMIS	Data Warehouse	MMIS Eligibility Extract	Connect Direct	NDM-MMIS
		12.06	MMIS	Data Warehouse	Full Adjudicated Claims Records Info	Connect Direct	NDM-MMIS
		20.13	IDPH	Data Warehouse	Vital Statistics (Post Launch)		
		33.09	MMIS	Data Warehouse	Month-End Claims Extract for DHS	Connect Direct	NDM-MMIS
		52	BBA	Data Warehouse	Medicaid Recovery A/R	FTP	
		53	BSCS	Data Warehouse	Medicaid Recovery A/R	FTP	
		55	Delta Dental	Data Warehouse	Hawki Encounters	FTP	
		57	HCBS	Data Warehouse	Medicaid Recovery A/R	FTP	
	In	58	IDPH	Data Warehouse	Date of Death File	SM	
		59	Maximus	Data Warehouse	Hawki Daily Decision File	FTP	
		35.03	MEDISPAN	Data Warehouse	Medispan Drug file	FTP	
		12.02	MMIS	Data Warehouse	APC Grouper Tapes		
		59.01	Maximus	Data Warehouse	Hawki Enrollments	FTP	
	Out		Data Warehouse	OnBase	CC_Load_Prov_Remit_Addr	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_DW_Claims_BackLoad	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_DW_Claims_Extract	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Inactivity_Latest_Billing - Refresh	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Inactivity_Latest_PayTo - Refresh	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Inactivity_Latest_Rendering - Refresh	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	WV_Provider_List (DW12)	SQL	DHSIMEOBDBP
			Data Warehouse	OnBase	CC_Inactivity_Provider_Eligible - Refresh	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Load_Prov_Corres_Addr	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	Clean_Claims_Paid (DW12)	SQL	DHSIMEOBCDP
		51	Data Warehouse	IFMC	Hawki Encounters	FTP	
		64	Data Warehouse	United Healthcare	Hawki Encounters	FTP	
			Data Warehouse	OnBase	CC_Load_Prov_Check_Addr	SQL	DHSIMEOBCDP
		50.01	Data Warehouse	Program Integrity (Ingenix)	Provider Data	FTP	
		51.02	Data Warehouse	IFMC	Hawki Survey Data	FTP	
		63	Data Warehouse	Wellmark	Hawki Encounters	FTP	
		41	Data Warehouse	TXIX Eligibility	Iowa Dept. of Publc Health - Death Dates	FTP	
		50.02	Data Warehouse	Program Integrity (Ingenix)	Claims Data	FTP	
		51.01	Data Warehouse	IFMC	Hawki Enrollments	FTP	
		51	Data Warehouse	AEA	Medicaid Recovery A/R	FTP	
		64	Data Warehouse	APS	Claims Data	FTP	
		64.01	Data Warehouse	APS	Provider Data	FTP	
		54.02	Data Warehouse	Title XIX Eligibility	Date of Death File	FTP	
		60	Data Warehouse	MCFU	Medicaid Recovery A/R	FTP	
		61	Data Warehouse	PCA	Medicaid Recovery A/R	FTP	
		30.15	Data Warehouse	Pharmacy POS	Recipient Eligibility		
Delta Dental							
	Out	55	Delta Dental	Data Warehouse	Hawki Encounters	FTP	
DIA Audits							
	Out	56	DIA AUDITS	Data Warehouse	Medicaid Recovery A/R	FTP	
Drug Rebate Management							

	In	11.01	Pharmacy Data Warehouse	Drug Rebate Management	Rebate Claims		
	In	11.02	Pharmacy Data Warehouse	Drug Rebate Management	Drug Rebate Labeler Data		
ELVIS							
	Out		ELVIS	OnBase	Load Records: CC_WV_Member_Load	SQL	DHSIMEOBCDP
			ELVIS	OnBase	CC_ELVIS_Transactions	SQL	DHSIMEOBCDP
			ELVIS	OnBase	Load Records: CC_WV_Member_Elig_Load	SQL	DHSIMEOBCDP
FACS							
	Out		FACS	Title XIX Eligibility	Foster Care Worker Info for Members	SM	
GHS							
	In	6.02	CMS	GHS	Quarterly Drug Rebate Data		
			MMIS	GHS	Part D File	SFTP	IME SFTP
			Title XIX Eligibility	GHS	Medicare Part D Enrollment File (Via MMIS)	Connect Direct	
			Title XIX Eligibility	GHS	Medicare Part D Enrollment File (Via MMIS)	Connect Direct	
			MMIS	GHS	Lock In File	SFTP	
	Out	6.01	GHS	CMS	64.9R Report Data		
			GHS	MMIS	NDC Rebate File	SFTP	IME SFTP
HCBS							
	Out	57	HCBS	Data Warehouse	Medicaid Recovery A/R	FTP	
HIPP							
	In	15.01	MMIS	HIPP	Paid Claims Extract	Connect Direct	NDM-MMIS
			Title XIX Eligibility	HIPP	TXIX Eligibility	SM	
			Title XIX Eligibility	HIPP	TXIX Eligibility	SM	
	Out	15.02	HIPP	MMIS	HIPP Claims (MARS Reporting)	Connect Direct	NDM-Other
		15.03	HIPP	MMIS	Title XIX Eligible File for HIPP Cost Effectiveness Process	Connect Direct	NDM-Other
		15.04	HIPP	MMIS	HIPP Resource File	Connect Direct	NDM-MMIS
HMO (Magellan)							
	Out	16.06	HMO (Magellan)	MMIS	Inpatient Encounter data	SFTP	IME SFTP
		16.07	HMO (Magellan)	MMIS	Other Encounter data	SFTP	IME SFTP
HMS							
	In	17.04	Advantis	HMS	Paid Claims Extract File -Month End	Connect Direct	NDM-MMIS
		20.12	IDPH	HMS	Vital Statistics		
	Out		HMS	MMIS	Revenue Collections History Requests	FTP	IME FTP
			HMS	MMIS	TPL Data Match Update File (TPL)	Connect Direct	
			HMS	MMIS	TPL Data Match Update File (HIPP)	Connect Direct	
		17.1	HMS	Pharmacy Data Warehouse	Pharmacy Claim Adjustments		
			HMS	MMIS	TPL Data Match Update File (Absent Parent)	Connect Direct	
ICAR							
	In	19.01	MMIS	ICAR	Child Support TPL Extract	Connect Direct	NDM-MMIS
	Out	19.02	ICAR	MMIS	ICAR TPL Update	Connect Direct	NDM-MMIS
IDPH							
	In	20.03	MMIS	IDPH	EPSDT Informing Extract	Connect Direct	NDM-MMIS
			Title XIX Eligibility	IDPH	TXIX Eligibility Extract (Children)	SM	
			Title XIX Eligibility	IDPH	TXIX Eligibility Extract (Children)	SM	
		20.09	MMIS	IDPH	Encounter, Yearly Birth Data	SFTP	IME SFTP
		20.08	MMIS	IDPH	Claims, Yearly Birth Data	SFTP	IME SFTP
		20.04	MMIS	IDPH	EPSDT Screening Informing Extract	Connect Direct	NDM-MMIS
		20.02	Title XIX Eligibility	IDPH	TXIX Child Eligibility-Monthly	SM	
		20.01	Title XIX Eligibility	IDPH	TXIX Child Eligibility-Daily	SM	

		20.05	MMIS	IDPH	EPSDT Claims Extract	Connect Direct	NDM-MMIS
	Out	58	IDPH	Data Warehouse	Date of Death File	SM	
		20.13	IDPH	Data Warehouse	Vital Statistics (Post Launch)		
		20.12	IDPH	HMS	Vital Statistics		
			IDPH	MMIS	Date of Death File	FTP	
IMCARS							
	Out	22.01	IMCARS	MMIS	Provider Charge Information	FTP	Manual
		22.02	IMCARS	MMIS	Provider DRG & APG Data	FTP	Manual
		22.03	IMCARS	MMIS	Provider, Procedure Type & Procedure Code Charges	FTP	Manual
		22.04	IMCARS	MMIS	DRG Code Weights	FTP	Manual
		22.05	IMCARS	MMIS	APG Code Weights	FTP	Manual
IME Server							
	In	36.02	MMIS	IME Server	Provider Address File	FTP	IME FTP
IMPA							
	In		MMIS	IMPA	IAMC8010-R001 - IowaCare Remittance Advice Files	FTP	IME FTP
			OnBase	IMPA	ReEnrollment Status Transfer	Web Service	
			OnBase	IMPA	Web Service Call (Push)	Web Service	
			MMIS	IMPA	AEA, LEA, and I & T Files	FTP	
		48.02	Title XIX Eligibility	IMPA	Presumptive Elig Update (Child, & Pregnant)	FTP	
			Title XIX Eligibility	IMPA	Presumptive Eligibility Updates	FTP	
	Out		IMPA	OnBase	IMPA Upload of Documents	DIP	
			IMPA	OnBase	ReEnrollment Index File (E-forms)	Web Service	
			IMPA	OnBase	Web Service Call (Pull)	Web Service	
			IMPA	COLD/DIP Server	EHR Application DIP	Web Service	
		42	IMPA	TXIX Eligibility	Presumptive Eligibility - Web	FTP	
			IMPA	Title XIX Eligibility	Presumptive Eligibility	FTP	
IRS							
	In	24.01	MMIS	IRS	Provider 1099 Tapes	IRS Web Portal	Web Portal
		24.02	MMIS	IRS	Corrected 1099s	FTP	Web Portal
		24.03	MMIS	IRS	1099 Verification File	FTP	Web Portal
		24.04	MMIS	IRS	1099 Correction File	FTP	IME FTP
ISIS							
	In		Title XIX Eligibility	ISIS	Provider Master File	FTP	
			Title XIX Eligibility	ISIS	Prior Auth Services	FTP	
			Title XIX Eligibility	ISIS	Facility/Waiver Eligibility Program Requests	FTP	
		48.05	Title XIX Eligibility	ISIS	Nursing Home Terminations	FTP	
			Title XIX Eligibility	ISIS	Fac/Waiv/GD/Term/Death Date Activity File	FTP	
	Out		ISIS	Title XIX Eligibility	Program Request Eligibility File	FTP	
		44.02	ISIS	TXIX Eligibility	Targeted Case Mgmt Enhanced Services	FTP	
			ISIS	Title XIX Eligibility	Client Participation (CP) Changes	FTP	
			ISIS	Title XIX Eligibility	Deleted Prior Auth Services	FTP	
			ISIS	Title XIX Eligibility	Prior Auth Services	FTP	
			ISIS	MMIS	CCO Reconciliation Files	FTP	
			ISIS	Title XIX Eligibility	County of Legal Settlement File	FTP	
			ISIS	TXIX Eligibility	Facility Information for Medicare Part-D	FTP	
		44.03	ISIS	TXIX Eligibility	Money Follows Person File	FTP	
		25.02	ISIS	TXIX Eligibility	Facility Waiver Member Eligibility Chgs	FTP	
		25.01	ISIS	Title XIX Eligibility	Waiver Services Prior Auths	FTP	

		44.04	ISIS	TXIX Eligibility	PACE Eligibility File	FTP	
Mathematica							
	In	26.01	MMIS	Mathematica	MSIS RX Claims File	FTP	IME FTP Server
		26.02	MMIS	Mathematica	MSIS Inpatient Claims Extract	FTP	IME FTP Server
		26.03	MMIS	Mathematica	MSIS LTC Claims Extract	FTP	IME FTP Server
		26.04	MMIS	Mathematica	MSIS Other Claims Extract	FTP	IME FTP Server
		26.05	MMIS	Mathematica	MSIS Recipient Extract	FTP	IME FTP Server
			CMS	Mathematica	Results		
Maximus							
	In	33.32	Title XIX Eligibility	Maximus	TXIX Elig & Referral daily - hawk-i (4 files)	FTP	
			Title XIX Eligibility	Maximus	TXIX Eligibility (Children)	FTP	
			Title XIX Eligibility	Maximus	TXIX Eligibility (Children)	FTP	
	Out	54.03	Maximus	Title XIX Eligibility	Hawk-I Decision File	FTP	
		59	Maximus	Data Warehouse	Hawki Daily Decision File	FTP	
		59.01	Maximus	Data Warehouse	Hawki Enrollments	FTP	
		59.02	Maximus	Data Warehouse	Hawki Perm Data	FTP	
	Out	59.03	Maximus	Data Warehouse	Hawki Survey	FTP	
McKesson							
	In		MMIS	McKesson	McKesson Provider Extract	SFTP	IME SFTP
			MMIS	McKesson	McKesson Practice Extract	SFTP	IME SFTP
			MMIS	McKesson	McKesson Member Extract	SFTP	IME SFTP
	Out		McKesson	MMIS	McKesson - HiTech Radiology	SFTP	IME SFTP
Medical Scan Station							
	Out		Medical Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
			Medical Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
MEDISPAN							
	Out	35.03	MEDISPAN	Data Warehouse	Medispan Drug file	FTP	
		35.01	MEDISPAN	Pharmacy POS	DTMS Pro-DUR		
		35.02	MEDISPAN	Pharmacy Data Warehouse	MEDISPAN Drug File		
MMIS							
	In		Noridian	MMIS	NEMT Encounter File	Connect Direct	
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - InstXover	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - ProfXover	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - PTBX	FTP	DHSIMEMR1
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - New1500	FTP	DHSIMEMR1
		37.5	ACS	MMIS	Debit Card Process - ACH Deposit Summary File	Connect Direct	
			HMS	MMIS	TPL Data Match Update File (TPL)	Connect Direct	
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - UB92	FTP	DHSIMEMR1
			HMS	MMIS	TPL Data Match Update File (HIPP)	Connect Direct	
			HMS	MMIS	TPL Data Match Update File (Absent Parent)	Connect Direct	
			Title XIX Eligibility	MMIS	Milliman (Rate Setting)	Connect Direct	NDM-MMIS
		22.06	SAM Updates	MMIS	APC Code Weights - Manual	FTP	
		22.02	SAM Updates	MMIS	APG Code Weights - Manual	FTP	
			SAM Updates	MMIS	DRG Code Weights - Manual	FTP	
			SAM Updates	MMIS	Provider, Procedure Type & Procedure Code Charges - Manual	FTP	
			SAM Updates	MMIS	Provider DRG & APG Data - Manual	FTP	
		9.01	Dakota Imaging System	MMIS	Claim Data Upload - UB04	FTP	DHSIMEMR1
		4.03	Check Write System	MMIS	Control File - Trigger File for Electronic RA Process	Connect Direct	

		ISIS	MMIS	CCO Reconciliation Files	FTP	
	37.4	ACS	MMIS	Debit Card Process - Account Maintenance Reject File	Connect Direct	
	37.3	ACS	MMIS	Debit Card Process - Account Maintenance Summary File	Connect Direct	
	37.2	ACS	MMIS	Debit Card Process - Account Maintenance Status File	Connect Direct	
		OCRA	MMIS	ID Cards Print File	SFTP	IME SFTP
In		SAM Updates	MMIS	Provider Charge Information - Manual	FTP	
		Title XIX Eligibility	MMIS	MHC Enrollment/Disenrollment	Connect Direct	
		Bloodhound	MMIS	Bloodhound Results File	SFTP	IME SFTP
		EDISS	MMIS	837 Institutional Claims - Meridian	Connect Direct	
				837 Institutional Claims - Meridian		
		EDISS	MMIS	837 Professional Claims - Meridian	Connect Direct	
				837 Institutional Claims - Meridian		
		ITE-PIPP	MMIS	PIPP Payment Request Adjudication	FTP	
		ITE-PIPP	MMIS	PIPP Payment Request	FTP	
		IDPH	MMIS	Date of Death File	FTP	
		OnBase	MMIS	TPL Lead File	FTP	IME FTP COLD
		Title XIX Eligibility	MMIS	Medicare Part D Enrollment File	Connect Direct	
		Title XIX Eligibility	MMIS	Date of Death State-ID Not Found	Connect Direct	
		Title XIX Eligibility	MMIS	FACS Information for IowaCare	Connect Direct	
		Title XIX Eligibility	MMIS	Add, Change, Delete, Prior Auth Services	Connect Direct	
		Title XIX Eligibility	MMIS	MHC Enrollment/Disenrollment	Connect Direct	
	9.01	Dakota Imaging System	MMIS	Claim Data Upload - PTAXIN	FTP	DHSIMEMR1
		Title XIX Eligibility	MMIS	Facility CP Change Report	Connect Direct	
	17.11	Advantis	MMIS	Non-Pharmacy Claim Adjustments	Connect Direct	NDM-MMIS
		Title XIX Eligibility	MMIS	60 Occ Facility-Waiver Program Req. Elig.	Connect Direct	
		Title XIX Eligibility	MMIS	Deleted Prior Auth Service Records	Connect Direct	
		Title XIX Eligibility	MMIS	Medicaid Member Eligibility Extract File	Connect Direct	
		Title XIX Eligibility	MMIS	Medicaid Member Eligibility Extract File	Connect Direct	
		GHS	MMIS	NDC Rebate File	SFTP	IME SFTP
	9.01	Dakota Imaging System	MMIS	Claim Data Upload - NEWDental	FTP	DHSIMEMR1
	9.01	Dakota Imaging System	MMIS	Claim Data Upload - Dental	FTP	DHSIMEMR1
	9.01	Dakota Imaging System	MMIS	Claim Data Upload - PTAOUT	FTP	DHSIMEMR1
		Title XIX Eligibility	MMIS	FACS Information for IowaCare	Connect Direct	
	15.04	HIPP	MMIS	HIPP Resource File	Connect Direct	NDM-MMIS
	30.01	Pharmacy Data Warehouse	MMIS	Drug Reference File	SFTP	IME SFTP
	22.05	IMCARS	MMIS	APG Code Weights	FTP	Manual
	22.04	IMCARS	MMIS	DRG Code Weights	FTP	Manual
	30.02	Pharmacy Data Warehouse	MMIS	POS Claims & Adjustments	SFTP	IME SFTP
	22.02	IMCARS	MMIS	Provider DRG & APG Data	FTP	Manual
	18.02	ABC System	MMIS	Medically Needy Transmission File	Connect Direct	NDM-Other
	19.02	ICAR	MMIS	ICAR TPL Update	Connect Direct	NDM-MMIS
	18.03	ABC System	MMIS	Medically Needy Worker File	Connect Direct	NDM-Other
	17.06	Advantis	MMIS	TPL Data Match Update File	Connect Direct	NDM-MMIS
	33.13	Title XIX Eligibility	MMIS	Client Services Report	Connect Direct	NDM-Other
	16.06	HMO (Magellan)	MMIS	Inpatient Encounter data	SFTP	IME SFTP
In	22.03	IMCARS	MMIS	Provider, Procedure Type & Procedure Code Charges	FTP	Manual
	15.03	HIPP	MMIS	Title XIX Eligible File for HIPP Cost Effectiveness Process	Connect Direct	NDM-Other
	15.02	HIPP	MMIS	HIPP Claims (MARS Reporting)	Connect Direct	NDM-Other

	13.09	Noridian-EDISS	MMIS	Medicare Part B Crossover Claims	Connect Direct	NDM-Other
	13.08	Noridian-EDISS	MMIS	Medicare Part A Crossover Claims	Connect Direct	NDM-Other
	13.04	Noridian-EDISS	MMIS	278 Prior Authorization Request Transactions	FTP	Noridian FTP
	13.03	Noridian-EDISS	MMIS	837 Institutional Claims	Connect Direct	NDM-Other
	13.02	Noridian-EDISS	MMIS	837 Dental Claims	Connect Direct	NDM-Other
	13.01	Noridian-EDISS	MMIS	837 Professional Claims	Connect Direct	NDM-Other
	1.02	3M	MMIS	DRG Grouper		
	1.01	3M	MMIS	APC Grouper		IME FTP COLD
	16.07	HMO (Magellan)	MMIS	Other Encounter data	SFTP	IME SFTP
	5.9	COLD/DIP Server	MMIS	IowaCare Extract Files	FTP	Manual
		McKesson	MMIS	McKesson - HiTech Radiology	SFTP	IME SFTP
		Title XIX Eligibility	MMIS	County Billing Adjustment File	FTP	IME FTP
		HMS	MMIS	Revenue Collections History Requests	FTP	IME FTP
		OCRA	MMIS	OCRA - Annual - From Member Services	FTP	IME FTP
	22.01	IMCARS	MMIS	Provider Charge Information	FTP	Manual
		First Data Bank	MMIS	MMIS PDD Drug Record Update from FDB	FTP	IME FTP
	33.14	Title XIX Eligibility	MMIS	ISIS Daily Waiver Services File	Connect Direct	NDM-Other
	48.16	Title XIX Eligibility	MMIS	Waiver Services Prior Auths	Connect Direct	IME FTP COLD
	48.14	Title XIX Eligibility	MMIS	Presumptive Elig (Child, Preg, BCCT)	Connect Direct	
	48.13	Title XIX Eligibility	MMIS	Nursing Home Client Participation Chgs	Connect Direct	
	48.12	Title XIX Eligibility	MMIS	Medicare Eligibility	Connect Direct	
	33.18	Title XIX Eligibility	MMIS	Month End Facilities File	Connect Direct	NDM-Other
		OCRA	MMIS	OCRA - Annual - Family Planning	FTP	IME FTP
	48.11	Title XIX Eligibility	MMIS	Managed Health Care - Daily Referral	Connect Direct	
	33.17	Title XIX Eligibility	MMIS	Delinquent Provider List	FTP	IME FTP
	33.15	Title XIX Eligibility	MMIS	MHC Transaction File -Daily	Connect Direct	NDM-Other
	33.19	Title XIX Eligibility	MMIS	Month End Waiver File	Connect Direct	NDM-Other
	33.2	Title XIX Eligibility	MMIS	TXIX Eligibility File -Daily	Connect Direct	NDM-Other
	33.21	Title XIX Eligibility	MMIS	TXIX Eligibility File -Monthly	Connect Direct	NDM-Other
	33.34	Title XIX Eligibility	MMIS	HIPP Insurance Carrier Extract Records-ISIS	Connect Direct	
	9.01	Dakota Imaging System	MMIS	Claim Data Upload - 1500	FTP	DHSIMEMR1
	48.09	Title XIX Eligibility	MMIS	Iowa Dept. of Publc Health - Death Dates	Connect Direct	
	48.1	Title XIX Eligibility	MMIS	Managed Healt Care - Monthly Referral	Connect Direct	
	33.16	Title XIX Eligibility	MMIS	MHC Transaction File -Monthly	Connect Direct	NDM-Other
Out	12.05	MMIS	Data Warehouse	MMIS Eligibility Extract	Connect Direct	NDM-MMIS
Out	13.07	MMIS	Noridian-EDISS	820 Payment Processed Transactions	FTP	Noridian FTP
	13.06	MMIS	Noridian-EDISS	835 Remittance Advice Transaction	FTP	Noridian FTP
	13.05	MMIS	Noridian-EDISS	278 Prior Authorization Response Transactions	FTP	Noridian FTP
	12.06	MMIS	Data Warehouse	Full Adjudicated Claims Records Info	Connect Direct	NDM-MMIS
	12.04	MMIS	Data Warehouse	Prior Approval Extract	Connect Direct	NDM-MMIS
	12.03	MMIS	Data Warehouse	Provider Extract	Connect Direct	NDM-MMIS
	12.02	MMIS	Data Warehouse	APC Grouper Tapes		
	12.14	MMIS	Data Warehouse	Procedure, Diagnosis & Drug	Connect Direct	NDM-MMIS
	17.05	MMIS	Advantis	Eligibility Master File (also called "Recipient Master File")	Connect Direct	NDM-MMIS
	12.01	MMIS	Data Warehouse	HMO Encounter Data	FTP	IME FTP
		MMIS	Magellan - EDI	4010A1 834 Benefit Enrollment FACS File	FTP	Noridian FTP
		MMIS	BMGI	CDAC Union Payment File	SFTP	IME SFTP
	30.2	MMIS	Pharmacy Data Warehouse	Medical Claims File	SFTP	IME SFTP

		MMIS	Bloodhound	Bloodhound Claims Extract	SFTP	IME SFTP
		MMIS	McKesson	McKesson Provider Extract	SFTP	IME SFTP
		MMIS	McKesson	McKesson Member Extract	SFTP	IME SFTP
	8.01	MMIS	County Billing System	Combined County Bill -Accounts Receivable File	Connect Direct	NDM-MMIS
		MMIS	Title XIX Eligibility	Medipass Provider List	SFTP	IME SFTP
		MMIS	Title XIX Eligibility	MFP - Services	FTP	IME FTP
	2.01	MMIS	AEA	Special Education Eligibility - IMS AEA Extract	Connect Direct	
	37.1	MMIS	ACS	Debit Card Process - Account Maintenance File	Connect Direct	
		MMIS	Magellan - EDI	4010A1 834 Benefit Enrollment FACS File	FTP	
		MMIS	TMS	NEMT Provider Extract	SFTP	
		MMIS	Data Warehouse	Monthly Claim Audit File	Connect Direct	
	24.04	MMIS	IRS	1099 Correction File	FTP	IME FTP
		MMIS	GHS	Part D File	SFTP	IME SFTP
	5.8	MMIS	COLD/DIP Server	IowaCare Remittance Advice Files	FTP	IME FTP COLD
	38	MMIS	Wells Fargo	ACH Deposit File	SFTP	
		MMIS	TMS	NEMT Broker/Member Extract	SFTP	
	45	MMIS	Title XIX Eligibility	HIPP - TPL	Connect Direct	
	45.01	MMIS	Title XIX Eligibility	Managed Health Care - Assignment	Connect Direct	
	45.02	MMIS	TXIX Eligibility	Nursing Home Terminations	Connect Direct	
		MMIS	COLD/DIP Server	Remittance Advice Files	FTP	IME FTP COLD
		MMIS	Title XIX Eligibility	MFP - Participants	FTP	IME FTP
	5.07	MMIS	COLD/DIP Server	County Billing Files	FTP	IME FTP COLD
		MMIS	Title XIX Eligibility	MFP - Finders	FTP	IME FTP
		MMIS	OnBase	Provider Address File	FTP	IME FTP
		MMIS	OCRA	OCRA - Feedback	FTP	IME FTP
Out		MMIS	Data Warehouse	NDC List Upload to Website	FTP	IME FTP
	3.28	MMIS	Data Warehouse	Family Planning Terminated Pregnancy File	FTP	IME FTP
		MMIS	Data Warehouse	Update for Fee Schedule	FTP	IME FTP
		MMIS	APS	HMO Encounter Data	FTP	IME FTP
	5.6	MMIS	COLD/DIP Server	IDPH License Files	FTP	IME FTP COLD
		MMIS	OnBase (For PCA)	Provider File	FTP	
	28.02	MMIS	Milliman	Rate Setting		
		MMIS	Magellan	Eligibility Extract	FTP	
		MMIS	Magellan	Provider Extract	FTP	
		MMIS	Magellan	Claim Extract	FTP	
		MMIS	Data Warehouse	Weekly Quality data for PART A & PART B	Connect Direct	
		MMIS	DAS - Print Center	Referring Provider Letters	FTP	
		MMIS	OnBase	Security List Extract	FTP	
		MMIS	GHS	Lock In File	SFTP	
		MMIS	ITE - Meridian	Provider Master File	SFTP	
		MMIS	OnBase (For PCA)	Member Eligibility files	FTP	
		MMIS	OnBase (For PCA)	Claim Files (All Types)	FTP	
		MMIS	OnBase (For PCA)	APG File	FTP	
		MMIS	Data Warehouse	Incarceration Data	FTP	IME FTP
		MMIS	IMPA	IAMC8010-R001 - IowaCare Remittance Advice Files	FTP	IME FTP
	17.04	MMIS	Advantis	Paid Claims Extract File -Month End	Connect Direct	NDM-MMIS
		MMIS	Magellan - ITE	Client Participation (CP) File	SFTP	
		MMIS	IMPA	AEA, LEA, and I & T Files	FTP	

		MMIS	Bloodhound	Bloodhound Utilization & Maintenance File	SFTP	IME SFTP
		MMIS	Title XIX Eligibility	Managed Health Care Member Assignment	Connect Direct	
		MMIS	Title XIX Eligibility	Third Party Liability	Connect Direct	
		MMIS	Title XIX Eligibility	Third Party Liability	Connect Direct	
		MMIS	Title XIX Eligibility	Coordination of Benefits	Connect Direct	
		MMIS	Title XIX Eligibility	Coordination of Benefits	Connect Direct	
		MMIS	APS	Eligibility Extract	FTP	
		MMIS	Noridian	835 Remittance File	FTP	
		MMIS	Data Warehouse	Mass Adjustment Processor	FTP	IME FTP
		MMIS	EDISS	278 Prior Authorization Response Transactions (Future)	Connect Direct	
		MMIS	ITE-PIPP	PIPP Payment Response	FTP	
		MMIS	EDISS - Meridian	5010 834 Benefit Enrollments	FTP	
		MMIS	EDISS - Meridian	5010 820 Electronic Remittance	FTP	
		MMIS	EDISS - Meridian	RX Enrollment Audit File	FTP	
		MMIS	EDISS - Meridian	5010 837 Encounter File	FTP	
Out		MMIS	Title XIX Eligibility	HIPP - TPL	Connect Direct	
	31.01	MMIS	RBA	Title XIX Monthly Report -Monthly		
	33.02	MMIS	Title XIX Eligibility	Managed Health Care ABC Transmission	Connect Direct	NDM-MMIS
	26.05	MMIS	Mathematica	MSIS Recipient Extract	FTP	IME FTP Server
	28.01	MMIS	Milliman	Actuarial Encounter Data	SFTP	IME SFTP
	29.02	MMIS	COLD/DIP Server	MMIS Report Files	FTP	IME FTP COLD Server
	30.03	MMIS	Pharmacy Data Warehouse	Adjustment Claims for Medically Needy	SFTP	IME SFTP
	30.04	MMIS	Pharmacy Data Warehouse	Recipient Eligibility	SFTP	IME SFTP
	26.03	MMIS	Mathematica	MSIS LTC Claims Extract	FTP	IME FTP Server
	30.07	MMIS	Pharmacy Data Warehouse	MMIS Providers File	SFTP	IME SFTP
	26.02	MMIS	Mathematica	MSIS Inpatient Claims Extract	FTP	IME FTP Server
	31.02	MMIS	RBA	Title XIX Monthly Report -YTD		
	31.04	MMIS	RBA	Title XIX Report of Expenditure -Services		
	31.05	MMIS	RBA	Title XIX Report of Expenditure -Eligibility		
	31.08	MMIS	RBA	ICF/MR Vendor Payment by County	OnBase COLD	
	33.01	MMIS	Title XIX Eligibility	Provider Master File	Connect Direct	NDM-MMIS
	33.1	MMIS	Title XIX Eligibility	Procedure, Drug & Diagnosis File Extract	Connect Direct	NDM-MMIS
	30.05	MMIS	Pharmacy Data Warehouse	Pharmacy Claims Paid	SFTP	IME SFTP
	20.08	MMIS	IDPH	Claims, Yearly Birth Data	SFTP	IME SFTP
	15.01	MMIS	HIPP	Paid Claims Extract	Connect Direct	NDM-MMIS
	17.07	MMIS	Advantis	Carrier File Extract Data	Connect Direct	NDM-MMIS
	17.09	MMIS	Advantis	Provider Extract File	Connect Direct	NDM-MMIS
	18.01	MMIS	ABC System	Medically NeedyTransmission File	Connect Direct	NDM-MMIS
	19.01	MMIS	ICAR	Child Support TPL Extract	Connect Direct	NDM-MMIS
	20.03	MMIS	IDPH	EPSDT Informing Extract	Connect Direct	NDM-MMIS
	26.04	MMIS	Mathematica	MSIS Other Claims Extract	FTP	IME FTP Server
	20.05	MMIS	IDPH	EPSDT Claims Extract	Connect Direct	NDM-MMIS
	24.02	MMIS	IRS	Corrected 1099s	FTP	Web Portal
	20.09	MMIS	IDPH	Encounter, Yearly Birth Data	SFTP	IME SFTP
		MMIS	McKesson	McKesson Practice Extract	SFTP	IME SFTP
	24.01	MMIS	IRS	Provider 1099 Tapes	IRS Web Portal	Web Portal
	6.07	MMIS	CMS	Other Encounter Data - Quarterly	FTP	IME FTP Server
	24.03	MMIS	IRS	1099 Verification File	FTP	Web Portal

		26.01	MMIS	Mathematica	MSIS RX Claims File	FTP	IME FTP Server
		20.04	MMIS	IDPH	EPSDT Screening Informing Extract	Connect Direct	NDM-MMIS
		4.05	MMIS	Check Write System	Remittance Advice -Flat File	Connect Direct	NDM-MMIS
		34.08	MMIS	University of Iowa	Provider Master File -Public Policy	FTP	UOI FTP Server
		34.09	MMIS	University of Iowa	Quarterly Recipient Eligibility -TCM	FTP	UOI FTP Server
	Out	36.02	MMIS	IME Server	Provider Address File	FTP	IME FTP
		4.01	MMIS	Check Write System	RCF Letter File	Connect Direct	
		4.1	MMIS	Check Write System	Remittance Advice Check Balance Report	Connect Direct	NDM-MMIS
		4.11	MMIS	Check Write System	RCF Check Register	Connect Direct	NDM-MMIS
		34.07	MMIS	University of Iowa	Provider Master File -Case Mgmt	FTP	UOI FTP Server
		4.14	MMIS	Check Write System	Bank Reconciliation File	Connect Direct	NDM-MMIS
		4.13	MMIS	Check Write System	RCF Check Balance Report	Connect Direct	NDM-MMIS
		4.06	MMIS	Check Write System	Remittance Advice -Box File	Connect Direct	NDM-MMIS
		4.07	MMIS	Check Write System	Remittance Advice Box Labels File	Connect Direct	NDM-MMIS
		4.08	MMIS	Check Write System	Remittance Advice Check Register File	Connect Direct	NDM-MMIS
		4.09	MMIS	Check Write System	Remittance Advice Mailing Summary Report	Connect Direct	NDM-MMIS
		33.03	MMIS	Title XIX Eligibility	Nursing Home Discharges Transmission	Connect Direct	NDM-Other
		23.04	MMIS	COLD/DIP Server	Provider Extract	FTP	IME FTP COLD Server
		4.12	MMIS	Check Write System	RCF Mailing Summary Report	Connect Direct	NDM-MMIS
		33.05	MMIS	Title XIX Eligibility	Coordination of Benefits -Monthly Full Master File	Connect Direct	NDM-MMIS
		33.06	MMIS	Title XIX Eligibility	TXIX TPL Extract Transmit File -Daily	Connect Direct	NDM-MMIS
		33.07	MMIS	Title XIX Eligibility	TXIX TPL Full Master Transmit File -Monthly	Connect Direct	
		33.08	MMIS	Title XIX Eligibility	Paid Claims File Extract for DHS	Connect Direct	NDM-MMIS
		33.09	MMIS	Data Warehouse	Month-End Claims Extract for DHS	Connect Direct	NDM-MMIS
		34.01	MMIS	University of Iowa	Pharmacy Claims Extract -Case Mgmt	FTP	UOI FTP Server
		34.06	MMIS	University of Iowa	Institutional Claims Extract -Public Policy	FTP	UOI FTP Server
		34.1	MMIS	University of Iowa	Quarterly Recipient Eligibility -Public Policy	FTP	UOI FTP Server
		34.11	MMIS	University of Iowa	Quarterly Encounter Data	FTP	UOI FTP Server
		34.02	MMIS	University of Iowa	Pharmacy Claims Extract -Public Policy	FTP	UOI FTP Server
		6.06	MMIS	CMS	Inpatient Encounter Data - Quarterly	SFTP	IME FTP Server
		34.03	MMIS	University of Iowa	Medical Claims Extract -Case Mgmt	FTP	UOI FTP Server
		33.04	MMIS	Title XIX Eligibility	Coordination of Benefits -Daily Change File	Connect Direct	NDM-MMIS
		34.04	MMIS	University of Iowa	Medical Claims Extract, Public Policy	FTP	UOI FTP Server
		34.05	MMIS	University of Iowa	Institutional Claims Extract -Case Mgmt	FTP	UOI FTP Server
		4.04	MMIS	Check Write System	Remittance Advice -Envelope File	Connect Direct	NDM-MMIS
Noridian							
	In		MMIS	Noridian	835 Remittance File	FTP	
	Out		Noridian	MMIS	NEMT Encounter File	Connect Direct	
OCRA							
	In		MMIS	OCRA	OCRA - Feedback	FTP	IME FTP
	Out		OCRA	MMIS	OCRA - Annual - From Member Services	FTP	IME FTP
			OCRA	MMIS	ID Cards Print File	SFTP	IME SFTP
	Out		OCRA	MMIS	OCRA - Annual - Family Planning	FTP	IME FTP
OnBase							
	In		Solimar VIA HIPS Mainframe	OnBase	HIPS PDF Notice Transfer	OnBase Sweep	
			ELVIS	OnBase	CC_ELVIS_Transactions	SQL	DHSIMEOBCDP
			ELVIS	OnBase	Load Records: CC_WV_Member_Elig_Load	SQL	DHSIMEOBCDP
			ELVIS	OnBase	Load Records: CC_WV_Member_Load	SQL	DHSIMEOBCDP
			IMPA	OnBase	IMPA Upload of Documents	DIP	

			Medical Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
			Medical Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
			HIPS Mainframe	OnBase	HIPS COLD Report Transfer	OnBase Import	
			IMPA	OnBase	Web Service Call (Pull)	Web Service	
			IMPA	OnBase	ReEnrollment Index File (E-forms)	Web Service	
			MMIS	OnBase	Security List Extract	FTP	
			ITE-PIPP	OnBase	PIPP Upload	DIP	
			Core Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
			Rightfax	OnBase	Rightfax Connector Tool	OnBase Import	
			Data Warehouse	OnBase	CC_DW_Claims_BackLoad	SQL	DHSIMEOBCDP
			MMIS	OnBase	Provider Address File	FTP	IME FTP
			Dakota Imaging System	OnBase	RTP Claim	DIP	DHSIMEOBCDP
			Core Scan Station	OnBase	OnBase Correspondence Scanning	Scan	
			Data Warehouse	OnBase	CC_DW_Claims_Extract	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Inactivity_Latest_Billing - Refresh	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Inactivity_Latest_PayTo - Refresh	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Inactivity_Provider_Eligible - Refresh	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Load_Prov_Check_Addr	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Load_Prov_Corres_Addr	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	CC_Load_Prov_Remit_Addr	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	Clean_Claims_Paid (DW12)	SQL	DHSIMEOBCDP
			Data Warehouse	OnBase	WV_Provider_List (DW12)	SQL	DHSIMEOBDBP
			Data Warehouse	OnBase	CC_Inactivity_Latest_Rendering - Refresh	SQL	DHSIMEOBCDP
		9.02	Dakota Imaging System	OnBase	Image Transfer	FTP	IME DI
	Out		OnBase	IMPA	Web Service Call (Push)	Web Service	
			OnBase	Email To User	IAMC7520-R001	Email	DHSIMEOBCDP
			OnBase	Email To User	IAMM2200-R001	Email	DHSIMEOBCDP
			OnBase	Email To User	IAMR7600-R001	Email	DHSIMEOBCDP
			OnBase	Email To User	IAMS6900-R001	Email	DHSIMEOBCDP
			OnBase	Email To User	IAMT9900-R002	Email	DHSIMEOBCDP
			OnBase	Email To User	Weekly Payment Reports	Email	
	Out		OnBase	Email To User	IAMC6500-R019	Email	DHSIMEOBCDP
			OnBase	MMIS	TPL Lead File	FTP	IME FTP COLD
			OnBase	Email To User	IAMC8502-R001	Email	DHSIMEOBCDP
			OnBase	Data Warehouse	MEM_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	Email To User	IAMB9010-R001	Email	DHSIMEOBCDP
			OnBase	IMPA	ReEnrollment Status Transfer	Web Service	
			OnBase	Data Warehouse	CHK_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	Data Warehouse	PRV_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	Data Warehouse	WV_MEM_ContactLog_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	Data Warehouse	WV_PRV_ContactLog_TB_Transfer (DW14)	SQL	DHSIMEOBCDP
			OnBase	DAS - Print Center	RTP Letter Printing	FTP	
			OnBase	DAS - Print Center	TPL Trauma & Lead Letter Printing	FTP	
			OnBase	Email To User	B-1 Reporting	Email	DHSIMEOBCDP
			OnBase	Email To User	IAMB9000-R001	Email	DHSIMEOBCDP
			OnBase	Data Warehouse	Remit Process	UNC	
PADSS							
	In	30.1	Pharmacy Data Warehouse	PADSS	POS Claims		
		30.11	Pharmacy Data Warehouse	PADSS	Drug File		
		30.08	Pharmacy Data Warehouse	PADSS	Providers File		

		30.09	Pharmacy Data Warehouse	PADSS	Recipient Eligibility		
	Out	30.14	PADSS	Pharmacy Data Warehouse	Process Reporting Data		
		30.16	PADSS	Pharmacy POS	Approved PA Requests		
Part A&B Buy-In							
	In	40	CMS	Part A&B Buy-In	Medicare A&B Response Billing File	Connect Direct	
			Title XIX Eligibility	Part A&B Buy-In	Medicaid Eligibility Extract	SM	
	Out		Part A&B Buy-In	Title XIX Eligibility	Medicare Transaction File	SM	
			Part A&B Buy-In	IME Member Services	Medicare A & B Reports		
			Part A&B Buy-In	ABC System	Medicare Transaction File	SM	
Pharmacy Data Warehouse							
	In	30.05	MMIS	Pharmacy Data Warehouse	Pharmacy Claims Paid	SFTP	IME SFTP
		30.2	MMIS	Pharmacy Data Warehouse	Medical Claims File	SFTP	IME SFTP
		30.07	MMIS	Pharmacy Data Warehouse	MMIS Providers File	SFTP	IME SFTP
		30.04	MMIS	Pharmacy Data Warehouse	Recipient Eligibility	SFTP	IME SFTP
		30.03	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		
		17.1	HMS	Pharmacy Data Warehouse	Pharmacy Claim Adjustments		
	In	35.02	MEDISPAN	Pharmacy Data Warehouse	MEDISPAN Drug File		
	Out	30.19	Pharmacy Data Warehouse	Pharmacy POS	Physician Lock-ins		
		30.22	Pharmacy Data Warehouse	Pharmacy POS	Pharmacy Lock-Ins		
		30.02	Pharmacy Data Warehouse	MMIS	POS Claims & Adjustments	SFTP	IME SFTP
		30.09	Pharmacy Data Warehouse	PADSS	Recipient Eligibility		
		30.08	Pharmacy Data Warehouse	PADSS	Providers File		
		30.23	Pharmacy Data Warehouse	Pharmacy POS	Adjustment Claims -MN		
		30.21	Pharmacy Data Warehouse	Pharmacy POS	Pharmacies File		
		30.13	Pharmacy Data Warehouse	Pharmacy POS	Full Medispan Drug File		
		11.01	Pharmacy Data Warehouse	Drug Rebate Management	Rebate Claims		
		30.11	Pharmacy Data Warehouse	PADSS	Drug File		
		30.24	Pharmacy Data Warehouse	Pharmacy POS	SMAC Rates File		
		30.1	Pharmacy Data Warehouse	PADSS	POS Claims		
		30.01	Pharmacy Data Warehouse	MMIS	Drug Reference File	SFTP	IME SFTP
		11.02	Pharmacy Data Warehouse	Drug Rebate Management	Drug Rebate Labeler Data		
		30.18	Pharmacy Data Warehouse	Pharmacy POS	Other Providers (Prescribers) FileResults		
Program Integrity							
	Out	50.03	Program Integrity	Data Warehouse	Medicaid Recovery A/R	FTP	
RBA							
	In	31.01	MMIS	RBA	Title XIX Monthly Report -Monthly		
		31.08	MMIS	RBA	ICF/MR Vendor Payment by County	OnBase COLD	
		31.05	MMIS	RBA	Title XIX Report of Expenditure -Eligibility		
		31.02	MMIS	RBA	Title XIX Monthly Report -YTD		
		31.04	MMIS	RBA	Title XIX Report of Expenditure -Services		
Rightfax							
	In		Iowa Medicaid Members	Rightfax	Member Incoming Faxes	Fax	
			Iowa Medicaid Providers	Rightfax	Provider Incoming Faxes	Fax	
	Out		Rightfax	OnBase	Rightfax Connector Tool	OnBase Import	
			Rightfax	Iowa Medicaid Members	Member Outbound Faxes	Fax	
			Rightfax	Iowa Medicaid Providers	Provider Outbound Faxes	Fax	
SAM Updates							
	Out		SAM Updates	MMIS	DRG Code Weights - Manual	FTP	

		22.02	SAM Updates	MMIS	APG Code Weights - Manual	FTP	
			SAM Updates	MMIS	Provider DRG & APG Data - Manual	FTP	
			SAM Updates	MMIS	Provider Charge Information - Manual	FTP	
			SAM Updates	MMIS	Provider, Procedure Type & Procedure Code Charges - Manual	FTP	
		22.06	SAM Updates	MMIS	APC Code Weights - Manual	FTP	
Title XIX Eligibility							
	In		MMIS	Title XIX Eligibility	HIPP - TPL	Connect Direct	
			MMIS	Title XIX Eligibility	Medipass Provider List	SFTP	IME SFTP
			CMS	Title XIX Eligibility	MMA - Medicare Part D	Connect Direct	
			ABC System	Title XIX Eligibility	IowaCare Premium File	SM	
			ABC System	Title XIX Eligibility	IowaCare Premium File	SM	
			ABC System	Title XIX Eligibility	MEPD Premium File	SM	
			ABC System	Title XIX Eligibility	LOG File - Approvals, Denials, and Pends	SM	
			CMS	Title XIX Eligibility	MMA Part D Response File	Connect Direct	
			CMS	Title XIX Eligibility	MMA Part D Response File	Connect Direct	
			MMIS	Title XIX Eligibility	Managed Health Care Member Assignment	Connect Direct	
			MMIS	Title XIX Eligibility	Third Party Liability	Connect Direct	
			MMIS	Title XIX Eligibility	Coordination of Benefits	Connect Direct	
			FACS	Title XIX Eligibility	Foster Care Worker Info for Members	SM	
			MMIS	Title XIX Eligibility	Coordination of Benefits	Connect Direct	
			ISIS	Title XIX Eligibility	County of Legal Settlement File	FTP	
			ISIS	Title XIX Eligibility	Program Request Eligibility File	FTP	
			ISIS	Title XIX Eligibility	Prior Auth Services	FTP	
			ISIS	Title XIX Eligibility	Deleted Prior Auth Services	FTP	
			ISIS	Title XIX Eligibility	Client Participation (CP) Changes	FTP	
			MMIS	Title XIX Eligibility	MFP - Participants	FTP	IME FTP
			MMIS	Title XIX Eligibility	Third Party Liability	Connect Direct	
		25.01	ISIS	Title XIX Eligibility	Waiver Services Prior Auths	FTP	
			MMIS	Title XIX Eligibility	MFP - Finders	FTP	IME FTP
			IMPA	Title XIX Eligibility	Presumptive Eligibility	FTP	
		18.05	ABC System	Title XIX Eligibility	Member Medical Eligibility -Monthly	SM	
		33.01	MMIS	Title XIX Eligibility	Provider Master File	Connect Direct	NDM-MMIS
		33.1	MMIS	Title XIX Eligibility	Procedure, Drug & Diagnosis File Extract	Connect Direct	NDM-MMIS
		33.02	MMIS	Title XIX Eligibility	Managed Health Care ABC Transmission	Connect Direct	NDM-MMIS
		33.03	MMIS	Title XIX Eligibility	Nursing Home Discharges Transmission	Connect Direct	NDM-Other
		33.04	MMIS	Title XIX Eligibility	Coordination of Benefits -Daily Change File	Connect Direct	NDM-MMIS
		33.05	MMIS	Title XIX Eligibility	Coordination of Benefits -Monthly Full Master File	Connect Direct	NDM-MMIS
		33.06	MMIS	Title XIX Eligibility	TXIX TPL Extract Transmit File -Daily	Connect Direct	NDM-MMIS
		54.02	Data Warehouse	Title XIX Eligibility	Date of Death File	FTP	
		18.04	ABC System	Title XIX Eligibility	Member Medical Eligibility -Daily	SM	
		33.07	MMIS	Title XIX Eligibility	TXIX TPL Full Master Transmit File -Monthly	Connect Direct	
		54.03	Maximus	Title XIX Eligibility	Hawk-I Decision File	FTP	
			MMIS	Title XIX Eligibility	MFP - Services	FTP	IME FTP
	In		Part A&B Buy-In	Title XIX Eligibility	Medicare Transaction File	SM	
		45.01	MMIS	Title XIX Eligibility	Managed Health Care - Assignment	Connect Direct	
		45	MMIS	Title XIX Eligibility	HIPP - TPL	Connect Direct	
		7.06	CMS	Title XIX Eligibility	Member Medicare Enrollment (EDB)	Connect Direct	
		7.05	CMS	Title XIX Eligibility	MMA - Medicare Part D		
		7.03	COBA Contractor	Title XIX Eligibility	Medicare Crossover Eligibility- Response	FTP	
		33.08	MMIS	Title XIX Eligibility	Paid Claims File Extract for DHS	Connect Direct	NDM-MMIS

Out	Title XIX Eligibility	Iowa Medicaid Members	MEPD Billing Statements	Mail		
	Title XIX Eligibility	COBA Contractor	Medicare Crossover-Dual Eligibles File	Connect Direct		
	Title XIX Eligibility	Iowa Medicaid Members	IowaCare Billing Statements	Mail		
	Title XIX Eligibility	Iowa Medicaid Members	IowaCare Billing Statements	Mail		
	Title XIX Eligibility	Iowa Medicaid Members	Certificate of Creditable Coverage	Mail		
	Title XIX Eligibility	Iowa Medicaid Members	IowaCare Eligibility ID Cards	Mail		
	Title XIX Eligibility	Iowa Medicaid Members	IowaCare Eligibility ID Cards	Mail		
	Title XIX Eligibility	Iowa Medicaid Members	MEPD Billing Statements	Mail		
	Title XIX Eligibility	GHS	Medicare Part D Enrollment File (Via MMIS)	Connect Direct		
	Title XIX Eligibility	GHS	Medicare Part D Enrollment File (Via MMIS)	Connect Direct		
	Title XIX Eligibility	MMIS	Medicare Part D Enrollment File	Connect Direct		
	Title XIX Eligibility	MMIS	Medicare Part D Enrollment File	Connect Direct		
		MMIS				
	Title XIX Eligibility	MMIS	FACS Information for IowaCare	Connect Direct		
	Title XIX Eligibility	MMIS	FACS Information for IowaCare	Connect Direct		
	Title XIX Eligibility	ABC System	IowaCare Auto-Close File	SM		
	Title XIX Eligibility	Data Warehouse	Medicaid Eligibility File	FTP		
	Title XIX Eligibility	MMIS	Date of Death State-ID Not Found	Connect Direct		
	Title XIX Eligibility	MMIS	MHC Enrollment/Disenrollment	Connect Direct		
	Title XIX Eligibility	Facility Providers	Nursing Home Cards	Mail		
	Title XIX Eligibility	ISIS	Prior Auth Services	FTP		
	Title XIX Eligibility	ISIS	Fac/Waiv/GD/Term/Death Date Activity File	FTP		
	Title XIX Eligibility	ISIS	Facility/Waiver Eligibility Program Requests	FTP		
	Title XIX Eligibility	ISIS	Provider Master File	FTP		
	Title XIX Eligibility	Maximus	TXIX Eligibility (Children)	FTP		
	Title XIX Eligibility	Maximus	TXIX Eligibility (Children)	FTP		
	Title XIX Eligibility	IMPA	Presumptive Eligibility Updates	FTP		
	Title XIX Eligibility	Data Warehouse	IowaCare Billing System Extract File	FTP		
	Title XIX Eligibility	ABC System	Medicaid Provider File	SM		
	Title XIX Eligibility	Milliman	TXIX Eligibility (Via MMIS)	Connect Direct		
	Title XIX Eligibility	HIPP	TXIX Eligibility	SM		
	Title XIX Eligibility	HIPP	TXIX Eligibility	SM		
Out	Title XIX Eligibility	IDPH	TXIX Eligibility Extract (Children)	SM		
	Title XIX Eligibility	IDPH	TXIX Eligibility Extract (Children)	SM		
	Title XIX Eligibility	IM Workers	WIFS Messages (Emails)	Email		
	Title XIX Eligibility	IM Workers	WIFS Messages (Emails)	Email		
	Title XIX Eligibility	ABC System	State Supp $1 Payments File	SM		
	Title XIX Eligibility	MMIS	Deleted Prior Auth Service Records	Connect Direct		
33.18	Title XIX Eligibility	MMIS	Month End Facilities File	Connect Direct	NDM-Other	
48.02	Title XIX Eligibility	IMPA	Presumptive Elig Update (Child, & Pregnant)	FTP		
7.07	Title XIX Eligibility	CMS	Medicare Enrollment Finder File (EDB)	Connect Direct		
7.04	Title XIX Eligibility	CMS	MMA - Medicare Part D	Connect Direct		
33.34	Title XIX Eligibility	MMIS	HIPP Insurance Carrier Extract Records-ISIS	Connect Direct		
33.32	Title XIX Eligibility	Maximus	TXIX Elig & Referral daily - hawk-i (4 files)	FTP		
33.21	Title XIX Eligibility	MMIS	TXIX Eligibility File -Monthly	Connect Direct	NDM-Other	
48.03	Title XIX Eligibility	ABC System	Medicare Eligibility	SM		
	Title XIX Eligibility	MMIS	MHC Enrollment/Disenrollment	Connect Direct		
33.19	Title XIX Eligibility	MMIS	Month End Waiver File	Connect Direct	NDM-Other	
	Title XIX Eligibility	MMIS	Facility CP Change Report	Connect Direct		
33.16	Title XIX Eligibility	MMIS	MHC Transaction File -Monthly	Connect Direct	NDM-Other	

		33.15	Title XIX Eligibility	MMIS	MHC Transaction File -Daily	Connect Direct	NDM-Other
		33.14	Title XIX Eligibility	MMIS	ISIS Daily Waiver Services File	Connect Direct	NDM-Other
		33.13	Title XIX Eligibility	MMIS	Client Services Report	Connect Direct	NDM-Other
		20.02	Title XIX Eligibility	IDPH	TXIX Child Eligibility-Monthly	SM	
		20.01	Title XIX Eligibility	IDPH	TXIX Child Eligibility-Daily	SM	
		33.2	Title XIX Eligibility	MMIS	TXIX Eligibility File -Daily	Connect Direct	NDM-Other
			Title XIX Eligibility	ABC System	Iowa Care Autoclose file	SM	
		48.05	Title XIX Eligibility	ISIS	Nursing Home Terminations	FTP	
			Title XIX Eligibility	MMIS	60 Occ Facility-Waiver Program Req. Elig.	Connect Direct	
			Title XIX Eligibility	MMIS	Add, Change, Delete, Prior Auth Services	Connect Direct	
			Title XIX Eligibility	MMIS	Medicaid Member Eligibility Extract File	Connect Direct	
			Title XIX Eligibility	MMIS	Medicaid Member Eligibility Extract File	Connect Direct	
			Title XIX Eligibility	CMS	MMA - Medicare Part D	Connect Direct	
			Title XIX Eligibility	Part A&B Buy-In	Medicaid Eligibility Extract	SM	
		33.17	Title XIX Eligibility	MMIS	Delinquent Provider List	FTP	IME FTP
			Title XIX Eligibility	MMIS	County Billing Adjustment File	FTP	IME FTP
		48.16	Title XIX Eligibility	MMIS	Waiver Services Prior Auths	Connect Direct	IME FTP COLD
		48.14	Title XIX Eligibility	MMIS	Presumptive Elig (Child, Preg, BCCT)	Connect Direct	
		48.13	Title XIX Eligibility	MMIS	Nursing Home Client Participation Chgs	Connect Direct	
		48.12	Title XIX Eligibility	MMIS	Medicare Eligibility	Connect Direct	
	Out	48.11	Title XIX Eligibility	MMIS	Managed Health Care - Daily Referral	Connect Direct	
		48.1	Title XIX Eligibility	MMIS	Managed Healt Care - Monthly Referral	Connect Direct	
		48.09	Title XIX Eligibility	MMIS	Iowa Dept. of Publc Health - Death Dates	Connect Direct	
			Title XIX Eligibility	MMIS	Milliman (Rate Setting)	Connect Direct	NDM-MMIS
TMS							
	In		MMIS	TMS	NEMT Broker/Member Extract	SFTP	
			MMIS	TMS	NEMT Provider Extract	SFTP	
	Out		TMS	Noridian-EDISS	NEMT Encounter File	Manual	
United HealthCare							
	In	64	Data Warehouse	United Healthcare	Hawki Encounters	FTP	
University of Iowa							
	In	34.04	MMIS	University of Iowa	Medical Claims Extract, Public Policy	FTP	UOI FTP Server
		34.09	MMIS	University of Iowa	Quarterly Recipient Eligibility -TCM	FTP	UOI FTP Server
		34.08	MMIS	University of Iowa	Provider Master File -Public Policy	FTP	UOI FTP Server
		34.07	MMIS	University of Iowa	Provider Master File -Case Mgmt	FTP	UOI FTP Server
		34.05	MMIS	University of Iowa	Institutional Claims Extract -Case Mgmt	FTP	UOI FTP Server
		34.03	MMIS	University of Iowa	Medical Claims Extract -Case Mgmt	FTP	UOI FTP Server
		34.02	MMIS	University of Iowa	Pharmacy Claims Extract -Public Policy	FTP	UOI FTP Server
		34.11	MMIS	University of Iowa	Quarterly Encounter Data	FTP	UOI FTP Server
		34.1	MMIS	University of Iowa	Quarterly Recipient Eligibility -Public Policy	FTP	UOI FTP Server
		34.01	MMIS	University of Iowa	Pharmacy Claims Extract -Case Mgmt	FTP	UOI FTP Server
		34.06	MMIS	University of Iowa	Institutional Claims Extract -Public Policy	FTP	UOI FTP Server
Wellmark							
	In	63	Data Warehouse	Wellmark	Hawki Encounters	FTP	
Wells Fargo							
	In	4.15	Advantis	Wells Fargo	Bank ReconciliationFile	Connect Direct	
		38	MMIS	Wells Fargo	ACH Deposit File	SFTP	
	Out	49	Wells Fargo	TXIX Eligibility	IowaCare Premium Payments	FTP	

Operational Requirements Matrix - Attachment L Instructions

General: Although many of the Responsibility, Requirement or Performance areas on the various worksheets are the same, each worksheet has a unique identifier. Those on the 'State Responsibilities' tab end with a 'S'; Operational Requirements identifiers end with a 'R'; Performance Measure identifiers end with a 'P'.

State Responsibilites Worksheet: Describes the responsibilities that the State will assume during the Contract. Each responsibility is prefaced with an identifier that links to the specified area listed below.

Identifier	Responsibility Area
GS	General Requirements and Staffing
IQAS	Internal Quality Assurance
MRS	Mail Room and Courier Service
MNS	Medically Needy
CES	Claims entry and receipt
CAS	Claims Adjudication
RFS	Reference
PMRS	Program Management Reporting
FRS	Federal Reporting Management
FMS	Financial Management and Reporting
EVSS	Eligibility Verification System (ELVS)
BRMS	Business Rules Management
MCS	Managed Care
TOS	Technical Operations Management and Support

Operational Requirements Worksheet: The Bidder shall use this worksheet to indicate whether their proposed solution will meet the Operational Statement of Work requirements associated with the areas listed below. Each requirement is prefaced with an identifier that links to the specified area listed below. Offerors shall indicate whether their proposed solution will meet each requirement by responding with a 'Y' or 'N' in column C.

Identifier	Operational Requirement Area
GR	General Requirements and Staffing
OTR	Operations Take Over Phase
IQAR	Internal Quality Assurance
CMR	Change Management Process
SCR	Systems Certification
MRR	Mail Room and Courier Service
MMR	Member Management
MNR	Medically Needy
PMR	Provider Management
CER	Claims Entry and Receipt
CAR	Claims Adjudication
ER	Encounter Management
RFR	Reference Management
PAR	Prior Authorization Management
TPLR	Third Party Liability Management
PMRR	Program Management Reporting
FRR	Federal Reporting Management
FMR	Financial Management and Reporting
PIMR	Program Integrity
MCR	Managed Care
EVSR	Eligibility Verification System
WSR	Web Services
WMR	Workflow Management
BRMR	Business Rules Management
TOR	Technical Operations Management and Support
CR	Certification Phase
TOVR	Turnover Phase

Performance Measures Worksheet: Describes performance measurements associated to the operational requirement areas listed on the Operational Requirements tab. The Bidder shall use this worksheet to indicate whether their proposed solution will meet the Performance Measures associated with the areas listed below. Each requirement is prefaced with an identifier that links to the specified area listed below. Offerors shall indicate whether their proposed solution will meet each requirement by responding with a 'Y' or 'N' in column C. These performance measurements will be used for Contract Management purposes throughout the duration of the Contract.

Identifier	Performance Measure Area
IQAP	Internal Quality Assurance
CMP	Change Management Process
MRP	Mail Room and Courier Service
MMP	Member Management
MNP	Medically Needy
PMP	Provider Management
CEP	Claims Entry and Receipt
CAP	Claims Adjudication
EP	Encounter
RFP	Reference
PAP	Prior Authorization Management
TPLP	Third Party Liability Management
PMRP	Program Management Reporting
FRP	Federal Reporting Management
FMP	Financial Management and Reporting
PIMP	Program Integrity Management
MCP	Managed Care
EVSP	Eligibility Verification System (ELVS)
WSP	Web Services
WMP	Workflow Management
TOP	Technical Operations Management and Support
TOVP	Turnover Phase

State Responsibilities

General Requirements and Staffing

GS-1	Monitor the performance of all contractor responsibilities.
GS-2	Review and approve proposed corrective action(s) taken by the Contractor.
GS-3	Monitor corrective actions taken by the Contractor.
GS-4	Review and approve all operational procedures.
GS-5	Determine Medicaid eligibility and transmit information to MMIS.
GS-6	Establish policy and make administrative decisions
GS-7	Approve all system edits, audits and changes to their dispositions.
GS-8	Review and approve automated communication with members, providers or other external stakeholders.
GS-9	Perform rate setting.
GS-10	Define business requirements.
GS-11	Establish priorities.
GS-12	Provide workspace within the IME environment.

Internal Quality Assurance

IQAS-1	Consult with the Contractor on quality improvement measures and determination of areas to be reviewed.

Mail Room and Courier Service

MRS-1	Pay all postage and external entity mailing costs for IME operational costs.
MRS-2	Identify the most cost effective way to print and mail.
MRS-3	Identify large-volume mailings.
MRS-4	Provide state owned vehicle for courier services.

Medically Needy

MNS-1	Calculate the amount of the spenddown needed.
MNS-2	Provide medically needy eligibility data to the MMIS contractor including conditional eligibility information, the certification period, spenddown amounts and responsible relative indicator.

Claims entry and receipt

CES-1	Determine and document methods and policies regarding claims receipt.
CES-2	Design claim forms uniquue to the Iowa Medicaid program and make revisions to claim forms.

CES-3	Approve the format and data requirements for electronic media claims submission.

Claims Adjudication

CAS-1	Determine methods and policies regarding provider reimbursement.
CAS-2	Define benefit plans, including coverage and limitations.
CAS-3	Perform Medicaid quality control functions in accordance with federal and state laws and regulations, with assistance from Contractor.
CAS-4	Ensure that data for claims paid outside of the MMIS are provided to the Contractor for inclusion on the MSIS reports.
CAS-5	Approve the request for EFT for the scheduled provider payment cycle.

Reference

RFS-1	Monitor file content and report detected errors to the Contractor for correction.
RFS-2	Establish allowed rates or fees.

Program Management Reporting

PMRS-1	Determine the frequency, format, content, media and number of copies of reports.
PMRS-2	Review and approve reports.

Federal Reporting Management

FRS-1	Provide direction on the requirements of each federal report.
FRS-2	Identify and approve changes to be made to the federal reporting.
FRS-3	Review all federal reports.
FRS-4	Initiate and interpret policy and make administrative decisions.
FRS-5	Determine the need, content, format, media and number of copies for each federal report.
FRS-6	Determine the schedule for production of all federal reports.

Financial Management and Reporting

FMS-1	Provide account coding and federal report coding requirement.
FMS-2	Approve manual payment and receivables.
FMS-3	Provide business rules for setting the status of account receivable to manage provider's due process rights.
FMS-4	Provide interface file layout and business processing rules for payment, journal, deposit and receivable files.

FMS-5	Provide business rules for sending account receivables to the state warrant offset program or other collection agent.
FMS-6	Provide interface file layout for state warrant offset processing.

Managed Care

MCS-1	Develop and manage contracts with managed care organizations.
MCS-2	Establish the payment rates for each managed care program.

Eligibility Verification System (ELVS)

EVSS-1	Approve the data elements and response messages for the Eligibility Verification systems.

Business Rules Management

BRMS-1	Review and approve all rules prior to implementation.

Technical Operations Management and Support

TOS-1	Provide an option for hosting the hardware in a secure environment.
TOS-2	Conduct Network management.
TOS-3	Provide an option to support operating system installation and management, including patches.
TOS-4	Provide an option for server and file back up.

Operational Requirements		
		Agreement to meet requirement (Y/N)
General Requirements and Staffing		
GR-1	Provide technical assistance for MMIS related issues such as availability of the system, system access and user notifications as system changes are implemented.	Y
GR-2	Provide adequate number of qualified staff during the Operations phase.	Y
GR-3	Provide sufficient staff to perform rules engine, benefit plan, workflow, interfaces and reporting management and maintenance as necessary to support Medicaid program management and federal reporting requirements .	Y
GR-4	Provide claims expert(s) who are qualified to research claim inquiries and provide expert witness testimony in judicial proceedings on the Agency's behalf.	Y
GR-5	Provide Quality Assurance (QA) Support Personnel to perform QA activities. A minimum of one staff member must have demonstrated experience in developing, executing and reporting formal quality assurance plans.	Y
GR-6	Provide Business Analysts who are responsible for meeting with IME policy and unit staff to capture and document modifications to the MMIS systems to support organization and mandated change. The analyst(s) must work across multiple levels of the organization and be able to identify and articulate the necessary workflow, configuration, rules, reporting requirements and interface modifications changes needed to support the business process change.	Y
GR-7	Coordinate and track all software used within the IME Operations, specifically the software packages brought in through the professional services contracts, such as MQUIDS, or Impact Pro.	Y
GR-8	Provide training to the IME staff and units on the use and operation of the Medicaid Enterprise Systems.	Y
GR-9	Create and maintain ongoing knowledge transfer to Professional Services Contractors and the Agency 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 Agency. The knowledge transfer will be conducted Monday through Friday, excluding the Agency 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.	Y
GR-10	Provide data interfaces with IME designated internal and external systems to ensure effective and efficient administration of the program.	Y

GR-11	Participate in program planning and evaluation activities to ensure the Agency is making informed decisions.	Y
GR-12	Support system integration of all software products used for operations within Iowa Medicaid Enterprise.	Y
GR-13	Support system modifications (including workflow, business rules, data capture) needed as requested by Iowa Medicaid Enterprise. Professional services contract units will make system requests through their unit manager.	Y
GR-14	Provide data and knowledge expertise to satisfy requirements of audits, certifications, and requests for information.	Y
GR-15	Accept and maintain accurate current and historical data. Ensure audit trails exist for all activity as per state and federal regulations regarding data retention.	Y
GR-16	Manage application security for the MMIS systems to ensure access is available and appropriate to the role description.	Y
GR-17	Provide a help desk to support IME staff. Technical issues identified by external stakeholders such as members or providers, will be routed through the appropriate unit and escalated to the Contractor's help desk.	Y
GR-18	Provide a HIPAA electronic data interface help desk for direct support to providers, billling agencies, or clearinghouses who are having difficulty with the submission of EDI transactions and sufficient staff dedicated to Iowa Medicaid providers via phone calls and e-mail communications	Y
GR-19	Ensure that all interfaces are delivered timely. Real-time exchange of data should occur whenever possible to ensure data is consistent and accurate.	Y
GR-20	Develop and maintain dashboards and reports through an electronic document management process to ensure the IME Operations has the appropriate information at the time needed to effectively and efficiently operate the program.	Y
GR-21	Ensure that the Medicaid Enterprise Systems and MMIS effectively apply all federal and state code, rules, and regulations to ensure claims are adjudicated accurately and efficiently.	Y

Operations Take Over Phase		
OTR-1	Develop and submit a project plan specific to Operations Take Over to Agency for approval.	Y
OTR-2	Offer opportunities to existing Iowa Medicaid CORE operations staff to continue in similar positions at Iowa Medicaid where appropriate.	Y
OTR-3	Work collaboratively with the existing CORE Contractor (Noridian Administrative Services) to ensure a seamless turn over.	Y
OTR-4	Ensure that projects "in process" are not delayed or placed at risk by the take over of operations and technical support of the existing MMIS and CORE claims operations.	Y
Internal Quality Assurance		
IQAR-1	Work with the Agency to implement a quality plan that is based on proactive improvements rather than retroactive responses.	Y
IQAR-2	Develop and submit to the Agency for approval, a Quality Assurance Plan establishing quality assurance procedures.	Y
IQAR-3	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 Agency regarding Contractor performance.	Y
IQAR-4	Submit quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to the Agency.	Y
IQAR-5	Provide quality control and assurance reports, accessible online by the Agency and Contractor management staff, including tracking and reporting of quality control activities and tracking of corrective action plans. The quality assurance report should at a minimum show the number of items sampled by category, the number of errors and the percent accurate.	Y
IQAR-6	For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.	Y
IQAR-7	Implement an Agency-approved corrective action plan within the timeframe negotiated with the Agency.	Y
IQAR-8	Provide documentation to the Agency demonstrating that the corrective action is complete and meets the Agency requirements.	Y
IQAR-9	Perform continuous workflow analysis to improve performance of Contractor functions and report the results of the analysis to the Agency.	Y
IQAR-10	Provide the Agency with a description of any changes to the workflow for approval prior to implementation.	Y

IQAR-11	Provide and maintain operational procedure documentation for repeatable processes, including but not limited to: mail room processing, manual claims review, system change migration, security maintenance.	Y
IQAR-12	Survey the submitters of a random sample of the CMRs to verify that the user was satisfied with the timeliness, communication, accuracy and result of the CMR process.	Y
Change Management Process		
CMR-1	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. Make additions and modifications to workflow processes. g. Manage user security levels of access.	Y
CMR-2	Provide an online tracking tool for the Agency 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: a. Allow online entry of new CMR requests. b. Image and include all attachments pertinent to each CMR, including request, business and technical requirements, test plan and test results and approval sign-off. c. Provide flexible online reporting and status inquiry into the Change Management System. d. Provide automatic notification to affected parties when a CMR status changes. e. Maintain and provide access to all changes made by the Agency or the Contractor to each CMR, identifying the change made, the person making the change and the date and time of the change. f. Show status report coding changes, attach test results and record all notes from the Agency and Contractor staff related to each CMR.	Y

CMR-3	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 (CMR) 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. Agency approval of the modification xv. Implementation date xvi. Indicate if implementation date is mandated by legislation or rules.	Y
CMR-4	Be responsive to all requests from the Agency for system modification, whether categorized as maintenance, defect, enhancement or modification.	Y
CMR-5	Complete the CMR on or before the requested completion date.	Y

CMR-6	Provide clear and complete responses to all CMRs including: a. Definition of the problem b. Proposed solution c. Proposed approach to implement the solution d. Proposed schedule for completion e. Constraints and assumptions f. Financial impact g. Stakeholder impact (e.g., provider, members, Agency) h. Estimated effort detailed by: i. Labor in hours ii. Hours per task iii. Hours per full-time equivalent (FTE) iv. Equipment v. General and administrative support in hours vi. Ongoing support requirements vii. Provider knowledge transfer viii. Documentation	Y
CMR-7	Maintain documented and proven code promotion procedures for promoting changes from the initiation of unit testing, through the final implementation to production. The promotion procedure must maintain separation of duties between solution developers and production promotion to ensure modifications are well tested prior to moving to production.	Y
CMR-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.	Y
CMR-9	Maintain adequate staffing levels to ensure CMRs are completed within the specified timeframe determined by the Agency.	Y
CMR-10	Ensure that all CMRs are addressed within timeframe determined by the Agency.	Y
CMR-11	The change management process must include confirmation that impacted documentation, operational procedures have been updated.	Y
CMR-12	Provide a status report to the Agency that includes new CMRs, closed CMRs, and the CMR status for high priority CMRs . The report shall include emergency production fixes and system outages during the reporting period. The report shall include performance standard results as requested by the Agency. The report should be delivered to the Agency at a frequency to be determined by the Agency.	Y

System Certification		
SCR-1	Deliver certifiable MMIS 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 Agency. The Contractor must correct all items not certified at no additional charge to the Agency.	Y
Mail Room and Courier Service		
MRR-1	Maintain the mail handling function for all paper forms and correspondence and be accountable for each claim from the time it is received. 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 Agency. Documents that are complete are sorted and batched by type.	Y
MRR-2	Scan, image, and stamp all hardcopy forms and correspondence 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 Contractor staff to monitor a batch of claims in the system as soon as the claims are batched.	Y
MRR-3	All outgoing mail will go through the IME mailroom including regular daily mail and small-volume mailings.	Y
MRR-4	Provide a print-ready copy of the documents to the printer the Agency selects (such as the state print shop or a commercial print shop).	Y
MRR-5	Develop and maintain screening instructions for each claim type. Screen all hard copy claims upon receipt. This includes: a. Date-stamp the claims. b. Sort and batch the claims. c. Screen the claims. d. Assign claim control numbers. e. Scan and image the claims	Y
MRR-6	Imaged claims must be immediately available for processing and viewing.	Y
MRR-7	Provide audit acceptable operations for processing mail containing checks.	Y

Member Management		
MMR-1	Process updates to member eligibility data transferred by the Agency for all medical assistance and process real time, daily or monthly or as directed by the Agency.	Y
MMR-2	Establish and adhere to a quality assurance process to reconcile the Agency's eligibility determination system and the MMIS systems. This process should be performed at a minimum frequency of monthly.	Y
MMR-3	Maintain and operate a process to access archived eligibility data.	Y
MMR-4	Manage dual eligibility coordination with CMS. Send a file to Medicare identifying individuals as dual eligible (Medicaid and Medicare) to indicate that a crossover claim should be generated. Receive Medicare enrollment information from Medicare and update eligibility for claims payment. Transfer dual information to the Agency's eligibility system for re-determination of eligibility.	Y
MMR-5	Maintain a minimum of 60 months of eligibility history including benefit plans, lock-in, managed care enrollment and waiver and long term care .	Y
Medically Needy		
MNR-1	Work effectively and collaboratively with the ELIAS eligiblity system to ensure that members potentially eligible for medically needy services are managed efficiently. Ensure ELIAS receives notification when the spend down requirements have been met.	Y
Provider Management		
PMR-1	Maintain all provider master data necessary to ensure efficient operations and accurate adjudication of claims.	Y
PMR-2	Implement process improvements in the MMIS software and Provider portal to simplify administrative processes for providers.	Y
PMR-3	Update all necessary information to track, consolidate and report 1099 information prior to issuance of the 1099. Accurate 1099 statements must be sent timely as per federal regulations.	Y
PMR-4	Manage the exchange of provider information with the IME Pharmacy Point of Sale in the most effective, and efficient manner possible.	Y
PMR-5	Support all provider management processes, including but not limited to enrollment, re-enrollment, EFT enrollment, EDI enrollment and testing, remittance advices, and managed care reporting.	Y
PMR-6	Collaborate with the Iowa Health Information Network to support a state wide provider directory and promote efficient management of provider data, including licensing and certification.	Y
Claims Entry and Receipt		

CER-1	Accept claims and other transactions via hard copy and electronic media. Electronic media claims are accepted in the form of direct data entry through the web portal or submission through standard Electronic Data Interchange processes.	Y
CER-2	Obtain written agreements from new providers wishing to submit claims via Electronic Data Interchange, using HIPAA approved, industry standard transactions. The Contractor must comply with all federal requirements for transaction standards and operating rules.	Y
CER-3	Receive and maintain control over electronic claims transaction.	Y
CER-4	Provide imaging of paper claims.	Y
CER-5	Develop and maintain screening instructions for each claim type. Screen all hard copy claims upon receipt. This includes:	Y
	a. Date-stamp the claims.	Y
	b. Sort and batch the claims.	Y
	c. Screen the claims.	Y
	d. Assign claim control numbers.	Y
	e. Scan and image the claims.	Y
CER-6	Deny entry of a paper claim into the MMIS unless it contains the Agency defined data elements. Return claims not meeting these criteria to the provider.	Y
CER-7	Screen all claims to ensure they are submitted on the correct claim form and the paper claim form is an original.	Y
CER-8	Log all claims returned to the provider to verify initial receipt.	Y
CER-9	Provide data entry through both batch and online mode.	Y
CER-10	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.	Y
CER-11	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:	Y
	a. Inventory management analysis by claim type, processing location and age.	Y
	b. Input control listings.	Y
	c. Records of unprocessable claims.	Y
	d. Inquiry screens, including pertinent header and detail claim data and status.	Y
	e. Claims entry statistics.	Y
	f. Data entry operator statistics, including volume, speed, errors and accuracy.	Y
CER-12	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.	Y

CER-13	Produce electronic copies of claims, claim attachments and adjustments and provide secure storage with ability to retrieve copies for state users upon request.	Y
CER-14	Identify and perform online correction to claims suspended because of data entry errors.	Y
CER-15	Develop quality control procedures for imaging operations to ensure that imaged copies are legible. Submit written quality control plan to the Agency for review.	Y
CER-16	Provide to the Agency claim inventory reports that will document the number of claims in each of the claims suspense area each day.	Y
CER-17	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.	Y
CER-18	Ensure that EDI transmittals contain control totals and that all submitted records are loaded on the file.	Y
CER-19	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.	Y
CER-20	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.	Y
CER-21	Test providers' readiness for EDI participation and allow only those providers passing testing standards to submit EDI claims.	Y
CER-22	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.	Y
CER-23	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.	Y
CER-24	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:	Y
	a. Assist providers in determining the best method of electronic transaction submission.	Y
	b. Enroll providers for electronic transaction submission.	Y
	c. Provide transmission assistance to billing agents, clearinghouses and software vendors.	Y
	d. Test submission software with the Agency trading partners.	Y
	e. Identify and troubleshoot technical problems related to EDI transactions.	Y
	f. Provide confirmation of electronic transaction submission.	Y

	g. Provide assistance to support direct data entry of claims and other transactions through the web portal.	Y
Claims Adjudication		
CAR-1	Maintain a claims pricing and adjudication module function to ensure 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.	Y
CAR-2	Provide that 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 time period 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.	Y
CAR-3	Produce a payment file to be sent to the Agency's financial institution. The use of the term “payment” 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.	Y
CAR-4	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.	Y
CAR-5	Provide accurate and complete registers and audit trails of all processing activities.	Y
CAR-6	Maintain inventory controls and audit trails for all claims and other transactions entered into the system to ensure processing to completion.	Y
CAR-7	Control attachments required for claims adjudication include but are not limited to:	Y
	a. Third-party liability and Medicare Explanation of Benefits.	Y
	b. Sterilization, abortion and hysterectomy consent forms.	Y
	c. Prior authorization treatment plans and emergency room reports.	Y
CAR-8	Ensure that every valid claim for a covered service provided by an enrolled provider to any eligible member is processed and adjudicated.	Y
CAR-9	Process all claims entered into the MMIS to the point of payment or denial.	Y
CAR-10	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.	Y
CAR-11	Edit all claims for eligible member, eligible provider, eligible service and correct reimbursement schedule.	Y
CAR-12	Provide real-time adjudication of all claims entered manually.	Y
CAR-13	Provide real-time claims status information to the provider through the web portal or EDI transaction response.	Y

CAR-14	Provide plain English explanations of all claim edits or warnings triggered by the adjudication process.	Y
CAR-15	Maintain business rules of all claim edits in plain English.	Y
CAR-16	Process and adjudicate all claims and claim adjustments in accordance with the Agency program policy.	Y
CAR-17	Run a payment cycle weekly or as directed by the Agency.	Y
CAR-18	Process credits and adjustments to provider payments.	Y
CAR-19	Process non-emergency medical transportation capitation payments and receive and store encounter data.	Y
CAR-20	Adjudicate claims based on the rate effective on the date of service unless otherwise directed by the Agency.	Y
CAR-21	Research and develop special payment circumstances including determining the proper payment amount for the service.	Y
CAR-22	Provide claim histories and copies of claims to the Agency upon request.	Y
CAR-23	Account for all claims entered into the MMIS system and identify the individual disposition status.	Y
CAR-24	Process any claims or partial claims that were not used to meet the medically needy spenddown amount.	Y
CAR-25	Accept and process all Medicare Part A and B crossover claims pursuant to the Agency standards.	Y
CAR-26	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.	Y
CAR-27	Support multiple methodologies for pricing claims as established by the Agency.	Y
CAR-28	Accurately calculate the payment amount for each service according to the rules and limitations applicable to each claim type and provider type.	Y
CAR-29	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.	Y
CAR-30	Recommend for the Agency approval specific edit parameters.	Y
CAR-31	Configure the fee schedules, per diems, DRG rates, APC rates and other rates and rules established by the Agency.	Y
CAR-32	Calculate members cost sharing responsibilities including co-payments and deductibles. Apply member liability to the claim as per the rules of the Agency.	Y

CAR-33	Track total annual cost-sharing for member household and limit cost-sharing to the amount allowed by federal or state law.	Y
CAR-34	Deduct TPL amounts as appropriate when pricing claims.	Y
CAR-35	Deduct member spenddown amounts as appropriate when pricing claims.	Y
CAR-36	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.	Y
CAR-37	Offset service plan payments for HCBS waivers (e.g., claims by provider) by any existing monthly client participation amount.	Y
CAR-38	Provide adequate qualified staff to resolve suspended claims.	Y
CAR-39	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.	Y
CAR-40	Recycle any claim type prior to denial, at the request of the Agency. Send recycled claims through the adjudication process at scheduled intervals. Deny claims after the Agency specified number of days.	Y
CAR-41	Conduct online real-time claims suspense resolution capabilities for all claim types.	Y
CAR-42	Receive approval from the Agency before establishing any new claim adjudication rules or changing the disposition status of existing claim adjudication rules in the system.	Y
CAR-43	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.	Y
CAR-44	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.	Y
CAR-45	Maintain the rules engine.	Y
CAR-46	Perform overrides of claim edits and audits in accordance with the Agency approved guidelines.	Y
CAR-47	Apply established edits to claims pursuant to the Agency criteria. Add, change or delete edits as directed by the Agency. Suspend claims for manual review and pricing if the claim cannot be automatically priced.	Y
CAR-48	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 Agency 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.	Y
Encounter Management		

ER-1	Accept medical and transportation encounter data from all Medicaid managed care organizations and the transportation broker conducting business in the State of Iowa who are required to submit encounter data to the 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.	Y
ER-2	Reject the entire month's encounter record if the file exceeds the Agency 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 Contractor and re-submitting the file in error.	Y
ER-3	Maintain the encounter data on a separate MMIS encounter history database for federal reporting, quality assessment and actuarial analysis.	Y
ER-4	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.	Y
ER-5	Organize and provide data to analyze member access to health and transportation services and the quality of health and transportation care providers.	Y
ER-6	Ensure accuracy and adequacy of encounter data received from managed care entities and the transportation broker.	Y
ER-7	Produce encounter data files and reports including data from the transportation broker.	Y
ER-8	Accept and log attestation from each contracting entity including HMOs, the Iowa Plan and the transportation broker for encounter data submission as required by 42 CFR 438.606.	Y
ER-9	Process edits against the encounter file to ensure the data is technically correct.	Y
ER-10	Generate error reports for each plan.	Y
ER-11	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.	Y
ER-12	Incorporate managed care encounter data received from the managed care organizations into the MMIS reporting system.	Y
ER-13	Maintain five years of encounter data history for all clean encounter data.	Y
ER-14	Count EPSDT screenings based on the procedure code on the encounter claim on accepted input files and retain for inclusion on the CMS-416. Include these EPSDT counts on the HMO Encounter EPSDT Counts Report.	Y

ER-15	Produce and send encounter data files to the Agency Contractors as required by the Agency.	Y
ER-16	Accept, test and integrate into the T-MSIS files managed care encounter data from Iowa Medicaid contracts, including hawk-i enrollment and encounter data on a frequency required by CMS. .	Y
ER-17	Download encounter data extract updates to the data warehouse for reporting monthly.	Y
ER-18	Accept and process encounter data in different formats.	Y
ER-19	Provide a monthly report detailing the receipt and disbursement of encounter data files. The report should identify encounter file name, business partner, date of receipt or production, and disposition of the file (rejected or accepted) .	Y

Reference Management		
RFR-1	Maintain a Reference Data module that contains rates and pricing information, and 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.	Y
RFR-2	Provide coding and pricing verification during claims processing for all approved claim types, assistance programs and reimbursement methodologies including capitated programs.	Y
RFR-3	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.	Y
RFR-4	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.	Y
RFR-5	Provide a master file of valid procedure, diagnosis, revenue and drug codes for use in the verification and pricing of Medicaid claims.	Y
RR-6	Provide a means of reporting any information from the files.	Y
RR-7	Provide and maintain customary charge data for provider's Medicaid customary charges.	Y
RR-8	Provide and maintain prevailing charge data for Medicaid charges.	Y
RR-9	Place benefit limits and maintain 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.	Y
RR-10	Enhance reference data to include additional attributes or code sets as needed to effectively manage state and federal payment rules.	Y
RR-11	Maintain Revenue codes in the following manner:	Y
	a. Maintain a revenue code data set for use in processing claims.	Y
	b. Accommodate pricing action codes and effective end dates for each revenue code.	Y
	c. Provide English descriptions of each revenue code in the revenue data set.	Y
RFR-12	Maintain current and historical reference data for all procedure codes and modifiers that include at a minimum the following elements:	Y
	a. Date-specific pricing segments including a pricing action code for each segment showing effective dates and end dates.	Y
	b. The Agency 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.	Y

	c. Pricing information such as maximum amount, fee schedule amounts and relative value scale (RVS) indicators with unlimited segments showing effective dates and end dates.	Y
	d. Prior authorization codes with unlimited segments showing effective and end dates.	Y
	e. English descriptions of procedure codes.	Y
	f. "Global" indicators for codes that include reimbursement for pre- and post- procedure visits and services.	Y
	g. Other information such as accident-related indicators for possible TPL, federal cost-sharing indicators and prior authorization required.	Y
RFR-13	Maintain procedure information that sets adjudication limitations and medical policy restrictions for automatic pricing of medical procedures according to the effective date.	Y
RFR-14	Identify when prior authorization and pre-procedure review approval is required.	Y
RFR-15	Restrict the use of procedure codes to those providers qualified to perform them.	Y
RFR-16	Accommodate variable pricing methodologies for identical procedure codes based on provider specific data.	Y
RFR-17	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:	Y
	a. Age	Y
	b. Gender	Y
	c. Place of service	Y
	d. Prior authorization codes with effective and end dates	Y
	e. Inpatient length of stay criteria	Y
	f. English description of the diagnosis code	Y
	g. Effective date	Y
	h. End date	Y
RFR-18	Maintain a master file of valid procedure, diagnosis, drug and revenue codes with attributes and appropriate pricing information for use in claims processing.	Y
RFR-19	Perform batch and online updates to all reference files in the MMIS subject to the Agency approval via the workflow process. Notify the Agency electronically with results of file updates.	Y
RFR-20	Maintain online access to all reference files with inquiry by the appropriate code.	Y
RFR-21	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.	Y
RFR-22	Make mass updates to the allowed fee or rate effective on a certain date.	Y

RFR-23	Maintain the per diem rates for hospitals with Medicaid-certified physical rehabilitation units as specified by the Agency. Update the rates as required by the Agency.	Y
RFR-24	Provide online inquiry and update capability for all files.	Y
RFR-25	Produce audit trail reports in the media required by the Agency showing before and after image of changed data, the ID of the person making the change and the change date.	Y
RFR-26	Edit all update transactions either batch or online for data validity and reasonableness as specified by the Agency. Report all errors from batch updates to the Agency.	Y
RFR-27	Accommodate multiple reimbursement methodologies including but not limited to DRG, APC, fee schedules and per diem.	Y
RFR-28	Maintain pricing files based on:	Y
	a. Customary	Y
	b. Fee schedule	Y
	c. Per diem rates	Y
	d. DRGs	Y
	e. APCs	Y
	f. Capitation rates for managed care plans	Y
	g. Administrative fees for primary care management, medical home and others as designated by the Agency	Y
	h. 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.	Y
	i. Multiple rates for long term care providers.	Y
	j. Encounter rates for federally qualified health centers and rural health centers.	Y
RFR-29	Maintain and update the DRG-based prospective payment file for inpatient hospital services and update the base rates periodically as authorized by the Agency. Apply an economic index to the base rates as authorized by the Agency.	Y
RFR-30	Maintain and update DRG and APC data sets which contain at a minimum by peer group, facility and effective date, unlimited occurrences of:	Y
	a. Price by code.	Y
	b. High and low cost outlier thresholds.	Y
	c. High and low length-of-stay outlier thresholds.	Y
	d. Mean length-of-stay.	Y
RFR-31	Maintain the fee schedules in the reference file and update on an annual basis or as authorized by the Agency including applying an economic index to the fee schedule rates.	Y

RFR-32	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.	Y
RFR-33	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.	Y
RFR-34	Reimburse managed care providers, Contractors and the non-emergency transportation broker on a monthly capitation basis based on rates provided by the Agency.	Y
RFR-35	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.	Y
RFR-36	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.	Y
Prior Authorization Management		
PAR-1	Maintain the prior authorization management module with responsibilities for medical and dental services are shared between the Agency, the Medical Services Contractor, and the Contractor.	Y
PAR-2	Operate a prior authorization system to load authorizations and track utilization of authorized services.	Y
PAR-3	Maintain edit disposition to deny claims for services that require prior authorization (PA) if no PA is identified or active.	Y
PAR-4	Accept prior authorizations requests through electronic data interchanges or the health information exchange using standard transaction sets. Apply business rules to determine if the prior authorization is approved, denied, or requires manual review.	Y
PAR-5	Direct PA requests that need manual review to the appropriate prior authorization Contractor as directed by the Agency.	Y
PAR-6	Scan, image and forward paper PA requests received from providers to the appropriate prior authorization Contractor as directed by the Agency.	Y
Third Party Liability Management		

TPLR-1	Maintain the Third-Party Liability (TPL) module to manage the private health insurance and other third party resources of Iowa's Medicaid members and ensure 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.	Y
TPLR-2	Generate TPL and trauma lead letters per the Agency policy and produce a report of all letters.	Y
TPLR-3	Generate a file of all paid claims and member eligibility monthly.	Y
TPLR-4	Process all files weekly or as directed by the Agency (TPL updates and claims updates) from Revenue Collection Contractor.	Y
TPLR-5	Process TPL updates manually entered by Revenue Collection Contractor.	Y
TPLR-6	Accept and process absent parent file from Child Support Recovery Unit weekly or as directed by the Agency.	Y
TPLR-7	Update member files to include the TPL plan and coverage information for HIPP members.	Y
TPLR-8	Manage the premium payment process.	Y
TPLR-9	Create and issue HIPP remittance advice.	Y
TPLR-10	Produce state-defined reports.	Y
TPLR-11	Create a member file for HIPP enrollees who are not Medicaid members (i.e., AIDS/HIV, HIPP).	Y

Program Management Reporting		
PMRR-1	Maintain the Program Management Reporting module to provide 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 Contractor. This does not include preparation of federal reports.	Y
PMRR-2	Produce all required reports and information in accordance with the timeframes and requirements specified by the Agency.	Y
PMRR-3	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.	Y
PMRR-4	Upon request, model proposed program modifications and report to the Agency financial, access, and utilization impacts.	Y
PMRR-5	Review all process summaries to verify accuracy and consistency within and between reports before delivery of the reports to the Agency.	Y
PMRR-6	Make recommendations on improvements to reporting process and assist the Agency in designing reports.	Y
PMRR-7	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 Agency.	Y
PMRR-8	Produce ad hoc reports on request.	Y
PMRR-9	Produce on a timeline approved by the Agency data extracts for delivery to external entities.	Y
PMRR-10	When an error in a report is identified either by the Core MMIS Contractor or by the Agency, 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.	Y
Federal Reporting		
FRR-1	Generate required reports to support federal reporting on demand and scheduled within timeframes and formats required by the state including but not limited to:	Y
	a. CMS 21 report Quarterly State Children's Health Insurance Program Statement of Expenditures for Title XXI.	Y
	b. CMS 21B	Y
	c. CMS21E statistical report	Y
	d. Quarterly ethnicity report	Y

	e. CMS 64 - Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program	Y
	f. CMS 37 Quarterly Projections for the Medical Assistance Program	Y
	g. T-MSIS Data extracts must be produced and transmitted in the formats identified by CMS.	Y
	h. CMS 372 cost neutrality assessment for waivers and other specified waiver reports.	Y
	i. CMS 416 report information in accordance with the federal specifications and the Agency specifications.	Y
	j. SF269 Federal Financial Status Report	Y
FRR-2	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.	Y
FRR-3	Modify reports supporting federal reporting as requested by the Agency. Modifications are made available within timeframes required by the state.	Y
FRR-4	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.	Y
FRR-5	Conduct research and respond to questions from CMS, OIG and state auditors regarding the T-MSIS data and federal reports.	Y
FRR-6	Prepare and deliver to the Agency the Quarterly Report of Abortions (CMS 64.9b).	Y
FRR-7	Prepare and deliver the report on expenditures under the Money Follows the Person program to the Agency.	Y
FRR-8	Identify and report the Federal Financial Participation (FFP) rate for each claim line.	Y
FRR-9	Produce a report of pharmacy drug rebate amounts for inclusion on federal reports.	Y
FRR-10	Regenerate, at no cost to the Agency, the T-MSIS file and federal reports when errors are identified or when there has been a mass adjustment of federal reports codes.	Y
Financial Management and Reporting		
FMR-1	Maintain the financial management module function to support accounts payable and accounts receivable activities including issuance of check-write and EFT files and remittance advices.	Y
FMR-2	Wells Fargo is the entity that produces and transmits the electronic fund transfers. The Contractor is responsible for producing checks for mailing.	Y
FMR-3	Include the following data in the claims reporting function:	Y
	a. All the claim records from each processing cycle.	Y

	b. Online entered, non-claim-specific financial transactions, such as recoupment's, mass adjustments, cash transactions.	Y
	c. Provider, member and reference data from the MMIS.	Y
	d. Individual claim records for all claims not paid through the MMIS.	Y
FMR-4	Perform mass adjustments as directed by the Agency.	Y
FMR-5	Provide electronic funds transfer and electronic remittance advices.	Y
FMR-6	Provide paper checks and remittance advices to specific provider groups as directed by the Agency.	Y
FMR-7	Provide electronic copy of the check payment register to the Agency following each check write, in the format and content approved by the Agency.	Y
FMR-8	Run a check-write payment cycle and EFT authorization on a schedule determined by the Agency.	Y
FMR-9	Issue remittance advices to all providers pursuant to the Agency guidelines and timeframes.	Y
FMR-10	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.	Y
FMR-11	Make twelve months of Explanation of Medicaid Benefits (EOMB) data information available to members via the Member Web Portal.	Y
FMR-12	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.	Y
FMR-13	Provide the Agency with electronic copies of remittance advices and EOMB forms.	Y
FMR-14	Provide the Agency of Inspections and Appeals a file of all checks paid out and Electronic Fund Transfers (EFTs) made.	Y
FMR-15	Produce electronic file of monthly billings for entities responsible for the non-federal share of claims.	Y
FMR-16	Print billings for entities responsible for the non-federal share of claims as directed by the Agency.	Y
FMR-17	Identify the non-federal shareof ICF/MR provider fee asssessment and ensure these amounts are not transferred to the accounts receivable system for collection by the Agency. Provide the ability to recoup and issue hold harmless add-on payments.	Y

FMR-18	Maintain the table of Integrated Information for Iowa (I/3) financial accounting system codes in the system.	Y
FMR-19	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.	Y
FMR-20	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 Agency.	Y
FMR-21	Accept and process the Agency of Administrative Services Vendor Offset file received weekly from the Agency.	Y
FMR-22	Transmit accounts that cannot be collected (e.g., provider overpayments) to the Revenue Collection Contractor.	Y
FMR-23	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.	Y
	a. 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.	Y
	b. An itemization of suspended claims.	Y
	c. Adjusted claim information showing both the original claim information and an explanation of the adjustment reason code.	Y
	d. 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.	Y
	e. Explanatory Messages relating to the claim payment cutback or denial.	Y
	f. 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.	Y
	g. Explanation of Benefits payment Messages for claim header and for claim detail lines.	Y
	h. Patient account and medical records numbers, where available.	Y
	i. Any additional fields as described by the Agency.	Y
FMR-24	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).	Y
FMR-25	Provide the flexibility to suppress the generation of zero-pay checks and EFTS but to generate associated remittance advices.	Y
FMR-26	Provide to the state each provider's 1099 information annually.	Y

FMR-27	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
FMR-28	Enter lien and assignment information to be used in directing or splitting payments to the provider and lien holder.	Y
FMR-29	Identify providers with credit balances and no claim activity during the Agency specified number of months and generate a quarterly report of credit account balance audits.	Y
FMR-30	Generate overpayment letters to providers when establishing accounts receivable.	Y
FMR-31	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.	Y
FMR-32	Provide reports on all financial transactions by source, including TPL recoveries, fraud and abuse recoveries, provider payments, drug rebates.	Y
FMR-33	Transmit financial data electronically from the MMIS directly to the Agency or the entity responsible for producing EFT.	Y
FMR-34	Manage the billing process for entities responsible for the non-federal share of specified services.	Y
FMR-35	Accumulate paid claims and Information on each claim line including member's county of legal settlement.	Y
FMR-36	Produce and mail a paper report and invoice to entities as directed by the Agency.	Y
FMR-37	Produce an electronic file for entities as directed by the Agency.	Y
FMR-38	Manage account receivable function to track all amounts due the Agency as a result of a transaction processed by the MMIS.	Y
Program Integrity		
PIMR-1	Provide weekly or as required by the Agency, a file of all paid claims to Program Integrity Contractor, Member Services Contractor and a Medicaid Fraud Control Unit (MFCU).	Y
PIMR-2	Provide weekly or as required by the Agency, a copy of the provider claims history profile report to the Agency of Inspection and Appeals.	Y
PIMR-3	Produce for the Agency of Inspection and Appeals an electronic summary of LTC.	Y
PIMR-4	Provide to the Agency Medicaid Fraud Control Unit, weekly or as directed by the Agency an electronic copy of all checks paid and Electronic Fund Transfers (EFTs) made.	Y
PIMR-5	Manage data interfaces between the Service Utilization and Review module managed by the Program Integrity Contractor and the MIDAS MMIS systems.	Y
Managed Care		

MCR-1	Accept and process member eligibility updates. Based upon member eligibility enroll or disenroll members in managed care plans or the transportation brokerage based on the Agency rules.	Y
MCR-2	Accept and process managed care and transportation broker provider data from Provider Services contractor.	Y
MCR-3	Calculate and issue administrative, incentive and capitation payments to the managed care contractors and the transportation broker.	Y
MCR-4	Adjudicate fee-for-service claims in accordance with the Agency rules.	Y
MCR-5	Generate reports as required by the Agency.	Y
MCR-6	Manage the payment process and issue the payments.	Y
MCR-7	Resolve fee-for-service and capitation payment errors.	Y
MCR-8	Issue enrollment rosters.	Y
MCR-9	Send electronic remittance advices to the managed care contractors and transportation broker.	Y
MCR-10	Send paid claims and encounter data to actuarial contractor.	Y
Eligibility Verifcation System (ELVS)		
EVSR-1	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 will be approved by the Agency.	Y
EVSR-2	Send the necessary data elements to the IVRS referred to as ELVS.	Y
EVSR-3	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.	Y
EVSR-4	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.	Y
EVSR-5	Ensure the system checks member identification using predefined access keys approved by the Agency.	Y
EVSR-6	Provide automated logging of all transactions and produce reports as required by the Agency.	Y
EVSR-7	Track and identify caller statistics, including provider type, provider number, number of inquiries made, duration and errors or incomplete calls.	Y
EVSR-8	Coordinate with the Agency to assure sufficient communication capabilities to accommodate all providers requiring utilization of the system.	Y
EVSR-9	Coordinate with telecommunication and software vendors to resolve operational and performance issues.	Y

EVSR-10	Override the system pronunciation of names as necessary to correct computer generated pronunciation.	Y
EVSR-11	Notify the Agency designees of operational issues within one hour of identification.	Y
EVSR-12	Provide knowledge transfer to the Provider Services contractor in the use of IVRS options and respond to questions from Provider Services Contractor.	Y
EVSR-13	Support and maintain the IVRS referred to as ELVS.	Y
EVSR-14	Integrate electronic eligibility verification through encoded member cards.	Y
Web Services		
WSR-1	Update the content of the web portal within two days of receipt of the Agency approval.	Y
WSR-2	Comply with the Agency usability and content standards (i.e., style guide) and provide a layout that has user-configurable resolution, fonts and color choices.	Y
WSR-3	Update interactive content, such as, but not limited to, alerts or current fee schedule on the web, as required by the Agency within approved timeframes.	Y
WSR-4	Monitor the web environment to evaluate the adequacy of infrastructure to support access by providers and members.	Y
WSR-5	Notify the Agency immediately of the downtime in the event of unscheduled downtime. If the Agency requires, provide a written and Agency-approved action plan to resume system activity and provide a time when the system is will be available. Weekly reports to the Agency must be produced detailing all system downtime.	Y
WSR-6	Obtain approval from the Agency of all documents and functionality (e.g., applications, manuals, handbooks, notices, welcome packets and others) before being posted on the web portal.	Y
Workflow Management		
WMR-1	Configure new workflow management system.	Y
WMR-2	Import and reconstruct the current IME workflow processes.	Y
WMR-3	Reconfigure workflows as required to support revised business processes.	Y
WMR-4	Create the process for assigning and transferring claims within the workflow.	Y
WMR-5	Monitor activities and distribute workloads.	Y
WMR-6	Provide a demonstration of the workflow as requested by the Agency.	Y
WMR-7	Destroy source documents according to procedures defined by the Agency.	Y
Business Rules Management		
BRMR-1	Provide knowledge transfer to the Contractors' and the Agency users in the use of the rules engine.	Y

BRMR-2	Maintain the rules within the rules engine and make all required modifications as directed by the Agency.	Y
BRMR-3	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 Agency.	Y
BRMR-4	Maintain a rules engine(s), which can be queried online.	Y
BRMR-5	Maintain the documentation to support the reason for each change to a rule as directed by the Agency.	Y
Technical Operations Management and Support		
TOR-1	Install and manage all Medicaid Management Information Systems components.	Y
TOR-2	Perform database administration and maintenance.	Y
TOR-3	Provide application security.	Y
TOR-4	Provide Help Desk support for MMIS components.	Y
TOR-5	Provide capacity management.	Y
TOR-6	Maintain interfaces with external applications.	Y
TOR-7	Maintain server hardware and software inventory.	Y
TOR-8	Provide Backup and Recovery processes and documentation.	Y
TOR-9	Perform MMIS component upgrades.	Y
TOR-10	Coordinate and oversee all COTS and custom software brought to the IME by professional services contracts to support IME operations. This includes software inventory, capacity management, and maintaining backup and recovery processes.	Y
TOR-11	Maintain a continuity of operations plan.	Y
Certification Phase		
CR-1	Update the CMS Certification Checklists to reflect changes or additions to system requirements that were submitted with the implementation advance planning document (IAPD.)	Y
CR-2	Validate the RTM against the CMS Certification Checklists to affirm the readiness of the systems to be reviewed for certification.	Y

CR-3	Complete the Certification Readiness documentation in accordance with the stage reviews. Collect the information and documentation needed by CMS to verify that the MMIS has been successfully operating using production data. 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 Contracto 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 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 request 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.	Y
CR-4	Assist the Agency in responding to CMS requests prior to the on-site certification visit(s) and during the site visit(s).	Y
CR-5	Provide necessary resources to the Agency for certification.	Y
CR-6	Assign an individual to coordinate all IME activities for the certification process.	Y
Turnover Phase		
TOVR-1	Create a schedule for turnover activities and submit the schedule for Agency approval.	Y
TOVR-2	Track both the Agency's and Contractor's responsibilities associated with the Turnover Phase.	Y
TOVR-3	Work closely with the successor contractor(s) during the planning for the Turnover Phase.	Y
TOVR-4	Provide a Turnover Plan to the Agency within six months before the start of the Turnover Phase. This Plan must include:	Y
	a. Proposed approach to the turnover.	Y
	b. Tasks and sub-tasks for the turnover.	Y
	c. Schedule for the turnover.	Y
	c. All enterprise production data, program libraries and documentation, including documentation update procedures for the turnover.	Y
	e. Furnish to the Agency a statement of resource requirements that would be required by the Agency or a successor Contractor(s) to take over the MMIS.	Y
TOVR-5	Provide the required turnover services. The Contractor 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 Agency and the successor contractor(s).	Y

TOVR-6	Transfer all non-proprietary source program code onto media approved by the Agency. The Contractor must submit a letter stating all proprietary source code is held by an escrow agent approved by the Agency and is current as of the date of system turnover.	Y
TOVR-7	Ensure that the Agency will be error free and complete when turned over to the Agency or the successor contractor(s).	Y
TOVR-8	Correct, at no cost to the Agency, any malfunctions that existed in the system prior to turnover or were caused by the lack of support by the Contractor as may be determined by the Agency.	Y
TOVR-9	Supply a detailed organizational chart and an estimate of the number, type of personnel to operate the equipment and other functions of the Agency. The estimate shall be separated by type of activity of the personnel, including, but not limited to, the following categories:	Y
	a. Data processing staff	Y
	b. Computer operators	Y
	c. Systems analysts	Y
	d. Systems programmers	Y
	e. Business analysts	Y
	f. Project management staff	Y
	g. Data entry and imaging operators	Y
	h. Provider services staff	Y
	i. Administrative staff	Y
	j. Provider field representatives	Y
	k. Clerks	Y
	l. Managers	Y
TOVR-10	Provide a statement that includes all resources required to operate the MMIS including but not limited to:	Y
	a. Data processing and imaging equipment	Y
	b. System and special software	Y
	c. Other equipment	Y
	d. Telecommunications circuits	Y
	e. Telephones	Y
	f. Office space	Y
TOVR-11	All turnover data must be delivered in an organized and structured format and must be approved by the Agency.	Y
TOVR-12	At the turnover date, transfer to the Agency or the successor contractor(s) as needed a copy of the MMIS data including but not limited to:	Y

	a. All necessary data and reference files.	Y
	b. Imaged documents stored on optical and magnetic disk.	Y
	c. All production computer programs.	Y
	d. All production scripts, routines, control language and schemas.	Y
TOVR-13	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 the procedures of updating computer programs and other documentation.	Y
TOVR-14	Provide knowledge transfer to the successor staff in the operation of the MMIS. Such knowledge transfer must be completed at least two months prior to the end of the Contract. Such knowledge transfer shall include:	Y
	a. Data entry, imaging and claims processing.	Y
	b. Computer operations.	Y
	c. Controls and balancing procedures.	Y
	d. Exception claims processing.	Y
	e. Other manual procedures.	Y
TOVR-15	On a schedule to be determined by the Agency, the Contractor must package, insure and deliver all hardware used in the MMIS to a location designated by the Agency.	Y
TOVR-16	At a turnover date to be determined by the Agency, the Contractor must provide to the Agency 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 Agency or its agent to operate the MMIS.	Y
TOVR-17	Turn over all:	Y
	a. Paper claims and paper claim adjustments.	Y
	b. Paper provider files.	Y
	c. Paper file maintenance forms.	Y
	d. Paper financial records.	Y
	e. All reports associated with the contract(s) throughout the Operations Phase must be provided to the Agency and placed in a designated folder determined by the Agency.	Y
	f. A turnover results report.	Y

Performance Measures		
		Agreement to meet requirement (Y/N)
Internal Quality Assurance		
IQAP-1	Perform quality assurance reviews on a statistically valid random sample basis of manually keyed claims.	Y
IQAP-2	Perform quality assurance reviews on a statistically valid random sample basis of electronic claims.	Y
IQAP-3	Perform quality assurance reviews on a minimum of twenty-five percent (25%) of the operational procedures quarterly, with a goal of one-hundred percent (100%) reviewed annually.	Y
IQAP-4	If the accuracy rate is less than ninety-eight percent (98%), a corrective action plan must be submitted to the Agency within ten (10) business days of the quality review for the Agency's approval.	Y
IQAP-5	Meet ninety-eight percent (98%) of the corrective action commitments within the agreed upon timeframe.	Y
IQAP-6	The sample size for random CMR surveys should be ten percent (10%) of the CMR workload, with a minimum of five (5) reviews per month. A report of results of the sample should be delivered to the Agency by the 15th of each month.	Y
Change Management Process		
CMP-1	Within ten (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 Agency.	Y
CMP-2	Provide updates to all documentation within ten (10) business days after the Agency approves the enhancement or modification for production.	Y
CMP-3	Notify the Agency within twenty-four (24) hours of discovering an issue or defect. 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 Agency for approval. This work must be done without impacting scheduled Agency requests.	Y
CMP-4	Submitters must be satisfied with the timeliness, communication, accuracy and result of the CMR process ninety-five percent (95%) of the time.	Y

Mail Room and Courier Service		
MRP-1	Return claims lacking a procedure and diagnosis code to the provider, unless an exception is made by the Agency, within one (1) business day.	Y
MRP-2	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 (1) business day.	Y
MRP-3	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y
MRP-4	one (1) hundred percent (100%) of claims and all other documents will be scanned and available within the system within a twenty-four (24) hour period of receipt excluding state holidays and weekends.	Y
Member Management		
MMP-1	Update the member eligibility database with electronically received data and provide the Agency with update and error reports within twenty-four (24) hours of receipt of daily updates. Update within two (2) hours of receipt of data for batch-processing environment. Resolve eligibility transactions that fail the update process within twenty-four (24) hours of error detection.	Y
MMP-2	Refer to the Agency all eligibility transactions that fail the update process and cannot be resolved by Contractor staff pursuant to edit rules or Agency approved standards within one (1) business day of attempted error resolution.	Y
MMP-3	Perform online updates for hardcopy update transactions to member data, except presumptive eligibility records, within one (1) business day of receipt.	Y
MMP-4	Add records for presumptively eligible individuals to the member eligibility file the same day as the eligibility determination.	Y
MMP-5	Maintain a ninety-eight percent (98%) keying accuracy rate for online updates.	Y
MMP-6	Identify and correct keying errors in online updates within one (1) business day of identifying the error.	Y
MMP-7	Produce and send notices to members based on adverse actions for denied ambulance and rehabilitation claims and denied and modified prior authorizations within three (3) business days of decision on the claim.	Y
MMP-8	Provide a weekly report to the Agency of all Notices of Denial (NOD) to members that were sent based on adverse actions for denied ambulance and rehabilitation claims, and denied and modified prior authorizations within five (5) business days of the NOD.	Y

MMP-9	Issue NOD to members within twenty-four (24) hours of the determination of the denial of ambulance claims and rehabilitation therapy services claims for occupational therapy, physical therapy and speech therapy.	Y
MMP-10	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y
MMP-11	Produce state-defined reports within the Agency required timeframe.	Y
MMP-10	Conduct a quality assurance reconciliation process at least monthly.	Y
Medically Needy		
MNP-1	All claims will be applied to the medically needy spenddown accounts according to the following timelines:	Y
MNP-2	a. Within twenty-four (24) hours of adjudication cycle for all Medicaid covered claims.	Y
MNP-3	b. Within forty-eight (48) hours of adjudication cycle for all Non-Medicaid covered claims.	Y
MNP-4	Identify at least ninety-five (95%) percent of the appropriate claims for the medically needy spenddown account for approved medically needy clients.	Y
MNP-5	Create and or update operational procedure manuals within ten (10) business days of the implementation procedure or change by the Agency.	Y
MNP-6	Produce state-defined reports within the required timeframe as defined by the Agency.	Y
Provider Management		
PMP-1	If the state develops an automated interface for licensing and or certification data, the Contractor must meet these standards for update of this licensing and certification data.	Y
PMP-2	a. Validate the licensing update process within two (2) business days of application of the update transmission.	Y
PMP-3	b. Resolve licensing transactions that fail the update process within two (2) business days of error detection.	Y
PMP-4	c. 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 (2) business days of attempted error resolution.	Y
PMP-5	Produce and mail provider 1099s by January 31st of each calendar year.	Y
PMP-6	Produce and make provider mailing labels available for printing in the state data center within one (1) business day of request.	Y
PMP-7	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y

PMP-8	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y
PMP-9	The provider web portal must have a minimum ninety-eight and a half percent (98.5%) availability, excluding IME approved scheduled maintenance.	Y
Claims Entry and Receipt		
CEP-1	Data enter ninety-eight percent (98%) of all hard copy claims and adjustment and or void requests within two business days of receipt.	Y
CEP-2	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 (1) business day of receipt.	Y
CEP-3	Return hard copy and clean claims that fail the prescreening process within one (1) business day of receipt.	Y
CEP-4	Maintain at least a ninety-six percent (96%) keying accuracy rate for data entered documents.	Y
CEP-5	Maintain a ninety-nine percent (99%) accuracy rate for electronic claims receipt and transmission.	Y
CEP-6	Produce and provide to the Agency all daily, weekly and monthly claims entry statistics reports within one (1) business day of production of the reports.	Y
CEP-7	Imaged claims must be immediately available for processing and viewing within four (4) hours.	Y
CEP-8	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 (10) seconds.	Y
CEP-9	Return an electronic receipt and or notification for claims submitted electronically within four (4) business hours of receipt.	Y
CEP-10	All EDI claims, including Medicare crossover claims, must be processed within one (1) business day after receipt.	Y
CEP-11	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y
CEP-12	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y
CEP-13	Maintain a service level (SL) percentage of at least ninety percent (90%) for incoming EDI calls as calculated by the following formula:	Y
	SL= ((T – (A+B)/T)*100)	Y
	Where T = all calls that enter the queue	Y

	A= calls that are answered after 30 seconds	Y
	B= calls that are abandoned after 30 seconds	Y
CEP-14	Maintain a service level (SL) percentage of at least ninety-five percent (95%) of EDI inquiries submitted through e-mail or direct secure messaging receive outreach (personal message response or phon response) within one (1) business day.	Y
CEP-15	Ninety-five percent (95%) of all provider clean claims are able to clear EDI editing and continue to be uploaded and processed in the system.	Y
Claims Adjudication		
CAP-1	Ninety percent (90%) of all clean claims must be adjudicated for payment or denial within ten (10) calendar days of receipt.	Y
CAP-2	Ninety-nine percent (99%) of all clean claims must be adjudicated for payment or denial within sixty (60) calendar days of receipt.	Y
CAP-3	one hundred percent (100%) of all claims must be adjudicated for payment or denial within one-hundred and twenty (120) calendar days of receipt.	Y
CAP-4	one hundred percent (100%) of all clean provider-initiated adjustment requests must be adjudicated within ten (10) business days of receipt.	Y
CAP-5	Claims processed in error must be reprocessed within ten (10) business days of identification of the error or upon a schedule approved by the state.	Y
CAP-6	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y
CAP-7	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y
CAP-8	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.	Y
Encounter		
EP-1	Process and report disposition of encounter file edit review to the submitting managed care organization within three (3) business days of receipt.	Y
EP-2	Provide encounter data files, in acceptable format, to the Agency recognized Contractors within five (5) business days of end of designated reporting period.	Y
EP-3	Report findings from audits of HMO, Iowa Plan and the transportation broker, encounters to the Agency within five (5) business days from the end of the reporting quarter.	Y
EP-4	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y

EP-5	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y
Reference		
RFP-1	Produce state-defined reports within the required timeframe as determined by the Agency.	Y
RFP-2	Update the CLIA laboratory designations within one (1) business day of receipt of file.	Y
RFP-3	Perform online updates to reference data within one (1) business day of receipt and the Agency authorization or on a schedule as approved by the Agency.	Y
RFP-4	Process procedure, diagnosis and other electronic file updates to the reference databases within two (2) business days of receipt and approval or upon a schedule approved by the Agency.	Y
RFP-5	Provide updated error reports and audit trails to the Agency within one (1) business day of completion of the update.	Y
RFP-6	Update, edit and adjudication documentation within three (3) business days of the request from the Agency.	Y
RFP-7	Update error text file documentation within three (3) business days of the Agency approval of the requested change.	Y
RFP-8	Maintain a ninety-nine percent (99%) accuracy rate for all reference file updates.	Y
RFP-9	Notify the Agency and correct errors within one (1) business day of error detection.	Y
RFP-10	Create and or update operational procedure manuals within ten (10) business days of the approval of the procedure implementation or change by the Agency.	Y
RFP-11	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y
Prior Authorization Management		
PAP-1	Process all single transaction prior authorizations within three (3) minutes of the receipt of the transaction and return the status of the prior authorization to the provider.	Y
PAP-2	Complete all prior authorization batch interface updates from prior authorization entities within one (1) business day of receipt of file if there are no critical errors.	Y
PAP-3	Forward all prior authorization requests to the appropriate prior authorization entities within four hours.	Y
PAP-4	Create and or update operational procedure manuals within ten (10) business days of the approval of the procedure implementation or change by the Agency.	Y
PAP-5	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y
Third Party Liability Management		
TPLP-1	Create and or update operational procedure manuals within ten (10) business days of the approval of the procedure implementation or change by the Agency.	Y
TPLP-2	Generate TPL and trauma lead letters within twenty-four (24) hours of receipt.	Y

TPLP-3	Process TPL updates within twenty-four (24) hours of receipt from the Revenue Collection contractor.	Y
TPLP-4	Update member files to include the TPL plan and coverage information for HIPP members within twenty-four (24) hours of receipt from the HIPP unit.	Y
TPLP-5	Generate a file of all paid claims and member eligibility by the fifth (5th) business day of each month for the previous month.	Y
TPLP-6	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y
TPLP-7	The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.	Y
Program Management Reporting		
PMRP-1	All standard production reports must be available on line for review by the Agency staff pursuant to the following schedule:	Y
	1. Daily reports – by 6:00 AM of the following business day.	Y
	2. Weekly reports – by 6:00 AM of the next business day after the scheduled production date.	Y
	3. Monthly reports – by 6:00 AM of the first (1st) business day after month end cycle.	Y
	4. Quarterly reports – by 6:00 AM of the fifth (5th) business day after quarterly cycle.	Y
	5. Annual reports – by 6:00 AM of the tenth (10th) business day after year end cycle (state fiscal year, federal fiscal year, waiver year or calendar year).	Y
	6. Balancing reports are to be provided to the Agency within two (2) business days after completion of the program management reporting production run.	Y
PMRP-2	Model results are to be returned to the Agency within two (2) business days of receipt of proposed business rules, or as directed by the Agency.	Y
PMRP-3	Deliver model reports timely for ninety (90%) of all requests.	Y
PMRP-4	When an error in a report is identified either by the Contractor or by the Agency, provide an explanation as to the reason for the error within one (1) business day and correct the report within one (1) business day following the date the error was identified unless the Agency authorizes additional time for correction.	Y
PMRP-5	Data files for all reports must be made available on the state data center servers and accessible online within one (1) business day of completion.	Y
PMRP-6	Create and or update operational procedure manuals within ten (10) business days of the approval of the procedure implementation or change by the Agency.	Y
PMRP-7	Produce Agency-defined reports within the required timeframe as determined by the Agency.	Y

PMRP-8	The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.	Y
Federal Reporting Management		
FRP-1	Create and or update operational procedure manuals within ten (10) business days of the approval of the procedure implementation or change by the Agency.	Y
FRP-2	Produce federal reports on the following schedule:	Y
	1. Quarterly reports – by 6:00 AM of the first (1st) business day following the final regular pay cycle of the quarter.	Y
	2. Annual reports – by 6:00 AM of the fifth (5th) business day after last pay cycle of the reporting year (state fiscal year, federal fiscal year, waiver year or calendar year).	Y
FRP-3	Produce PERM data within the required timeframe determined by the Agency.	Y
FRP-4	Modify changes to federal reports within five(5) business days of request by the state.	Y
FRP-5	Respond to questions from CMS, OIG and state auditors within the timeframes determined by the Agency.	Y
FRP-6	Produce Agency-defined reports within the required timeframe determined by the Agency.	Y
FRP-7	The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.	Y
Financial Management and Reporting		
FMP-1	Create and or update operational procedure manuals within ten (10) business days of the approval of the procedure implementation or change by the Agency.	Y
FMP-2	Produce Agency-defined reports including, but not limited to accounts payable and receivable reports, within the required timeframe determined by the Agency.	Y
FMP-3	Produce, post and mail the Explanation of Medicaid Benefits (EOMB) within five (5) business days of the pay cycle.	Y
FMP-4	Produce, post and mail all remittance advices within one (1) business day of the pay cycle.	Y
FMP-5	Perform mass adjustments within five (5) business days of being directed to do so by the Agency.	Y
FMP-6	Deliver the EFT and check file as directed by the Agency.	Y
FMP-7	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 (1) business day of the last pay cycle of the month.	Y
FMP-8	Print and mail RCF letters and checks, including lien holder provider checks as determined by the Agency.	Y

FMP-9	The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.	Y
Program Integrity Management		
PIMP-1	All required reports must be available online for review by the Agency staff pursuant to the following schedule:	Y
	1. Daily reports - by 10:00 AM of the following business day.	Y
	2. Weekly reports – by 10:00AM of the next business day after the scheduled production date.	Y
	3. Create and or update operational procedure manuals within ten (10) business days of the approval of the procedure implementation or change by the Agency.	Y
	4. Produce the Agency-defined reports within the required timeframe as determined by the Agency.	Y

Managed Care		
MCP-1	Process payments on a schedule approved by the Agency.	Y
MCP-2	Meet a ninety-eight percent (98%) accuracy rate for all capitation rate assignments.	Y
MCP-3	Meet a ninety-eight percent (98%) accuracy rate on appropriate payment or denial, of fee-for-service claims for managed care members.	Y
MCP-4	Create and or update operational procedure manuals within ten (10)business days of the approval of the implementation procedure or change by the Agency.	Y
MCP-5	Produce Agency-defined reports within the required timeframe determined by the Agency.	Y
Eligibility Verifcation System (ELVS)		
EVSP-1	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.	Y
EVSP-2	The IVRS referred to as ELVS must be available ninety-eight percent (98%) of the time, twenty-four (24) hours a day and seven (7) days a week.	Y
EVSP-3	Update IVRS referred to as ELVS upon receipt of a change in eligibility.	Y
EVSP-4	Update ELVS information near real-time as claims are adjudicated and cost sharing responsibilities change.	Y
EVSP-5	Correction of system pronunciation of names within one (1) business day of identification of problem.	Y
EVSP-6	Update voice response scripts to correct errors within one (1) business day of identification of problem.	Y
EVSP-7	Notify the Agency designees of operational issues within one (1) hour of identification.	Y
EVSP-8	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y
EVSP-9	Produce the Agency-defined reports within the required timeframe determined by the Agency.	Y
EVSP-10	The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.	Y

Web Services		
WSP-1	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y
WSP-2	Produce the Agency-defined reports within the required timeframe determined by the Agency.	Y
WSP-3	The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.	Y
Workflow Management		
WMP-1	Create and or update operational procedure manuals within ten (10) business days of the approval of the implementation procedure or change by the Agency.	Y
WMP-2	Produce the Agency-defined reports within the required timeframe determined by the Agency.	Y
WMP-3	The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.	Y
Business Rules Management		
BRMP-1	Update the rules engine with Agency-approved modifications in accordance with the change management process standards.	Y
Technial Operations Management and Support		
TOP-1	The MMIS operational systems must be available from 6:00am to 6:00PM Monday through Saturday ninety-eight (98%) of the time.	Y
TOP-2	Documentation must be reviewed quarterly and updated within ten (10) business days of identifying inaccurate or incomplete information.	Y
TOP-3	In the event of a disaster, system recovery must be completed within three (3) calendar days.	Y
Turnover Phase		
TOVP-1	One hundred percent (100%) of all turnover activities must be completed and approved by the Agency prior to final payment to the Contractor.	Y