Table of Contents
Section 1

Table of Contents
Section 1 (continued)

Section 1
General Information

1.1 Overview

1.1.1 Purpose of Procurement

The State of New York, Department of Health (DOH), "the Department," is conducting this procurement to select a contractor to design, develop, implement, and operate a Replacement Medicaid System which will, at a minimum, meet the functionality of the current Medicaid Management Information System (MMIS) and Electronic Medicaid Eligibility Verification System (EMEVS); to enhance that functionality as specified in Section 7 of this Request for Proposals (RFP); and to implement and operate a Medicaid data warehouse and related data marts as specified in Section 8. The operations responsibilities of the contractor are specified in Sections 7 and 8 of this RFP. The approach to replacement of the Medicaid systems is detailed in Section 6 of this RFP.

The Department intends that the selected contractor transfer an existing system, or components of existing systems, and modify that system(s) to meet the needs of New York State's Medicaid programs. The transfer base may be an MMIS, components of MMISs from several states, or commercial systems. It is the Department's desire that the offerors identify "best of breed" in selecting the transfer base components.

It is important that the resulting New York State Medicaid system have the capability to not only meet the current needs of the New York program, but be sufficiently flexible to meet future needs of the program. Since the quality of the new system is of paramount importance to the Department, the selection of the contractor during this procurement will be based on the "best value" approach in which, although price will be a factor, the overall value to the Department will be the prime determinate.

1.1.2 Procurement Objectives

Through this procurement, the Department intends to obtain the services of a contractor for the transfer, modification, installation, and ongoing operation of a certifiable Replacement Medicaid System and to perform certain business functions as assigned by the Department. The Department will not accept the

simple transfer of an existing system; the contractor must be prepared to modify its proposed base system(s) to conform to the requirements described in this RFP.

Offerors may propose the integration of components from a single system or multiple systems but must utilize a system architecture flexible enough to accommodate user input during the completion of joint application design (JAD) sessions.

1.1.3 Overall Approach to the Contract

The approach to the contract for the implementation and operation of the Replacement Medicaid System is constrained by the contracts with the incumbent contractors and by the deadline for implementing electronic data interchange (EDI) standards imposed by the Health Insurance Portability and Accountability Act.

The contracts with the incumbent contractors were scheduled to terminate on October 31, 1998. The Department has negotiated extensions of those contracts as follows:

- The MMIS contract with Computer Sciences Corporation (CSC) will be extended for two (2) years (through October 31, 2000). During this time period, CSC will continue to operate the MMIS, will ensure that it is Year 2000-compliant, and will make other changes at the direction of the Department.

- The EMEVS contract with Deluxe Electronic Payment Systems (DEPS) will be extended for one (1) year (through October 31, 1999). During this time period, DEPS will continue to operate the EMEVS, will upgrade the telecommunications network to ensure that it does not fail before replacement, will ensure that it is Year 2000-compliant, and will make other changes at the direction of the Department.

The contractor selected as a result of this procurement will have the responsibility to develop, implement, and operate the Replacement Medicaid System. This replacement will be accomplished in phases as follows:

- By November 1, 1999, the contractor shall design, develop, and implement the EMEVS replacement. This will include several components of the Replacement Medicaid System:

The Eligibility Verification System (EVS) and other elements of the Electronic Commerce component (Section 7.5)

The Client Eligibility Data Repository (Section 7.2)

The Utilization Threshold and Post and Clear components of Service Utilization Management (Section 7.8)

The Prospective Drug Utilization Review (Section 7.14) and point-of-service drug claims capture (Section 7.5)

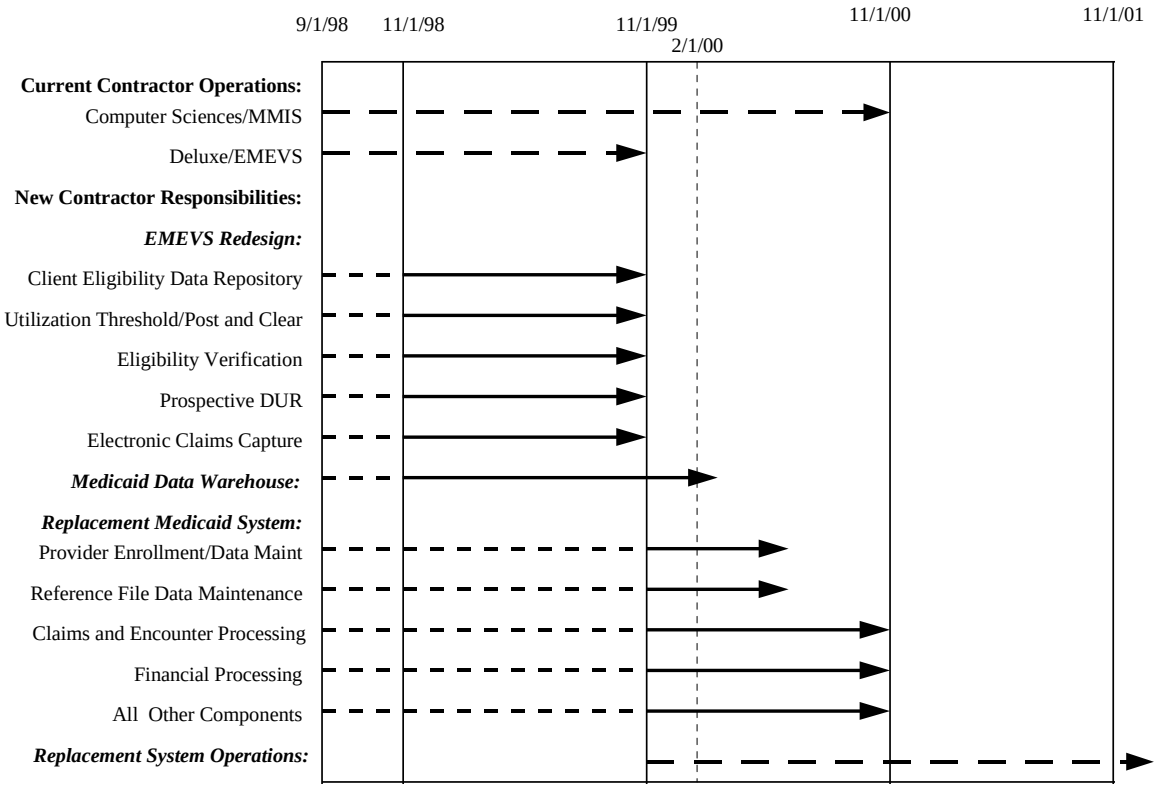
The "EMEVS redesign" shall also include the ability to receive all claim types electronically in compliance with the Health Insurance Portability and Accountability Act.

- The selected contractor shall design the Medicaid data warehouse as defined in Section 8 of this RFP. By February 28, 2000, the contractor must implement the Medicaid data warehouse, which includes completion of the metadata, design of the database, conversion and population of the database with a minimum of twenty-four (24) months of data, and access to the data with tools that permit users to create and run queries and generate reports.

- By November 1, 2000, the contractor shall implement and begin operations of all other Replacement Medicaid System components described in Section 7 and all other Medicaid data warehouse components defined in Section 8. The contractor may implement these components in phases and begin operations, so long as all the components are implemented by October 31, 2000 and operations begin by November 1, 2000.

This overall approach is illustrated in Exhibit 1.1.

Exhibit 1.1
Timeline for Implementation of the New York State Replacement Medicaid System



1.1.4 Schedule of Procurement Activities

The schedule of procurement activities is as follows:

RFP Release	March 2, 1998
Procurement Library Available	March 4, 1998
Offerors' Conference	March 26, 1998
Questions Due	April 3, 1998
Letter of Intent Due	April 3, 1998
Proposals Due	June 19, 1998, 5:00 p.m., Eastern Time
Contractor Selection	September 1, 1998
Contractor Starts Work	September 8, 1998

1.1.5 Term of Contract

The Department intends to award a contract that may extend for up to eight (8) years and six (6) months. The base period shall be six (6) years and shall include all implementation and operations tasks. The Department shall have the option to extend the contract for up to two (2) one- (1-) year periods. The Department shall also have the option to extend the contract in one- (1-) month increments for up to six (6) months.

1.2 Usage of Common Terms in This RFP

Comprehensive definitions of the terms and acronyms used in this RFP are provided in Appendix B. For convenience, some of those terms are discussed in the following paragraphs.

1.2.1 Welfare Management System (WMS)

Medicaid eligibility is established by the Local Departments of Social Services (LDSS). In support of this process, the LDSS use the Welfare Management System (WMS) to enter the information necessary to establish eligibility. The WMS employs edits along with automated and manual processes to ensure that proper Medicaid policies are enforced.

The WMS is operated by the Human Services Application Service Center (HSASC). The State agencies responsible for setting eligibility determination policy are the Office of Temporary and Disability Assistance and the Bureau of Medicaid Eligibility (Office of Medicaid Management). These organizational entities are described in more detail in Section 1.4 of this RFP.

There are a number of Medicaid systems operated by the HSASC that, along with the WMS, support Medicaid eligibility determination. These systems are:

- Medical Assistance Budget Eligibility Logic (MABEL)
- Restriction/Exception Processing
- Principal Provider Processing
- Pay-in Processing

- Client Notice System (CNS)
- State Data Exchange (SDX) Processing
- Electronic Eligibility Decision Support System (EEDSS)
- Growing Up Healthy (GUPH) Processing
- Prepaid Capitation Processing (PCP)
- Prenatal Care Assistance Program (PCAP) Processing

All of the logic in these systems must be incorporated into the Client Eligibility Data Repository, as specified in Section 7.2.

1.2.2 MMIS and EMEVS

The acronym "MMIS" is generally used to refer to a Medicaid Management Information System that has been certified by the Health Care Financing Administration (HCFA) as meeting the requirements of Section 1903(r) of the Social Security Act, as amended. Section 1903(r) requires that all states have approved systems but also allows for enhanced funding of such systems.

In New York State, the current MMIS is associated primarily with claims processing and standard reporting and does not include many of the common functions generally considered to be integral to an MMIS. For example, eligibility, provider, and reference data maintenance functions are performed on separate New York State systems operated by the HSASC. Data is transmitted weekly to the MMIS for use in claims processing. The MMIS is operated by the current fiscal agent contractor, Computer Sciences Corporation (CSC). In addition to claims processing, CSC also operates the Medicaid Override Application System (MOAS), as described in Section 7.8, and provides retrospective drug utilization review under a subcontract with Pharmark.

The acronym "EMEVS" refers to the Electronic Medicaid Eligibility Verification System. The EMEVS is unique to New York in terms of the functions it performs. These functions include:

- Eligibility verification system (EVS), including point-of-service (POS) devices; audio response unit (ARU), which is the New York voice response system; PC-based dial-in; remote job entry (RJE) for selected providers; and computer-to-computer connection.

- Utilization threshold (UT), a mechanism by which providers can request authorization for services that are subject to benefit limitations.

- Post and clear, a mechanism by which certain providers must obtain authorization to perform services. For example, a prescribing provider (e.g., a physician) prescribes a drug or orders a lab test. The prescription or order via the EMEVS establishes the "posting" and creates a service authorization. The pharmacy or lab, via the EMEVS, "clears" the posting and receives a service authorization. If the service authorization exists, a valid claim is paid; if not, the claim is denied.

- Prospective Drug Utilization Review (ProDUR) and drug claim capture. The EMEVS captures the drug claims interactively and conducts the utilization review. If necessary, the EMEVS sends alerts on drug-to-drug interaction, etc., back to the pharmacy. Otherwise, the claim is captured and transmitted to the MMIS for processing.

- Health plan enrollment, a mechanism by which certain health plans can enroll clients into the health plan. A transaction is sent to the WMS for normal processing of the enrollment.

To reduce confusion, this RFP will use the terms MMIS and EMEVS to refer to the current New York State Medicaid systems.

1.2.3 Replacement Medicaid System

The contractor shall design, develop, implement, and operate new Medicaid systems to replace the MMIS and EMEVS. Throughout this RFP, this new system will be referred to as the Replacement Medicaid System. This system must meet and enhance the current functionality of the MMIS and EMEVS, as described in Section 7. It must also support the data warehouse and related data marts, as specified in Section 8.

1.2.4 Fee-for-Service and Capitation Payments

The term "fee for service" is widely used to refer to payments made to providers for specific services rendered. The term applies regardless of the basis for calculating the payment. The method of payment under Department policy may be based on a fee schedule (e.g., reimbursement of physician services based on a set fee for the reported procedure code), on a provider-specific rate for a service, or on an occurrence of a service (e.g., DRG reimbursement of inpatient hospital services). For New York State, the term "fee for service" includes both "fee-based" and "rate-based" providers.

Throughout this RFP, the term "fee for service" is used in the context described above. In New York State, the providers that are reimbursed on the basis of a fee schedule are described in this RFP as "fee-based providers" while providers that are reimbursed on the basis of provider-specific rates are described as "rate-based providers."

The opposite of a fee-for-service program is a program by which a provider, a health plan, or other approved entity is reimbursed a fee (or "capitation payment") for each enrolled client for the specified time period, typically one (1) month. This per-member-per-month payment is made to the entity whether or not any specific services are provided to the client during that month.

1.2.5 Contractual Terms in the RFP

The use of the terms "shall," "must," and "will" refers to a mandatory requirement or condition to be met by the contractor. Where functionality or conditions are left to the option of the contractor, the term "may" is used.

1.3 Description of the New York State Medicaid Program

1.3.1 Overview

The New York State Department of Health is the single State agency responsible for administering the Medicaid program in the State of New York. The program is managed by the Office of Medicaid Management (OMM). In

addition, the following organizations have functional responsibility for certain aspects of the program:

- Office of Managed Care (OMC)
- Fiscal Management Group
- Office of Temporary and Disability Assistance
- Office of Children and Family Services
- Human Services Application Service Center (HSASC)
- Local Departments of Social Services (LDSS)
- Local Departments of Health
- Office of Mental Health (OMH)
- Office of Mental Retardation/Developmental Disabilities (OMR/DD)
- Office of Alcohol and Substance Abuse Services (OASAS)
- Office of the State Comptroller
- Department of Law, Medicaid Fraud Unit

1.3.2 Medicaid Eligibility

The New York State Medicaid program provides medical assistance to approximately three million (3,000,000) eligible clients. This includes the categorically needy population, those deemed categorically needy, and those eligible for services under federally authorized waiver programs. It also includes a medically needy program.

The following categorical groups are covered by the New York State Medicaid program, subject to income and assets limitations:

- Aged, blind, and disabled persons, including persons receiving Supplemental Security Income (SSI)

- Families receiving assistance under the Temporary Assistance to Needy Families (TANF) program who are eligible for Medicaid as Low Income Families (LIF)

- Persons receiving safety net benefits who are eligible for Medicaid under Singles/Childless Couples (S/CC) or LIF

- Poverty-level groups

- Persons for whom the State must pay Medicare premiums and reimburse providers for Medicare coinsurance and deductible, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLIMB), and Qualified Disabled Working Individuals (QDWI)

The New York State Medicaid program also covers medically needy individuals who are not receiving assistance but whose medical costs make them eligible for Medicaid, including:

- SSI-related individuals

- ADC-related individuals

1.3.3 Scope of Medical Services

The New York State Medicaid program provides all the mandatory and many of the optional services to eligible clients, either through fee-for-service or managed care capitated services. Exhibit 1.2 provides a list of the services.

Exhibit 1.2
Scope of Services of the New York State Medicaid Program

Inpatient hospital services
Outpatient hospital diagnostics and treatment center and emergency room services, including rural health clinic and federally qualified health center services
Laboratory and X-ray services
Ordered ambulatory services
Residential health care facility services
Services provided in intermediate care facilities for the developmentally disabled
Physician services
Nurse practitioner services
Midwife services
Eye care services, including optometry services, eyeglasses, and low-vision aids
Clinical psychology services

Exhibit 1.2
Scope of Services of the New York State Medicaid Program

Home health services
Personal care services
Long-term home health care program services
Early and periodic screening and diagnosis of individuals under age twenty-one (21) and treatment of conditions found (known as the Child/Teen Health Program in New York State)
Family planning services and supplies
Private-duty nursing services
Physical therapy, occupational therapy, speech therapy, and audiology
Prescription and non-prescription drugs
Medical/surgical supplies and durable medical equipment
Prosthetic and orthotic devices, including hearing aids
Inpatient psychiatric facility services for individuals under age twenty-two (22) and age sixty-five (65) and over
Hospice services
Comprehensive Medicaid case management services
Transportation services
Services of child care agencies
Rehabilitation services within residential programs licensed by the Office of Mental Health (Community Residences, Family-Based Treatment, and Teaching Family Homes)
Freestanding inpatient residential alcoholism treatment programs
Home- and community-based services under Federal waivers
Medicare Part B coinsurance and deductible payments for services not otherwise covered under the State Plan (e.g., chiropractic services)
Rehabilitative services, such as Early Intervention and School Supportive Health
Dental services
Mental health clinic
Continuing day treatment (CDT)
Intensive psychiatric rehabilitation therapy
Partial hospitalization
Rehabilitation services in community residences, family-based treatment, and teaching family homes
Comprehensive psychiatric emergency programs

1.3.4 Controls on Services

The New York State Medicaid program has implemented various control mechanisms to ensure appropriate utilization of services. For example, frequency editing is done on specific procedures to check for overutilization. The Utilization Threshold program places threshold limits on select categories of service, e.g., laboratory. An override must be obtained by the client's health care professional if additional care is medically necessary. A third process requires prior approval or prior authorization for certain services. For example, non-emergency transportation requires the prior authorization of the

local commissioner of social services. Select dental procedures require prior approval of the local professional director.

1.3.5 Provider Reimbursement

Within the limitations prescribed by Federal laws and regulations, the Department has established various methods of determining provider reimbursement levels for the provision of fee-for-service Medicaid-covered services. These methods, which include both service-based fees and provider-specific rates, are described briefly below.

The reimbursement methodologies currently utilized by the New York State Medicaid program include:

- Prospective diagnosis-related groups (DRGs) for inpatient hospital; similar to Medicare with adjustments to reflect transfer cases, cost outliers, and day outliers
- Prospective inclusive rates for outpatient hospital
- Cost-based, case-mix-adjusted reimbursement for nursing homes and Intermediate Care Facilities for the Mentally Retarded
- Fee schedules for physicians, dentists, and other practitioners
- Provider-specific rates for rural health clinics, Federally Qualified Health Centers, clinics, home health agencies, and laboratories and X-ray providers
- The lowest of maximum allowable charge (MAC), amount billed, or estimated acquisition cost (EAC) (for legend drugs), plus dispensing fee, for pharmacy
- Monthly case payment rates for certain mental health providers
- Rate add-ons for select mental health providers

1.4 Organization of the New York State Medicaid Program

Although the Office of Medicaid Management is the primary office within the State agency involved in the management of the New York State Medicaid program, a number of other agencies participate in the program. This section presents a description of each of these agencies.

1.4.1 Office of Medicaid Management (OMM)

The Office of Medicaid Management is responsible for the administration of the Title XIX program and for fee-for-service operations. The Director of OMM has organized the Office into the areas described in the following sections.

1.4.1.1 Bureau of Medicaid Policy and Utilization Review

This Bureau manages all aspects of the Medicaid fee-for-service ambulatory and inpatient categories of service, special programs designed to improve the quality and utilization of Medicaid services, interfaces with the Office of Managed Care (OMC) on managed care issues, and interfaces with OMH and OASAS on mental health and substance abuse issues, respectively. The Bureau's functions include:

- Developing, implementing, monitoring, and evaluating Medicaid provider policy and programs
- Providing technical assistance on Medicaid policies and programs
- Defining specific program and policy requirements for systems projects to ensure quality and appropriate utilization
- Conducting medical reviews to evaluate utilization of services, including focused reviews for the Recipient Restriction program and other initiatives
- Developing and implementing Medicaid cost-containment proposals
- Drafting, negotiating, executing, and overseeing Medicaid contracts (other than Medicaid systems contracts)
- Reviewing fee and rate methodologies and reimbursement

- Enrolling fee-based providers, scheduling and distributing rosters and reports, document retrieval, and certifying provider fraud control and provider services

- Overseeing the policy area for both the prospective and retrospective DUR program, in conjunction with the DUR Board

1.4.1.2 Bureau of Medical Review and Evaluation

This Bureau implements policies and standards governing the quality and availability of services provided under the Medicaid program and reviews medical services provided to Medicaid clients to ensure that such services are cost-effective. The Bureau meets these goals by:

- Maintaining prior-approval controls on requests for goods and services to be reimbursed by Medicaid on a fee-for-service basis

- Performing prepayment review of Medicaid claims for medical necessity and price

- Developing computer editing to support clinical review and reimbursement protocols

- Assisting Medicaid auditors and the Medicaid fraud control staff by interpreting program standards and providing expert testimony

- Updating Medicaid fee and rate schedules and relevant sections of MMIS provider manuals

- Enrolling rate-based providers and maintaining the rate file

1.4.1.3 Bureau of Program and Data Analysis

This Bureau prepares multi-year budget trends and analyzes program initiatives to identify total costs and underlying trends as well as coordinates rate-setting functions. Bureau activities include:

- Preparing budget trends, conducting fiscal analysis of program initiatives, and managing State and Federal cash needs as they relate to Medicaid client services

- Monitoring the implementation of program initiatives that have budgetary impacts

- Organizing Medicaid claims data to facilitate the analysis of Medicaid program trends to provide guidance for policy development

- Identifying and analyzing the budgetary impact of legislation, Federal programs, and other payor actions on the Medicaid program

- Monitoring other agency Medicaid actions and analyzing their impact

- Establishing rates for home care and interfacing with other Office and Department staff to establish Medicaid rates for all other areas

- Providing local government units with information relative to the impact of initiatives on local budgets

1.4.1.4 Bureau of Medicaid Eligibility

This Bureau develops and promulgates rules and regulations to determine financial eligibility as the point of entry for Medicaid program. It develops and maintains automated systems to support this function. Activities include:

- Ensuring reduction of expenses through utilization of the client's own resources, health insurance, and Medicare benefits

- Implementing Medicaid eligibility policy for all individuals who are under sixty-five (65) and who do not have special needs

- Implementing Medicaid eligibility policy for the aged and special needs populations, including blind and disabled individuals, as well as administering the Medicaid program in the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the Department's long-term care facilities

1.4.1.5 Bureau of Medicaid Systems

This Bureau develops contract specifications for reprocurement of Medicaid systems, ensures compliance with Federal requirements, and oversees development of system enhancements. Bureau functions include:

- Proposing and coordinating upgrades to Medicaid systems, including the MMIS and EMEVS along with the WMS and associated subsystems
- Tracking, prioritizing, and interfacing with Medicaid programs on systems development projects for Medicaid and related systems
- Providing personal computer and local area network support for the Office of Medicaid Management
- Drafting, negotiating, and executing Medicaid systems contracts and monitoring compliance with such contracts
- Coordinating with the Health Care Financing Administration for enhanced funding of Medicaid systems initiatives

1.4.1.6 Downstate Medicaid Operations

This Bureau ensures consistent implementation of the Medicaid program in New York City and adjacent counties. Bureau functions include:

- Providing technical assistance to the New York City Medicaid program
- Developing and implementing enhancements to Medicaid systems to ensure consistency of data while reducing New York City's requirement for resources through automation
- Resolving complex issues for Medicaid clients in New York City and in Nassau and Suffolk counties

1.4.1.7 Division of Quality Assurance and Audit

The Division of Quality Assurance and Audit (QA&A) views itself as an organization that is flexible enough to mix traditional audit and review methodologies with innovative ways to increase State revenues, decrease expenditures, and improve State and local district operations to meet DOH's priorities and goals.

The Division's mission is to support DOH priorities and goals through:

- Ensuring the fiscal and operational integrity of State and local systems and programs
- Performing audits, reviews, evaluations, and investigations regarding the economy and efficiency of Department programs
- Pursuing identified overpayments
- Identifying and developing revenue generation and cost-reduction opportunities that contribute to the attainment of program and management goals
- Providing consultation and technical assistance to the Department and local districts for improvement of management and operational processes

1.4.2 Office of Managed Care

New York implemented a mandatory managed care program, called The Partnership Program, under a Section 1115 waiver, approved by the Department of Health and Human Services on July 15, 1997. This program will build on the voluntary program that was implemented under the statewide Managed Care Act of 1991.

The program will initially enroll Temporary Assistance to Needy Families (TANF) and Home Relief clients and will be implemented in five (5) thirteen-(13-) month phases on a county-by-county basis beginning in October 1997. Mandatory enrollment of Supplemental Security Income (SSI) and SSI-related populations is expected to begin, again on a county-by-county basis, on August 1, 1998.

The Office of Managed Care is responsible for the overall design, implementation, and oversight of the New York State Medicaid managed care program. The Office of Managed Care has been organized into a number of bureaus, each with its own functional responsibilities.

1.4.2.1 Intergovernmental and Consumer Affairs Unit

This Bureau is responsible for the oversight of all contracting activities under the Medicaid managed care program. Bureau functions include:

- Providing liaisons with LDSSs
- Monitoring county grant programs
- Developing and implementing marketing guidelines for managed care organizations
- Developing and overseeing the Medicaid managed care enrollment process
- Responding to inquiries concerning consumer rights and responsibilities

1.4.2.2 Bureau of Managed Care Financing

This Bureau is responsible for all activities related to payment for managed care activities. Bureau functions include:

- Developing managed care rates and negotiating final rates with managed care plans
- Managing the Federal reimbursement process
- Evaluating and monitoring the fiscal solvency of managed care plans

1.4.2.3 Bureau of Managed Care Program Planning

This Bureau is responsible for the development and implementation of Medicaid managed care services. Bureau functions include:

- Overseeing the development of the Special Needs Plans (SNPs) for Severely and Persistently Mentally Ill (SPMI) adults, Severely Emotionally Disturbed (SED) children, and AIDS populations
- Overseeing the development of service plans for other special populations
- Managing programs for populations legally excluded from managed care

- Revising regulation, policy, and procedures as required

1.4.2.4 Bureau of Quality Management and Outcomes Research

This Bureau is charged with ensuring the provision of appropriate health care by all managed care providers. Bureau functions include:

- Developing and implementing a quality assurance program
- Establishing a medical appeals process
- Collecting and analyzing encounter data and plan-reported data to evaluate delivery of care, clinical processes, and health outcomes
- Distributing quality assurance data and evaluations to managed care plans and the public

1.4.2.5 Bureau of Certification and Surveillance

Primary responsibility for managed care organization (MCO) oversight resides with the Bureau of Certification and Surveillance. Specific functions include:

- Providing approval and certification of MCOs, including integrated delivery systems and workers' compensation plans
- Providing ongoing surveillance of MCO operations
- Investigating complaints against managed care plans

1.4.3 Office of Continuing Care

1.4.3.1 Bureau of Long-Term Care

This Bureau ensures that quality institutional and home care services are provided at a reasonable cost to Medicaid clients. Bureau functions include:

- Ensuring that policies regarding nursing facilities and the Office of Mental Retardation and Developmental Disabilities are supporting Medicare

maximization, reduction of the length of stay, and utilization of adult day care facilities

- Developing managed long-term care initiatives
- Administering the Partnership for Long-Term Care Program, with emphasis on financing research design, data collection, and analysis as well as public education efforts
- Ensuring policies relating to personal care and other home care programs are supportive of Medicaid cost-containment while providing necessary services to Medicaid clients

1.4.4 Other State Agencies

The contractor will have contact with a number of other State agencies during the contract period. There are numerous State agencies that are users of Medicaid data and information, either printed reports or report images on magnetic tape, that can be manipulated. The following paragraphs describe those New York State agencies that have more direct involvement in the operation of the Medicaid program.

1.4.4.1 Office of Temporary and Disability Assistance

The New York State Department of Social Services (DSS) formerly was the single State agency for Medicaid as well as the oversight agency for income maintenance and Medicaid eligibility determination. The responsibility for the Medicaid program was transferred to the Department of Health, and DSS was changed to the Department of Family Assistance (DFA). Subsequently, DFA was reorganized into three (3) separate State agencies.

The Office of Temporary and Disability Assistance (OTDA) is one (1) of the successor agencies to DSS/DFA. This agency has the responsibility for implementation of the Temporary Assistance to Needy Families (TANF) program. This agency will also continue to provide the State supervision of the determination of TANF and Medicaid eligibility.

1.4.4.2 Office of Children and Family Services

The second successor agency to DFA is the Office of Children and Family Services (OCFS). Although this agency may be a consumer of Medicaid data, it will not directly participate in the operation of the Medicaid program.

1.4.4.3 Human Services Application Service Center (HSASC)

The data center and systems development and maintenance staff that were previously known as the System Support and Information Services (SSIS) component of DSS have been separated and placed into a new organization. The Human Services Application Service Center (HSASC) has been created to combine the computer and systems applications-related expertise of the Department of Labor, the former Department of Social Services, and the former Division for Youth. Potentially, other human services agencies in New York State may participate in this organization, which will focus on the development of cross-agency applications and ensure that issues that were previously agency-specific are addressed in a comprehensive and coordinated manner.

HSASC will report to a Board of Commissioners which will establish policies, provide direction, and set priorities for human services systems and operations.

1.4.4.4 Office of the State Comptroller

To fulfill the State Comptroller's duties and responsibilities relating to the Medicaid program, as defined by the State Constitution and State statutes, the Office of the State Comptroller (OSC) assigns on-site staff located at the contractor's facility to conduct quality assurance reviews of Medicaid claims and payment processing which include both prepayment and postpayment reviews, performance audits of the Medical Assistance program, and special projects related to the Medical Assistance program. The unit is a major user of Medicaid data.

1.4.4.5 Department of Law

Investigation and prosecution of Medicaid fraud is performed by the Medicaid Fraud Control Unit (MFCU) of the Department of Law. The unit is a major user of Medicaid data.

1.4.4.6 Office for Technology

First formed in January 1996 as the Governor's Task Force on Information Resource Management, the new Office for Technology (OFT) was formally established in July 1997 as part of the Office of the Governor. OFT is composed of technology- and program-based experts. It also includes an advisory council of information resource management executives. OFT is charged with coordinating New York State's technology resources.

OFT is composed of twenty (20) staff, most of whom are on loan from their respective State agencies. The work of OFT is accomplished through work groups, councils, and leadership groups. The products of OFT are "preferred standards," which agencies are expected to adopt over time as their systems change or as they make major modifications to their operations. OFT pursues an agenda of building an infrastructure, standardizing effort, developing the work force, and spurring creativity in government to achieve three (3) goals: to save State resources, increase interagency and intergovernmental communication, and improve citizen and private-sector access to New York State government.

1.4.5 Related Programs

There are several State agencies which manage specialized programs that serve both Medicaid and non-Medicaid populations or whose program is similar to Medicaid. These agencies are described in the following sections.

1.4.5.1 Elderly Pharmaceutical Insurance Coverage (EPIC)

The State of New York provides pharmaceutical assistance covering prescriptions for the elderly population with limited income earnings. This program is separate from Medicaid and is funded solely by State funds.

The EPIC program recently acquired a claims processing contractor through a competitive procurement. Therefore, the Replacement Medicaid System will not be required to process EPIC claims at this time. There will be an interface with the EPIC system to support participant eligibility verification and provider audit referrals, as defined in Sections 7.2 and 7.5.

1.4.5.2 Office of Alcohol and Substance Abuse Services (OASAS)

The Office of Alcohol and Substance Abuse Services (OASAS) is responsible for providing, directly and through a network of independent public, proprietary and not-for-profit entities, a consortium of services, for persons suffering from alcoholism and alcohol and substance abuse. The agency licenses and monitors several different levels of care, most of which are eligible for Medicaid reimbursement. These include detoxification services, inpatient rehabilitation, methadone maintenance, day rehabilitation and clinic services.

- Rate-setting for inpatient rehabilitation, day rehabilitation and clinic services
- Licensure and certification of Medicaid eligible services
- Monitoring third-party systems for "best practices"
- Production of bi-weekly billings for OASAS-operated inpatient treatment centers
- Extensive analysis of client eligibility, encounter and claims data to support rate-setting and program support activities
- Analysis of program services, such as hospital base detoxification services and DRG billings
- In New York City, the OASAS certified Methadone Maintenance Treatment Programs submit, in addition to regular Medicaid claims, documentation of attendance by clients eligible for transportation reimbursement. This information is processed and forwarded to the New York City Medical Assistance Program for direct reimbursement to the clients

1.4.5.3 Office of Mental Health (OMH)

The Office of Mental Health (OMH) is charged with ensuring the provision of quality mental health services to the residents of New York State. OMH assumes multiple roles with respect to the medical assistance program. It is a provider agency that establishes billing accounts for Medicaid-eligible clients and a service provider. OMH is an advocacy for clients requiring benefits. OMH also operates a partially capitated Medicaid prepaid capitation plan, the

Prepaid Mental Health Plan (PMHP). Specific Medicaid-related functions include:

- Processing of Medicaid eligibility applications for OMH inpatients, residents in State-operated residential programs, and residents in non-State-operated children's programs under a memorandum of understanding (MOU) with the single State agency

- Certification and licensure of mental health programs (State- and non-State-run) and, jointly with DOH, certification of all mental health Special Needs Plans within the Partnership Program

- Development, implementation, operation, monitoring, and evaluation of mental health Special Needs plans for Medicaid clients with serious mental illness

- Monitoring and evaluation of mental health care quality through ongoing analysis of Medicaid fee-for-service and managed care encounter data

- Development of Medicaid regulations in conjunction with DOH for OMH-licensed programs

- Establishment of criteria and functions for managed care organizations with respect to behavioral health care

- Operation of adult inpatient facilities, children's inpatient facilities, community residences (SOCR), residential care centers for adults (SORCCA), and family care homes (FC)

- Billing for outpatient claims for Medicaid eligibles for adjudication and payment; outpatient claims includes Clinic, Continuing Day Treatment (CDT), Partial Hospitalization (PH), Intensive Psychiatric Rehabilitation Treatment (IPRT), Intensive Case Management (ICM), and Rehabilitation Services (Keyes SOCR)

- Billing for inpatient claims and PMHP premium claims for adjudication and reporting purposes only

1.4.5.4 Office of Mental Retardation and Developmental Disabilities (OMRDD)

The Office of Mental Retardation and Developmental Disabilities (OMRDD) provides a wide array of services to developmentally disabled clients and their families. Approximately 6.1 million services are provided each year, of which ninety percent (90%) are eligible for Medicaid reimbursement. Similar to OMH, OMRDD assumes multiple roles with respect to the medical assistance program. It is a provider agency that establishes billing accounts for Medicaid-eligible clients, a service provider, and a provider agency. Specific functions include:

- Certification and licensure of State- and voluntary-operated programs, including ICFs/MR, clinics, community residences, day treatment, and HCBS waiver programs
- Establishment of criteria and functions for managed care organizations with respect to the developmentally disabled population
- Operation of ICFs/MR, day treatment, clinics, community residences, and HCBS waiver programs
- Billing all appropriate payors for services provided under State-operated programs; ninety-five percent (95%) of such billings are to Medicaid

1.4.6 Current Medicaid Contractors

The current Medicaid contractors are identified in the following paragraphs.

1.4.6.1 Computer Sciences Corporation

Computer Sciences Corporation (CSC) is the current fiscal agent contractor. Under this contract, CSC operates and maintains the current MMIS, operates the MOAS, and performs certain provider relations responsibilities. CSC also makes modifications to the MMIS to meet evolving user requirements.

1.4.6.2 Deluxe Electronic Payment Systems

Deluxe Electronic Payment Systems (DEPS) is the current EMEVS contractor. DEPS maintains and operates the EMEVS network, including maintaining inventory of TRANZ 330 point-of-service (POS) devices. DEPS also operates and maintains the EMEVS software that performs the functions

of eligibility verification (POS, audio response, PC dial-in, remote job entry, and host-to-host), Utilization Threshold, Post and Clear, and ProDUR review and pharmacy claim capture.

1.4.6.3 Pharmark

CSC contracts with Pharmark to provide the retrospective Drug Utilization Review (DUR) processing. Under this contract, Pharmark provides hardware, software, and linkages to the Department. The hardware resides at the current MMIS facility at 800 North Pearl Street but is maintained by Pharmark.

1.4.6.4 Drug Updating Services

The New York State Medicaid program uses two (2) updating services. DEPS subcontracts with First Data Bank to provide criteria for prospective DUR. Pharmark also uses First Data Bank criteria for retrospective DUR. The Department contracts with Medispan for drug pricing updating for the prices used in claims processing.

1.4.6.5 Teleswift Corporation

The Department contracts with Teleswift Corporation for Voice Interactive Phone Services (VIPS). This system provides telephone access to the Medicaid Automated Name Search (MANS) and Provider Check Amounts. The hardware is located at the HSASC at 40 North Pearl Street. The system accesses the WMS to obtain information for MANS and obtains the information on the last two (2) provider check amounts from CSC.

Teleswift Corporation also operates a client voice response system. Clients may call a toll-free number and will get a response that they are eligible or not eligible for Medicaid. The message is in both English and Spanish.

The current Teleswift contract expires on November 2, 1998 and is renewed annually at the discretion of the Department.

1.4.6.6 Managed Care Data Warehouse

Sybase, Inc. and Consultec, Inc. have been engaged by the Office of Managed Care (OMC) to develop and implement the OMC data warehouse. Additional information on this initiative is presented in Section 8.2.1.

Table of Contents
Section 2

Table of Contents
Section 2 (continued)

Section 2
Procurement Administration

2.1 RFP Administration

This Request for Proposals (RFP) is being issued by the State of New York, Department of Health (the Department). The Department is the sole point of contact for all offerors from the date of release of the RFP until the contract is fully executed and signed.

2.1.1 Legal Basis

The procurement process for this RFP will be conducted in accordance with the Federal regulations contained in 42 CFR 434.10, 45 CFR 95.613, and 45 CFR 74, as well as applicable procurement policies and procedures established by the State of New York, including relevant provisions of the State Finance Law.

2.1.2 Contact Point

All questions regarding substantive elements of this RFP shall be submitted in writing to:

Ms. Joan E. Johnson, Director
Bureau of Medicaid Systems
Office of Medicaid Management
New York State Department of Health
One Commerce Plaza, Room 727
Albany, New York 12210

Procedural questions must be in writing and may be submitted by facsimile to (518) 473-0601 or by electronic mail to jej03@health.state.ny.us (Joan E. Johnson).

2.1.3 RFP Issuance and Amendments

Prior to its release, this RFP was reviewed and approved by the Office of the Attorney General, the Office for Technology, the Department of Health, and Region II of the Health Care Financing Administration. Its contents represent the best available statement of the requirements and needs of all these participants.

The Department reserves the right to amend the RFP at any time prior to the proposal due date by issuing written addenda. All written addenda to the RFP, along with the RFP itself, will become part of the contract.

Formal RFP amendments will be used to provide the answers to the offerors' questions submitted to the Department. Amendments will be sent to all offerors who have submitted a timely Letter of Intent (see Section 2.2.3).

2.1.4 Procurement Protest

Any party that contends to be adversely affected by this RFP or the rules of procurement must file a written protest with the Director of the Office of Medicaid Management (OMM) within four (4) weeks of issuance of this RFP.

The Director of OMM shall promptly issue a decision in writing on the protest. A copy of that decision shall be furnished to the aggrieved party and shall state the reason for the action taken.

2.2 Procurement Process

The process established by the Department for the procurement of the Replacement Medicaid System contractor is described in the following sections.

2.2.1 Procurement Library

The Department has established a Procurement Library containing reference materials describing the New York State MMIS, the New York State EMEVS, and the New York State Medicaid program. The Department has assembled this information to assist offerors in the preparation of proposals and to ensure

that all offerors have equal access to such information. The minimum contents of the Procurement Library are identified in Appendix C of this RFP.

These materials, documentation, and other written information will be available for review in the Procurement Library beginning on the date specified in Section 1.1.4 and ending on the proposal due date. The Department reserves the right to add additional materials to the Procurement Library at any time until five (5) business days prior to the proposal due date. Prospective offerors that submit a Letter of Intent will be notified by the Department of any additions of material to the Procurement Library.

2.2.1.1 Access to Library by Appointment Only

Prospective offerors may have access to the Procurement Library up until the proposal due date by contacting the Department officials named below for an appointment:

Ms. Gayle Shinder or Ms. Jeannette Udwary
Office of Medicaid Management
New York State Department of Health
One Commerce Plaza, Room 727
Albany, New York 12210
Phone: (518) 473-0925, (518) 473-4952

No other State personnel may schedule appointments. Access to the Procurement Library by prospective offerors (and any representatives thereof) shall be by appointment only.

Appointments shall be made at least twenty-four (24) hours in advance. Offerors may review Procurement Library materials from 8:00 a.m. to 5:00 p.m. (Eastern Time), Monday through Friday, with the exception of official State holidays. The Procurement Library will be located at One Commerce Plaza, Seventh Floor, Albany, New York. No prospective offeror will be allowed to schedule more than two (2) consecutive-day sessions at a time.

2.2.1.2 Copying of Library Materials

Copies of materials contained in the Procurement Library will be made available. The Department will provide copies of up to two hundred fifty (250) pages for each offeror at no cost. Additional copies will be provided at a cost of

twenty-five cents ($0.25) for each page image. Offerors must pay for the copies at the completion of each reproduction task.

No materials shall be removed, in whole or in part, from the Procurement Library nor shall prospective offerors or their representatives write on, or otherwise deface, any materials in the Procurement Library or remove or deface materials in the Department offices.

2.2.1.3 Accuracy

If any materials, documentation, information, or data are discovered to be inaccurate or incomplete, such inaccuracy or incompleteness shall not constitute a basis for challenging the contract award, contract rejection, or renegotiation of any payment amount or rate after contract award. All statistical information contained in the Procurement Library represents the best information available to the Department at the time of RFP preparation.

Requirements specified in this RFP shall take precedence over any documentation in the Procurement Library if a conflict exists.

2.2.2 Questions and Answers

Prospective offerors may submit questions concerning this RFP, in writing, to the contact individual named in Section 2.1.2.

Questions received by the Department after the final due date specified in Section 1.1.4 may not be answered.

All questions pertaining to this RFP must be submitted in writing and should cite the RFP Section and page number. The Department will accept written questions transmitted by fax or by electronic mail or delivered by the U.S. Postal Service, a commercial service, and/or in person by the date specified in Section 1.1.4. Requests for materials and information not in the Procurement Library should be sent as written questions to the contact specified in Section 2.1.2.

Following receipt of the submitted questions, Department staff will prepare written responses to all questions received and send a copy of the answers to all offerors that submit a timely Letter of Intent. To the extent practicable, questions will remain as written. However, the Department may consolidate and paraphrase questions received. The Department's intention is to complete

all responses within approximately two (2) weeks of the deadline for receipt of written questions.

Offerors should clearly understand that the only official answer or position of the Department will be the one stated in writing and issued to all prospective offerors. Verbal responses provided during the Offerors' Conference (or at any other time) do not represent the official answer or position of the Department, and the Department shall not be bound in any way by any such verbal answer.

2.2.3 Letter of Intent

A Letter of Intent to submit a proposal in response to this RFP should be submitted by each prospective offeror and must be received by the date specified in Section 1.1.4. Only those prospective offerors who have submitted a timely Letter of Intent will receive all subsequent mailings related to the RFP, including answers to questions submitted to the Department. Submission of a Letter of Intent does not bind the prospective offeror to submit a proposal nor does failure to submit a Letter of Intent prevent an offeror from submitting a proposal.

2.2.4 Offerors' Conference

An Offerors' Conference will be held by the Department on the date and time specified in Section 1.1.4. The conference will be held in the following location:

Hearing Room A, 2nd floor
Legislative Office Building
The Governor Nelson A. Rockefeller Empire State Plaza
Albany, New York

The Offerors' Conference is intended to be an interactive exchange of information, and appropriate Department staff will attend to clarify RFP content. The Department will attempt to provide tentative answers to all written questions received prior to the Offerors' Conference.

Offerors are reminded that the official answers and positions of the Department will be those stated in writing and issued to all prospective offerors who have submitted a Letter of Intent. The verbal responses given at the Offerors' Conference are not binding on the Department unless confirmed in writing.

2.2.5 Use of Fax Machines and Electronic Mail

The Department may use facsimile (fax) machines and electronic mail (e-mail) to transmit information (e.g., questions, RFP addenda) to prospective offerors. However, the Department will also use the U.S. Postal Service or a commercial overnight delivery service to send originals.

Prospective offerors assume sole responsibility for ensuring that the Department actually receives (complete and in a timely manner) written questions, proposals, requests for copies of the RFP, and other inquiries (whether transmitted by fax, e-mail, the U.S. Postal Service, a commercial delivery service, or delivered in person) from the prospective offeror.

2.2.6 Agreement to Accept and Abide by the RFP and RFP Process

By the act of submitting a proposal in response to this RFP, each offeror (including the offeror's parent organization and proposed subcontractors, agents, and employees of the offeror) agrees and consents, without reservation, substitution, or limitation, to each of the following:

- Accept as lawful and binding and abide by the proposal submission requirements and rules and the procurement procedures, processes, and specifications identified in this RFP, including any RFP addenda and all appendices to this RFP.

- Accept as lawful and binding, and consent to the Department's use of, the evaluation methodology and evaluation process as described in Section 9 of this RFP.

- Accept as lawful and binding, and consent to, the Department's sole, unrestricted right to reject any or all proposals submitted in response to this RFP.

- Accept as lawful and binding the Department’s right to:

  Accept all or part of a selected offeror’s proposal.

Utilize any and all ideas submitted in the proposals received, unless those ideas are covered by legal patent or proprietary rights.

Amend any part of this RFP, at any time, upon written notification to potential offerors and organizations which have submitted a Letter of Intent.

Direct any offeror to submit proposal modifications addressing subsequent RFP amendments.

Select and award the contract to other than the lowest priced offeror.

Waive or modify minor irregularities in proposals received after notification to the offeror and to make typographical corrections to proposals, with the concurrence of the offeror.

Correct computational errors with the written concurrence of the offeror.

Change start dates stated to the offerors.

Request offerors to clarify their proposal and/or submit additional information pertaining to their proposal.

Use reference sources other than those listed in the proposal for verifying the accuracy of the expertise and experience of the corporation and the individuals proposed for the engagement.

Terminate review of proposals found technically or financially deficient or non-responsive.

Disqualify any offeror whose conduct or proposal fails to conform to the requirements of this RFP.

Request best and final offers from any offeror that submits a technically acceptable proposal.

Eliminate any requirements unmet by all offerors upon notice to all parties submitting proposals.

- Accept the substantive, professional, legal, procedural, and technical propriety of the scope of work in the RFP.

- If awarded a contract as the result of this RFP, accept the contractual language found in Section 11 of this RFP.

- Accept the propriety and legality of the Department retaining an outside consultant to assist the Department with this procurement.

2.2.7 Proposal Submission Requirements

The detailed requirements for submission of proposals are described in the following sections. Deviations from these requirements may render a proposal nonresponsive.

2.2.7.1 Submission of Proposals

Proposals shall be prepared in two (2) components: a Technical Proposal and a Price Proposal, prepared in accordance with the requirements stated in this RFP.

Sealed proposals shall be delivered no later than 5:00 p.m., Eastern Time, as follows:

Technical Proposal:

New York State Department of Health
855 Central Avenue
Albany, New York 12206

Price Proposal:

New York State Department of Health
Corning Tower, Room 1315
The Governor Nelson A. Rockefeller Empire State Plaza
Albany, New York 12237-0016

Proposals must be physically received at this location on or before the date specified in Section 1.1.4. Late proposals will be rejected.

The original and twelve (12) copies of the Technical Proposal must be submitted under sealed cover, and the original and six (6) copies of the Price

Proposal must be submitted under **separate** sealed cover. One (1) copy each of the Technical and Price Proposals must be unbound.

Offerors mailing their proposals or using a commercial delivery service shall allow sufficient time for delivery of their proposals by the time specified. Proposals received after that time will not be considered and will be returned unopened.

The outside cover of the separate, sealed package containing the Technical Proposal shall be clearly marked:

> New York State Department of Health
> Replacement Medicaid System - Technical Proposal
> (Offeror Name)

The outside cover of the separate, sealed package containing the Price Proposal shall be clearly marked:

> New York State Department of Health
> Replacement Medicaid System - Price Proposal
> (Offeror Name)

All proposals shall clearly indicate the name, title, mailing address, daytime telephone number, and fax number of the offeror's authorized agent with the authority to bind the offeror to the provisions of the proposal and to answer official questions concerning the proposal.

2.2.7.2 Proposal Bond

A proposal bond in the amount of one hundred thousand dollars ($100,000.00), issued by a surety company authorized to do business in the State of New York is required.

The bond may be submitted in the form of a certified check, cashier’s check, or surety bond payable to the State of New York. All such sureties must be dated within thirty (30) calendar days of the proposal opening date and shall be valid for no less than one hundred eighty (180) calendar days from the proposal opening date. The proposal bond must identify this RFP.

An offeror shall forfeit the proposal bond if the offeror is selected to be the contractor and thereafter:

- Fails to sign a contract by the date set in the Notice of Intent to Award (see Section 2.2.9)

- Is unable to obtain the required letter of credit within thirty (30) calendar days of contract signing (see Section 11.7.5)

The proposal bond will be returned to the selected offeror after contract signing and acceptance by the Department of the letter of credit. Proposal bonds from unsuccessful offerors will be returned at contract signing.

If an unsuccessful offeror files a timely protest of the intended contract award, then the proposal bond from that offeror will continue to be held until resolution of the protest.

2.2.7.3 Proposal Amendments and Rules for Withdrawal

Prior to the proposal due date, a submitted proposal may be withdrawn by submitting a written request for its withdrawal, signed by the offeror's authorized agent and providing an explanation for the action, to the individual specified in Section 2.1.2. Return postage cost will be borne by the offeror.

Offerors are allowed to make amendments or corrections to their proposals at any time prior to the proposal due date, without penalty. To amend or correct a proposal, an offeror shall request that its proposal be returned. Return postage cost will be borne by the offeror. The proposal must be resubmitted to the Department prior to the proposal due date specified in Section 1.1.4 in order to be considered for evaluation.

2.2.7.4 Acceptance of Proposals

The Department will accept receipt of all proposals properly submitted. After receipt of proposals, the Department reserves the right to sign a contract, without negotiation, based on the terms, conditions, and premises of the RFP and the proposal of the selected offeror.

The Department reserves the right to waive minor irregularities in proposals, providing such action is in the best interest of the Department. If the Department waives minor irregularities, such waiver shall in no way modify the

RFP requirements or excuse the offeror from full compliance with RFP specifications and the other contract requirements if the offeror is awarded the contract. The Department also reserves the right to request clarification or correction of proposal responses.

The Department reserves the right to negotiate proposal changes with the ultimately selected offeror which are in the best interest of the State.

The Department will accept alternate proposals from offerors. However, each proposal must stand entirely on its own.

2.2.7.5 Proposal Life

All proposals must be responsive to all requirements in this RFP in order to be considered for contract award. The proposal and its conditions must remain valid for one hundred eighty (180) calendar days from the proposal due date.

2.2.7.6 Department Right to Reject Proposals

The Department reserves the right, at its sole discretion, to reject any or all proposals. The Department reserves the right, at its sole discretion, to cancel this procurement at any time.

2.2.7.7 Selection Committee

A Selection Committee under the direction of the Department of Health will review proposals deemed by the Evaluation Committee as best meeting the requirements of this RFP. From this review, the Selection Committee will formulate a recommendation to the Commissioner, who will make the selection.

2.2.8 Oral Presentations and Demonstrations

The Department reserves the right to require offerors to make an oral presentation and/or product demonstration. It will be the Department's option to determine the schedule and format for all oral presentations and demonstrations. Offerors will be notified in advance of the time and location of presentations and demonstrations.

2.2.8.1 Purpose of Oral Presentations and Demonstrations

The purpose of oral presentations and demonstrations will be to provide offerors an opportunity to 1) answer questions or concerns raised by the Department in the course of reviewing the Technical Proposals and 2) assist the Department in verifying the capabilities and qualifications of the offeror, the proposed project staff, and any proposed subcontractors. Information gathered during oral presentations/demonstrations will be used in evaluating and scoring Technical Proposals.

2.2.8.2 Questions and Other Requirements

During oral presentations or demonstrations, original proposal enhancement cannot be permitted nor may an offeror modify its Technical Proposal. Offerors shall not attend, in whole or in part, presentations by their competitors nor shall offerors interfere with the oral presentations of their competitors.

Offerors may receive written questions from the Department in advance of their scheduled presentation/demonstration. These may include 1) structured questions asked of all offerors making a presentation/demonstration and 2) such specific questions and requests for clarification of the offeror's Technical Proposal as the Department deems appropriate. At the oral presentations or demonstrations, offerors may be asked follow-up or clarifying questions by evaluators.

For the oral presentations, the Department may, at its discretion, establish such procedures and rules of conduct as it may deem appropriate, and the Department will enforce such procedures and rules of conduct.

2.2.9 Contract Award Notice

Upon completion of the evaluation of the Technical and Price Proposals, the Evaluation Committee will submit its recommendation for award to the Selection Committee. When the Selection Committee and the Commissioner of the Department have approved the recommendation, it will issue a Notice of Intent to Award. The notice will be sent by certified mail to all offerors.

2.2.9.1 Contract Signature Process

When the Notice of Intent to Award has been issued, the Department will submit the contract to the selected offeror. If the Department and the offeror fail to reach a satisfactory agreement on the terms of the contract, the Department may enter into discussions with the next best offeror. When a satisfactory agreement is achieved, the contract will be presented to HCFA for approval for Federal financial participation and to the appropriate State authorities for approval. Upon approval by HCFA and the appropriate State authorities, the contract will be fully executed.

The Department reserves the right to cancel this procurement prior to contract signing and not operate a contract hereunder, if deemed in the best interest of the Department.

2.2.9.2 Contractor Debriefings

Unsuccessful offerors may, upon receipt of the Notice of Intent to Award, request a meeting for debriefing and discussion of their proposals by contacting, in writing, the individual identified in Section 2.1.2.

Debriefings will be held as soon as possible after the Notice of Intent to Award has been issued.

Debriefings will not involve a discussion of the content of proposals received from other offerors.

2.2.9.3 Protest of Intended Contract Award

Offerors may protest the intended contract award by submitting a certified letter to the Commissioner of Health. Such letter must be submitted within five (5) business days of receipt of the Notice of Intended Award. The letter must state the reason(s) for the protest and the remedy requested for its resolution.

The Commissioner of Health or her designee will review the facts presented in the letter and render a written decision. Any appeal of that decision must be made to the Commissioner of Health within fifteen (15) business days of receipt of the initial protest decision. Any subsequent review of the decision shall be handled through a court of competent jurisdiction.

2.3 Procurement Rules

To facilitate the Replacement Medicaid System contractor procurement process, the following rules have been established.

2.3.1 Restrictions on Contacts With State Personnel

Contacts with State personnel are restricted from the issue date of this RFP until a contractor is approved by the Office of the State Comptroller. Offerors are not allowed to communicate with any State staff regarding this procurement, except for appropriate communications with the individual named in Section 2.1.2 and State representatives during the Offerors' Conference and during any oral presentations or demonstrations.

Violation of this provision may result in the rejection of the proposal of the offending offeror.

2.3.2 Cost Liability

All costs incurred by the offerors during the preparation of their proposals and for other procurement-related activities will be the sole responsibility of the offerors. The Department will not reimburse the offerors for any such costs.

2.3.3 Independent Price Determination

By submission of a proposal, the offeror certifies that:

- The prices proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other offeror or with any other competitor;

- Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the offeror on a prior basis, directly or indirectly, to any other offeror or to any other competitor; and

- No attempt has been made, or will be made, by the offeror to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

By signing the proposal, each person certifies that:

- The person is the responsible party within the offeror's organization regarding the decision as to the prices being offered and that he/she has not participated in any action contrary to the above; or

- The person is not the responsible party within the offeror's organization regarding the decision as to the prices being offered but that the person has been authorized, in writing, to act as agent for the person(s) responsible for such decisions in certifying that such person(s) has not, and will not, participate in any action contrary to the above, and as their agent does hereby certify, he/she has not and will not participate in any action contrary to the above.

2.3.4 Disposition of Proposals

The successful proposal will be incorporated into the resulting contract and will be a matter of public record following the award of the contract.

All material submitted in response to this RFP shall become the exclusive property of the State of New York.

2.3.5 Freedom of Information and Privacy Acts

All materials associated with the procurement are subject to the terms of the Freedom of Information Act; the Privacy Act; and all rules, regulations, and interpretations of these Acts, including those from the Offices of the Attorney General of the United States, HHS, and HCFA.

By submission of a proposal, the offeror agrees that the Privacy Act of 1974 (Public Law 93-579) and the Regulations and General Instructions issued pursuant thereto are applicable to this procurement and to the resulting contract, and to all subcontracts thereunder.

All the proposals upon submission will become the property of the Department. The Department will have the right to disclose all or any part of a proposal to public inspection based on its determination of what disclosure will serve the public interest. Prospective offerors are further advised that, except for trade secrets and certain personnel information (both of which the Department has reserved the right to disclose), all parts of proposals must be disclosed to those members of the general public making inquiry under the New York State Freedom of Information Law (NYS Public Officers Law, Article 6). Should an offeror wish to request exception from public access to information contained in its proposal, the offeror must specifically identify the information and explain in detail why public access to the information would be harmful to the offeror. Use of generic trade secret legends encompassing substantial portions of the proposal or simple assertions of trade secret interest without substantive explanation of the basis therefore will be regarded as non-responsive to this requirement for specificity and explanation. Non-responsive requests for exception from public access will not be considered by the Department in the event a Freedom of Information request for proposal information is received.

2.3.6 Use of Subcontractors

In the event of a proposal submitted jointly by more than one (1) organization, one (1) organization shall be designated as the prime contractor, and the prime contractor shall be solely responsible for ensuring the performance of all aspects of the contract. All other participants shall be designated as subcontractors. Any use of subcontractors for this contract shall meet the requirements of this RFP.

Once the Notice of Intent to Award is issued and a contract is awarded, the use of additional subcontractors by the prime contractor (for any portion of the scope of work) is subject to the prior written consent of the Department. The Notice of Intent to Award constitutes written consent for those subcontractors

included in the proposal. The Department may request such additional information and written assurances, with respect to subcontractors, as deemed necessary to ensure that only qualified, competent vendors perform services under the RFP and contract and to ensure that the scope of work is performed in a professional and timely manner.

At any time during the contract period, the contractor shall not subcontract out, in whole or in part, any portion of the scope of work to an individual(s), corporation(s), partnership(s), agent(s), subsidiary(ies), and/or public agency(ies) without the prior express written consent of the Department.

2.3.7 Equal Opportunity Commitment

The Department is in full accord with the aims and effort of the State of New York to promote equal opportunity for all persons and to promote equality of economic opportunity for minority group members and women who own business enterprises and to ensure there are no barriers, through active programs, that unreasonably impair access by Minority and Women-Owned Business Enterprises (M/WBE) to State contracting opportunities.

Prospective offerors to this RFP are subject to the provisions of Article 15-A of the Executive Law and regulations issued thereunder:

1. Contractors and subcontractors shall undertake or shall continue with existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability, or marital status. For these purposes, affirmative action shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.

2. Prior to the award of a State contract, the contractor shall submit an Equal Employment Opportunity (EEO) Policy Statement to the contracting agency within the time frame established by that agency.

3. The contractor's EEO Policy Statement shall contain, but not necessarily be limited to, the following items. The contractor, as a precondition to entering into a valid and binding State contract, shall, during the performance of the State contract, agree to the following:

a. The contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability, or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts.

b. The contractor shall state in all solicitations or advertisements for employees that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability, or marital status.

c. At the request of the contracting agency, the contractor shall request each employment, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein.

4. Except for construction contracts, prior to an award of a State contract, the contractor shall submit to the contracting agency a staffing plan of the anticipated work force to be utilized on the State contract or, where required, information on the contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency. The form of the staffing plan shall be supplied by the contracting agency.

5. After an award of a State contract, the contractor shall submit to the contracting agency a work force utilization report, in a form and manner required by the agency, of the work force actually utilized on the State contract, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency.

In addition, offerors are also required to submit, within their proposals, a section describing how the offeror proposes to identify and utilize M/WBEs with which it may subcontract or from which it may obtain supplies (and or

equipment, commodities, etc.) for this offering, as well as the dollar amount, if known, of any such subcontract or purchase. Offerors are also required to complete both the Subcontracting Information Form found in Appendix D for themselves and any subcontractors or vendors they plan to use. The items contained in this paragraph are considered to be requirements of all offerors and may be evaluated by the respective evaluation review committees.

For purposes of this procurement the goals for subcontracting with Minority and Women-Owned businesses are five percent (5%) and five percent (5%). The goals for the purchase of supplies (equipment and/or commodities, etc.) from M/WBEs respectively are five percent (5%) and five percent (5%); and the employment goal for the hiring of protected class persons is five percent (5%). Definitions of Minority and Women-Owned Business Enterprises also can be found in Appendix D. The directory of certified businesses, prepared by the Governor's Office of Minority and Women's Business Development, for use by contractors in complying with the provisions of Executive Law, Article 15-A, and the related regulations, is available through the Empire State Development Web site at http://www.empire.state.ny.us/mwb.htm.

In order to assist prospective offerors in their attempts to demonstrate effective affirmative action efforts, the Department suggests offerors consider any or all of the following steps while developing their responses to this RFP:

1. Contact all known M/WBEs that may appropriately serve as a subcontractor(s) or a vendor(s) under the contract.

2. Keep a "contact" list of M/WBEs contacted for this particular RFP along with the name of your contact and the result of the contact(s).

3. Use the M/WBEs contacted as a possible resource for additional contacts.

In the event your firm did not obtain the desired results from steps 1-3 above, the Department suggests that prospective offerors consider these additional steps (and keep a contact record of the same):

4. Contact area minority business associations, contractor associations, purchase councils, or professional organizations serving the area in which the contract will be performed.

5. Contact the New York State Department of Economic Development, Division of Minority and Women Business Development for assistance at (518) 474-1979 or (212) 827-6259.

6. Contact area community-based organizations that serve the minority community and local elected, appointed, religious, or other acknowledged leaders who also may serve as resources.

The above-noted provisions are set forth to aid prospective offerors that may require assistance in their attempt to comply with departmental affirmative action initiatives. However, prospective offerors are at liberty to propose a course of action of their own that is reasonable and accomplishes the aim of the aforementioned provisions.

THIS PAGE INTENTIONALLY LEFT BLANK

Table of Contents
Section 3

Table of Contents
Section 3 (continued)

Section 3
General Contract Requirements

3.1 Location

3.1.1 Facility

The contractor is required to establish a facility within thirty (30) miles of the State Capitol building in Albany, New York. All work specified in this RFP (including receipt of paper claims and generation of checks) is required to be performed in this facility. Exempt from this requirement are 1) the computer facility and 2) the required back-up and recovery facilities. These two (2) functions may be performed anywhere in the continental United States.

In addition to the New York State facility, upon implementation of the Replacement Medicaid System the contractor shall maintain an office in New York City. The purpose of this office shall be to provide on-site assistance to providers, as specified in Section 7.3.1. In addition, the contractor shall use the New York City office to receive paper claims from, and distribute checks to, New York City providers.

To reduce the burden on the contractor, the Department has elected to extend the contracts of the incumbent contractors. The facility at 800 North Pearl Street shall be used solely for continuing MMIS operations. The contractor selected under this procurement **shall not** use that facility for either implementation or operations.

3.1.2 Contract Management Staff

The Department will assign staff to be located on-site with the contractor to perform contract management functions. These monitoring functions include monitoring compliance with contract provisions, performance in accordance with performance standards set forth in this RFP, and serving as the liaison between the contractor and the Department and other State agencies. The contractor shall provide adequate working space, conference space, and free parking at the local development site to accomplish all of the contract monitoring activities in an efficient and professional manner.

The contractor shall provide dedicated working space at the contractor's local facility for up to eleven (11) Department personnel. These personnel will be

working on-site at the contractor's facility full-time. The work space shall be equipped with eleven (11) workstations and five (5) laser printers connected to the Department's local area network. Each workstation shall have access to the MMIS/EMEVS, the Replacement Medicaid System, including the Medicaid data warehouse and the WMS. Minimum requirements for the Department's work area are as follows and are subject to Department approval:

- Four (4) private offices with locking doors, each with furniture and equipment appropriate for manager-level activities: file cabinet, desk, desk chair, two (2) additional chairs, bookcase, white board, phone, workstation, data line, LAN connection, and office supplies necessary to carry out contract management and monitoring duties; one (1) of the offices shall be for the director of contract monitoring and shall include a credenza and conference table with four (4) chairs

- Six (6) partitioned work areas, each with furniture and equipment appropriate for professional staff: four (4-) drawer file cabinet, desk, desk chair, bookcase, white board, phone, workstation, data line, LAN connection, and offices supplies necessary to carry out project monitoring activities

- One (1) additional partitioned work area with the space and furniture to support three (3) PC workstations , data lines, and LAN connection; this area should include three (3)two(2) high-speed laser printers to support all contract monitoring staff

- Secretarial area in front of the director's office, to include secretarial desk with wing, desk chair, bookcase, two- (2-) drawer file cabinet, cork bulletin board, two (2) side chairs for visitors, workstation, data line, and LAN connection

- One (1) dedicated conference room with space, table, and chairs for a minimum of twelve (12) people, a large white board, conference phone, one (1) workstation, data line, and LAN connection

- One (1) dedicated facsimile machine with plain-paper capability, supporting both legal- and letter-size paper, and automated to send or received faxes unattended

- One (1) dedicated photocopy machine with sorting, collating, stapling, and automatic feed capabilities sufficient to support up to twenty-five thousand (25,000) copies per month

- Twenty (20) file cabinets and two (2) supply cabinets to support the contract monitoring staff

- Mail receipt and distribution area with large table and two (2) bins

- Office supplies and paper for the facsimile and photocopy machines

This space shall be made available and maintained exclusively for Department use until the end of the contract.

3.1.3 Office of the State Comptroller Staff

The State Comptroller will assign staff to be located at the contractor's facility. The Office of the State Comptroller (OSC) staff will perform certain prepayment and postpayment reviews of the claims and payment process, conduct performance audits of the Medical Assistance program, and complete special project studies related to the State's Medicaid program as needed.

The contractor shall provide dedicated lockable office space for up to thirty (30) OSC staff to include, for each person, a desk, a desk chair, and a side chair; file space and cabinets; a telephone; and, multi-function workstations with access to the Medicaid systems (current MMIS/EMEVS and the Replacement Medicaid System, including the Medicaid data warehouse); WMS inquiry for both upstate and New York City; TIP production development for both upstate and New York City; electronic communication with the local social service districts, other State agencies, a data line connection with the OSC LAN and the Department's LAN, and Medicaid providers; and a copier and facsimile machine. In addition, the contractor will provide space for two (2) private offices for the OSC managers, a secretary/reception area, and a dedicated conference room with space for a minimum of twelve (12) people. Parking space shall be provided for the on-site staff and for at least two (2) visitor vehicles.

In addition to the general audit requirements set forth in Section 3.2.3.3, OSC, in support of its constitutional responsibility to audit all State expenditures, requires that certain tests be performed before any claims are released for payment. The OSC representative will sign off on all payment instruments

before their release and is authorized to withhold any check considered appropriate in the exercise of professional judgment. These checks would require further approval before release.

Claim audits may be performed using a sampling technique as determined by OSC for each payment cycle run. For the audit of statistically sampled claims, the contractor will be required to retrieve and copy approximately three hundred (300) microfilmed claims (not to exceed four hundred [400] per week) which OSC requests for each payment cycle.

Sufficient contractor priority, time, and resources shall be available to OSC audit staff to enable them to complete the prepayment audit before checks are approved for release and approved for release and other tests of the integrity of the files used in all aspects of the adjudication process.

3.1.4 Quality Assurance and Audit Staff

The Division of Quality Assurance and Audit (QA&A) will assign staff to be located on-site at the contractor's facility. The contractor shall provide lockable office space for up to thirty (30) QA&A staff, to include, for each person, a desk, a desk chair, and a side chair; file space and cabinets; a telephone; a workstation with access to the MMIS/EMEVS, the Replacement Medicaid System, including the Medicaid data warehouse, and the WMS; a data line and connection to the Department's LAN; access to a copier and facsimile machine; and access to a conference room, by appointment, with a conference telephone. Free parking space shall be provided for the on-site staff and for at least two (2) visitor vehicles.

The space for the QA&A staff may be co-located with the space for the contract management staff.

3.1.5 Federal Reviewers

The contractor shall provide lockable office space for up to three (3) staff from Federal agencies, when required, for the performance of Federal reviews. The space shall include a conference table; a telephone; file cabinets; and a workstation with access to the MMIS/EMEVS, the Replacement Medicaid System, and the WMS. The contractor shall also provide access to a copier and facsimile machine and free parking for the on-site staff and at least one (1) visitor vehicle.

3.2 General System Requirements

This section presents overall system requirements necessary to support the New York State Medicaid program and to perform required contractor responsibilities.

3.2.1 Year 2000 Compliance and System Date Requirements

The New York State Replacement Medicaid System must accommodate the Year 2000 within the architecture of the system. This shall include the century component in all dates. In addition, the system shall accommodate the appropriate number of days in a month and shall accommodate leap years. This requirement shall apply to edits at the time of data entry and on any edits that use dates in any portion of the system.

The acceptance criteria for the Replacement Medicaid System shall include the following statement of compliance made, in writing, by the contractor:

- That the system is in compliance with the Year 2000 warranty statement set forth in Section 11.7.8 of this RFP

- That any third-party products, whether commercially available or developed under this contract, are in compliance with the Year 2000 warranty statement set forth in Section 11.7.8

If any part of the Replacement Medicaid System, including the Medicaid data warehouse, is non-compliant with the warranty, the statement shall identify the nature of such non-compliance and the action that the contractor is taking to achieve compliance. If a third-party product is non-compliant with the warranty, the statement shall identify the nature of the non-compliance, its impact on the operation of the Replacement Medicaid System, and what action the contractor is taking to achieve compliance.

3.2.2 Compliance With Federal Standards

The New York State Replacement Medicaid System must be in compliance with the national standards as prescribed by the Health Insurance Portability

and Accountability Act of 1996 and the Balanced Budget Act of 1997 and any other Federal requirements that are effective as of the date of the offeror's proposal.

3.2.2.1 Compliance With Electronic Data Interchange (EDI) Standards

The Health Insurance Portability and Accountability Act (HIPAA) requires all payors to accept electronic transactions in a standard format. The transactions subject to this requirement are:

- Claims and equivalent encounter information
- Enrollment or disenrollment in a health plan
- Eligibility for a health plan
- Health care payment and remittance advice statements
- Health plan premium payments
- First report on injury
- Health claims status inquiry and response
- Referral certification and authorization
- Coordination of benefits
- Claim/encounter attachments

It is expected that HCFA will adopt the standards for most transaction sets and related code sets (data elements) by February 1998. HIPAA requires that Medicaid agencies be prepared to accept the electronic standards within two (2) years (by February 2000). The New York Replacement Medicaid System shall be capable of complying with these standards in accordance with this schedule. The single exception to this time frame is the standards for claim/encounter attachments. It is anticipated that HCFA will adopt standards for claim/encounter attachments by February 1999, with implementation required by February 2001.

3.2.2.2 Compliance With National Identifiers

The HIPAA also requires that HCFA designate unique identifiers for:

- Individuals
- Employers
- Health plans
- Health care providers

The timing for designation and compliance with this requirement is the same as with electronic transactions: designation by February 1998 and implementation by February 2000. The New York Replacement Medicaid System must be capable of complying with these standards in accordance with this schedule.

3.2.2.3 Compliance With Other HIPAA Requirements

The HIPAA further requires that HCFA designate:

- Security standards
- Safeguards for electronic information systems
- Electronic signatures

Again, HCFA is expected to designate standards by February 1998 with Medicaid agency compliance required by February 2000. The New York Replacement Medicaid System must be capable of complying with these standards in accordance with this schedule.

3.2.2.4 Compliance With Federal Statistical Reporting

The Balanced Budget Act of 1997 requires that, effective for claims filed on or after January 1, 1999, states must provide for electronic transmission of claims and encounter data consistent with the Medicaid Statistical Information System (MSIS).

Previously, MSIS reporting has been voluntary, and New York has elected to submit a HCFA-2082 report in lieu of electronic statistical reporting. Under the Act, New York will be required to participate in MSIS reporting. The Replacement Medicaid System must incorporate those requirements.

In addition to meeting these requirements, the Department intends to continue to produce the paper HCFA-2082 report, along with a separate report for Managed Care.

3.2.2.5 Implementation of New Policies

The New York State Medicaid program will be required to implement policy changes to comply with new Federal requirements. To the extent that these requirements exist at the time of proposal submission, the contractor will be required to implement these policies as an integral part of the Replacement Medicaid System. Examples include:

- Implementation of New York State TANF requirements
- Implementation of two (2) new eligibility groups for which the State will pay Part B premiums (Section 4732 of the Balanced Budget Act)
- Child Health Initiatives

3.2.3 Security, Confidentiality, and Auditing

The contractor must ensure that the Replacement Medicaid System development and operations are in accordance with both State and Federal regulations and guidelines related to security, confidentiality, and auditing.

3.2.3.1 Security

The contractor shall follow all applicable technical standards for site and system security during the development of the Replacement Medicaid System. These standards are currently defined in Federal Information Processing Standards Publications 31, 41, and 73 published by the National

Technical Information Service. As security standards are revised, as discussed in Section 3.2.2.3, the contractor must meet the revised standards.

The contractor must develop a plan for the physical and system security for each of its facilities used in meeting the requirements of this RFP. This plan shall be submitted initially to the Department within thirty (30) calendar days of contract signing. The contractor shall submit an updated plan annually no later than the anniversary date of the contract signing. This plan shall identify all potential threats and hazards to the physical sites and systems, including the probability of occurrence, and shall identify the assets and controls to protect against such threats and hazards. The contractor may submit this plan in conjunction with the error and disaster recovery plan required in Section 3.2.5.

The Department shall approve, reject, or request modifications of the plan within fifteen (15) calendar days of receipt.

3.2.3.2 Confidentiality

Protection of the confidentiality of client records is an important standard and is applicable, not only to the contractor, but to all contractor employees. The contractor must ensure that all employees are aware of the provisions of the Privacy Act of 1974 and the consequences for violation of those provisions.

3.2.3.3 Auditing

The contractor must ensure that the Replacement Medicaid System facilitates auditing of individual transactions. Automated audit trails must be provided throughout the system to identify and track results of transaction processing; changes to master file data (client, provider, reference, etc.); and all edits encountered, resolved, or overridden.

Audit staff from the Department, the Office of the State Comptroller (OSC), and the Federal Department of Health and Human Services (DHHS) are authorized to perform audits relating to the services rendered by the contractor and any subcontractors. The audit includes, but is not limited to, the following capabilities and applies to the current system and the Replacement Medicaid System:

- Auditing claims after payment to determine that all regulations have been satisfied, the claim has been adjudicated and paid correctly, and any

system or regulation changes have been properly made. Automated audit trails must be provided throughout the system to identify and track results of transaction processing; changes to master file data (client, provider, reference, etc.); and all edits encountered, resolved, or overridden. The system has, and must maintain, the capability to revise affected files after completion of the audit.

- Analyzing provider refunds and claim adjustments to determine the cause of erroneous expenditures that have been brought to the State's attention by providers

- Using computer audit programs to generate audit modules to perform random or spot quality control audits on all claims processing and related files

- Storing, retrieving, and executing programs on-line, whether such programs are generated by the audit staff, are part of the contractor's production system, or are generated by contractor staff

- Processing of test data to determine that the system is operating properly

- Sampling and reconciling subsystem files to ensure accurate and timely maintenance

- Tabulating claims rejected because of processing errors broken down by type of error and personnel involved

- Reviewing manually processed transactions, i.e., those claims that are paid by overriding edit checks or are manually priced

- Reviewing the contractor's organization, policies, procedures and practices, effectiveness of control, operating efficiency, facility and software security, and back-up procedures

- Reviewing the contractor's compliance with contract terms, system specifications, health law, Department or Federal regulations, administrative directives, and program documentation

- Reviewing any phase or aspect of the Replacement Medicaid System for any purpose related to the system

In order to properly perform the audit function, the following are required:

- **Access to files, documentation, and contractor personnel** - The audit staff shall be given access to all contractor personnel and facilities. The contractor shall provide read-and-copy access to all the files. Such files shall include, but are not limited to, the inventory control files, recipient master file, formulary, diagnosis and procedure files, provider master files, all pricing files, intermediate files, and adjudicated claims file.

  In addition to access to computer files, access to the following types of documentation includes, but is not limited to:

  All software and operating manuals

  All documentation, including rules, regulations, memos, internal reports, and detail design documentation, as well as the facilities and the right to photocopy any and all documentation

  All contractor-supplied training materials

- **Computer resources** - Access to computer resources includes, but is not limited to:

  All application programs and libraries

  All systems programs and libraries

  The operating system, including job accounting/software

  Computer time

  The audit staff must be promptly notified of any changes made to computer programs and adjustments to edit checks between processing runs.

  Data retrieval requirements - The contractor shall provide continuous access to two (2) microfilm reader/printers for copying claims, remittance advices, and requests for exemptions from Medicaid utilization thresholds. The contractor shall provide the personnel and resources necessary for the automated and/or manual sampling of claims and reference file data, including the retrieval of historical data and any necessary follow-up, that may be required to meet any System Performance Review requirements.

Further, the contractor shall provide for the retrieval of original claim forms and canceled checks.

3.2.4 System Reliability and Performance Standards

The contractor must ensure that the Medicaid systems perform their functions reliably and accurately. Expectations for error and disaster recovery are presented in Section 3.2.5. Performance standards for the Medicaid systems are presented in Sections 7 and 8 and are summarized in Appendix E.

3.2.5 Error and Disaster Recovery

Full and complete back-up copies of all data and software shall be maintained and proficiently backed up on tape or optical disk and stored in an approved off-site location. The contractor shall maintain or otherwise arrange for an alternate site for its system usage in the event of a catastrophic or other serious disaster event.

For purposes of this RFP, "disaster" means an occurrence(s) of any kind whatsoever that adversely affects, in whole or in part, the error-free and continuous operation of the Replacement Medicaid System or affects the performance, functionality, efficiency, accessibility, reliability, and security of the system. The Department and contractor will jointly determine when unscheduled system downtime shall be elevated to a disaster status. Disaster events may include natural disasters, human error, computer virus, unauthorized access (i.e., “hacking”), or a malfunctioning of the hardware or electrical supply.

Within thirty (30) calendar days of contract signing, the contractor shall submit an error and disaster recovery plan to the Department. The Department shall approve, reject, or request modification of the plan within fifteen (15) calendar days of receipt. Features of this plan must include the following:

3.2.5.1 The contractor shall establish and maintain a weekly back-up that is adequate and secure for all computer software and operating programs; databases; files; and system, operations, and user documentation (in electronic and non-electronic form).

3.2.5.2 The contractor shall establish and maintain daily back-ups that are adequate and secure for all computer software and operating programs; databases; files;

and systems, operations, and user documentation (in electronic and non-electronic form) that are updated on a daily basis.

3.2.5.3 The contractor shall establish and maintain complete daily back-ups of all data and software and support the immediate restoration and recovery of lost or corrupted data or software.

3.2.5.4 Disaster planning documentation and procedures must be approved by the Department before system operations begin.

3.2.5.5 All proposed off-site procedures, locations, and protocols must be approved by the Department in advance of the start of system operations.

3.2.5.6 The contractor must maintain at least one (1) copy of all back-ups in a secure and off-site location.

3.2.5.7 The contractor shall demonstrate an ability to meet back-up requirements by submitting to the Department and maintaining an Error and Disaster Recovery Plan that addresses the following:

- Checkpoint/restart capabilities
- Retention and storage of back-up files and software
- Hardware back-up for the main processor
- Hardware back-up for data entry equipment
- Network back-up for telecommunications
- Data entry back-up

3.2.5.8 The contractor shall demonstrate a disaster recovery capability no less than every two (2) calendar years, in accordance with 45 CFR 95.621(f).

3.2.5.9 The contractor shall provide for a back-up processing capability at a remote site(s) from the contractor's primary site(s) such that normal payment processing, as well as other system and Department services deemed necessary by the Department, can continue in the event of a disaster or major hardware problem at the primary site(s).

3.2.5.10 In the event of a disaster, the contractor shall be capable of providing eligibility verification and related components immediately and operating other Replacement Medicaid System components within forty-eight (48) hours and must be able to provide service during the interim period such that the performance standards in this RFP are met.

3.2.5.11 The recovery period, in the event of a catastrophic or natural disaster, shall be at the earliest possible time, but in no event shall resumption of normal business functions exceed seven (7) calendar days.

3.2.5.12 The recovery period, in the event of other disasters caused by such things as criminal acts, human error, malfunctioning equipment or electrical supply, etc., shall be at the earliest possible time, but in no event shall resumption of normal business functions exceed five (5) calendar days.

3.2.5.13 The contractor shall take all steps necessary to fully recover the data and system from the effects of a disaster and to reasonably minimize the recovery period.

3.2.5.14 If the Replacement Medicaid System becomes unavailable during the contract period, the Department shall require the contractor to convert to the back-up site. In this event, the contractor must return to the original Replacement Medicaid System site within ninety (90) calendar days, subject to the approval of the Department. The Department approval will depend on the contractor's ability to demonstrate that the Replacement Medicaid System is again fully operational and appropriate communication links are available.

3.2.6 System Access and Navigation

The contractor must offer graphical user interface (GUI) on-line access. The following standards address GUI on-line access.

The Replacement Medicaid System must provide standard and consistent use of point-and-click and other screen navigation mechanisms across functional areas, using such techniques as menus, windowing, and cursor/location-sensitive inquiries. The Replacement Medicaid System shall support multitasking and shall be menu-driven and command-driven for maximum flexibility and ease of use. For example, a user should be able to access Reference information while inquiring on a paid claim, without having to return to a main menu. The Replacement Medicaid System shall allow forward/backward movement in multiple screen displays and shall allow forward and backward scrolling within a screen or window. On-line, context-

sensitive help shall be available, and descriptive error messages shall be provided for all on-line errors. Help and error messages should be context-sensitive to the extent possible. The Replacement Medicaid System shall allow cross-functional area navigation.

The Replacement Medicaid System shall provide on-line inquiry, given appropriate access security and password protection, to all system-maintained files and data. Access methods must include data element code (both primary and alternate index keys) or name (e.g., Soundex).

3.2.7 Remote Access

The contractor must provide access to the Replacement Medicaid System by remote users, including providers, pharmacies, local districts, etc., through a variety of communications channels and protocols in order to support client eligibility verification, service authorization, electronic claims capture, POS claims adjudication, prospective DUR, and prospective medical utilization review. The contractor shall also provide access to an electronic bulletin board(s) and an Internet Web site(s) to support access to on-line provider manuals, posted remittance advice statements, provider bulletins, etc. The contractor shall provide access through a variety of access mechanisms, including:

- Lease lines (if appropriate and required)
- Direct-dial communications operating at a variety of data transfer speeds
- Dial-up telephone inquiry via toll-free lines
- Computer-to-computer communications for qualified providers

3.2.8 Geographic Coding

All transactions accepted by the Replacement Medicaid System must be assigned standard geographic coding (commonly known as geocoding) to accommodate use of the transactions by commercial geographic information systems (GISs). This coding shall support the mapping requirements of the Medicaid data warehouse as specified in Section 8.5.2.2.

3.3 Key Personnel

The following paragraphs present the requirements for key personnel for the Replacement Medicaid System implementation and operations activities. Also presented are key personnel for implementation and operations of the Medicaid data warehouse.

Throughout the RFP, the Department will reiterate that the Medicaid data warehouse is a component of the Replacement Medicaid System. Reference to the Replacement Medicaid System will include the Medicaid data warehouse unless otherwise specified.

The Department recognizes that there will be overlap in the duties of certain positions that are key to both implementation and operations. In particular, there will be both implementation and operations during the second year of the contract. While the Department does not expect the contractor to provide two (2) individuals to meet a single position requirement, the Department will expect a key person with dual roles to meet the highest requirement for on-site time.

3.3.1 Key Personnel for Replacement Medicaid System Implementation

The contractor shall designate the following key personnel who will be responsible for the completion of all tasks during the Implementation Phase:

- Project/Account Manager
- System Implementation Manager
- Database Administrator
- Systems Administrator

The general responsibilities, minimum qualifications, and expected start date for these key personnel are summarized in Appendix K. **Designated personnel may serve in only one (1) key position during the Implementation Phase.** All key personnel shall be employed full-time at the contractor's local site for the entire Implementation Phase.

3.3.2 Key Personnel for Replacement Medicaid System Operations Phase

The contractor shall designate the following key personnel who will be responsible for the completion of all tasks during the Replacement Medicaid System Operations Phase:

- Account/Contract Manager
- Operations/Claims Processing Manager
- Systems Manager
- Database Administrator
- Systems Administrator
- Provider Services Manager

The general responsibilities, minimum qualifications, and expected start date for these key personnel are summarized in Appendix K. **Designated personnel may serve in only one (1) key position.** The Database and Systems Administrators may be part-time as defined in Section 6.3.2.1.

3.3.3 Key Personnel for Medicaid Data Warehouse Operations

The contractor shall designate the following key personnel who will be responsible for the implementation and operation of the Medicaid data warehouse.

- The Systems Implementation Manager identified in Section 3.3.1 shall also be responsible for the management of all tasks related to the implementation of the data warehouse.
- The Database Administrator shall be responsible for the design of the data warehouse database and for the design of related datamarts.
- The Systems Manager shall be responsible for maintenance and evaluation of the data warehouse.

3.4 Quality Management

The Department will require the contractor, in partnership with the Department, to maintain a continuous focus on the importance of delivery of quality systems and services. The contractor must develop a plan within sixty (60) calendar days of contract signing that will implement, rigorously apply, and constantly improve a quality assurance management program. This plan shall embody the contractor's endorsement of the fundamental importance of quality by promoting, reinforcing, and acknowledging quality management in all contractor activities. The Department shall review and approve, reject, or request modification of the plan within fifteen (15) calendar days of receipt.

Examples of items that should be addressed in the quality assurance management plan include the following:

- Description of the contractor's internal controls for review of key deliverables before they are submitted to the Department
- Details concerning the contractor's approach to program management that will ensure on-time and accurate completion of regular and ad hoc tasks
- Details concerning the contractor's approach to program management to ensure a proactive approach to doing business
- Overall approach to communications with the Department that will result in a clear understanding by key personnel of the ongoing status of operations and any issues that arise
- A plan for sampling the work performed by the contractor's staff to ensure the product or service is accurate and consistent with State and Federal policy
- Description of a coordinated approach to problem resolution that includes coordination among contractor staff in various units and between contractor and Department staff

3.4.1 Operations Assessment

Quality management encompasses taking a proactive approach to analyzing and assessing the quality and accuracy of performance. The contractor shall

develop, implement, and maintain procedures to assess the quality and accuracy of its performance of day-to-day operations responsibilities and correct any deficiencies. Depending on the scope of the contractor's responsibilities to the State, operations assessment activities may include:

- Reviewing monthly samples of both hard-copy and electronically submitted Medicaid claims to evaluate system integrity through accuracy of claims payment, client eligibility for dates of service, etc.
- Evaluating system edits and audits for posting accuracy
- Evaluating service authorizations for appropriateness and accuracy
- Reviewing database and file updates to ensure timeliness and accuracy (i.e., eligibility, provider, reference, etc.)
- Assessing current backlogs, including the reasons for the backlogs
- Analyzing reasons for system downtime
- Determining the accuracy of system reports

The contractor will be responsible for reporting to the Department, in writing, its findings on a monthly basis, including an analysis of the impact of any inaccuracies found; developing a corrective plan for the Department review within a Department-approved time frame; implementing the Department-approved correction plan; and reporting, in writing, the results of the corrective actions and recommendations for further system improvements.

The contractor has the responsibility to meet the performance standards defined throughout this RFP. The Department has the responsibility to monitor the contractor's operations to determine if those operations are in compliance with these and other performance criteria specified in this RFP. To meet this monitoring responsibility, the Department must rely on self-reporting by the contractor.

The contractor shall provide monthly reports in a format approved by the Department that present metrics on the results of operations for each Performance Standard defined in Section 7 and summarized in Appendix E, for each Performance Standard defined in Section 11.10, and any other operations performance measurement identified in this RFP.

In addition, the contractor shall provide a Monthly Operations Report in a format approved by the Department that shall include the following information:

- Monthly Operations Report, including, at a minimum:

  Summary statistics for the month and for contract-year-to-date which includes transactions processed by transaction type, transaction disposition, payments made by type of payment, and transactions pended

  Claims/encounter preprocessing statistics

  Monthly rejects

  Key data entry statistics, including data entry error sampling

  Cumulative pend statistics by edit reason and entity responsible for resolution, including pend aging report

  On-line pend resolution statistics for the month and for contract-year-to-date, including time to resolve, time to resolve with CCF, and time to resolve with Department resolution

  Computer system monthly usage statistics, including downtime statistics

  Operations calendar providing a three- (3-) month prospective processing cycle plan

  MOAS statistics for the month and contract-year-to-date, including clerical prescreen, microimaging, clerical/computer review, and professional review

  Monthly financial information, including personnel staffing by contractor's organizational structure

  Provider relations statistics for the month and contract-year-to-date, including provider relations call statistics, provider training activity, and provider outreach activity

- Monthly Financial Report, including personnel staffing by contractor organizational unit

- Provider Relations Report, including:

  Provider telephone inquiry statistics for the month and contract-year-to-date, calls abandoned, calls attempted, and average call length

  Provider training activity

  Provider outreach activity

- Monthly Evolution Report, including a staffing summary and a detailed evolution project report

3.4.2 Fraud Detection and Prevention

Due to the growth of health care fraud and the fact that most health care fraud occurs in large claims processing systems, the Department requires the contractor to implement an advanced fraud detection and prevention program as part of its contract with the State of New York.

Specific components of the contractor's fraud detection and prevention program will be dependent on the specific operations scope of work. From the State's perspective, a Medicaid fraud detection and prevention program should include components that encompass the life cycle of Medicaid claims processing. These activities may be carried out as part of the routine operations of other business areas. These include:

- **Random selection of claims** - This involves using standard sampling techniques to pick out a representative set of providers and to investigate each claim's history. This helps to locate unknown and unanticipated patterns of fraud.

- **Prepayment aggregate monitoring tools** - This involves the development and implementation of tools to aid the claims submission system in detecting fraud **before** a payment is made. Large payments

should always be reviewed and acceleration rates should always be monitored.

- **Measurement systems and methodologies -** This includes the constant examination of Medicaid fraud, determining ways to measure the effects of fraud, and developing methodologies to prevent fraud as it continues to evolve. It may also include the development of a front-end, prepayment fraud, waste, and abuse detection module as a part of the contractor's fraud detection and prevention program. The requirements for the module are provided in Section 9.2.8.1.

- **Relationship between fraud control teams and claims processing operations -** Technology cannot replace the important role humans play in the detection and prevention of fraud. Contractor fraud control units should perform prepayment fraud detection activities under the direction of the Medicaid Fraud Control Unit (MFCU), which will also have day-to-day control over fraud-focused claim suspension criteria.

The contractor will be responsible for developing and implementing a fraud detection and prevention program. The contractor shall submit its program within thirty (30) calendar days after start of full Replacement Medicaid Systems operations for Department and State review and approval and shall report, on a quarterly basis, the results of its fraud detection and prevention activities. In the development of this program, the contractor will coordinate with the Medicaid Fraud Control Unit of the Office of the Attorney General and with the SUR and provider audit units of the Department and with the on-site staff of the Office of the State Comptroller.

3.4.3 Business Reengineering Studies

The contractor shall be responsible for performing recurring business reengineering studies of the business process and work flow of the Medicaid program. The purpose of these studies is to provide a mechanism to regularly reexamine the business processes and work flows used to support the New York State Medicaid program in order to identify changes that will a) improve the administrative efficiency and responsiveness of the program, b) improve quality control, and c) facilitate the Department's attainment of the primary objectives for the Medicaid program.

The contractor shall be required to reassess the effectiveness and efficiency of the reengineered business processes and work flows. The contractor shall be

expected to refine and upgrade the business processes (including automated processes), as necessary, throughout the contract term. The contractor shall provide State staff with complete and timely training on the refined and upgraded business processes and work flows.

The contractor shall perform up to three (3) such studies in each year of the contract, subject to the prior review and approval of the Department. All studies shall be documented and undertaken in close coordination with Department management and staff.

3.4.4 Complaint Tracking and Reporting

The contractor shall provide a complete, accurate, efficient, and timely system and administrative process for the logging, tracking, and reporting to the Department of all verbal and written complaints received by the contractor (or referred to the contractor) from providers, clients, legislative offices, other outside parties, and State staff in the course of the contractor's day-to-day activities. The system shall track complaints related to the New York Replacement Medicaid System operation and maintenance, provider and client services, and medical review and prior authorization. This system shall also be used to facilitate and document timely follow-up by the contractor in the resolution of complaints and to generate statistical reports on the complaints, complaint patterns, and complaint resolution.

3.4.5 Customer Service

Obtaining a high level of customer service from the contractor is a major goal of this procurement. A commitment to customer service is meant to pervade every aspect of service delivery by the contractor.

The Department wishes to contract with a vendor whose staff have a strong commitment to the tenets of customer service. The most basic premise of customer service is an attitude among staff that it is their responsibility to provide service to the customer. Good customer service skills are evident in contractor staff who:

- Return calls promptly.
- Are well-prepared for meetings with the customer.

- Do not rely on their customer to conduct research for them.

- Deliver accurate, high-quality products on time.

The level of service required by the Department is high because of the impact that poor customer service can have on working relationships and the ability to move forward with important projects. The work at hand presents many complex and complicated problems. It is imperative that poor customer service not be one of them.

The contractor is expected to serve four (4) different types of customers: the Department, local districts, Medicaid providers, and Medicaid clients. Each of these types will require a separate focus from the contractor to ensure that its customer service needs are being met. The contractor shall submit a Customer Service Plan within sixty (60) calendar days after contract signing that details its approach to ensuring a high level of customer service for each of the customer types. The Department shall review and approve, reject, or request modification to the plan with fifteen (15) calendar days of receipt.

Examples of items to be included in the Customer Service Plan are listed below:

- Description of the contractor's definition of superior customer service

- Description of the contractor's plans to train its staff in the basics of delivering superior customer service
-
- Method of ensuring that staff are delivering superior customer service

- Strategy for continuously improving the quality of customer service

- Plan for identifying breakdowns in customer service and resolving problems

- Description of the contractor's plans for conducting customer satisfaction surveys; the surveys shall be conducted by an independent firm, and the findings shall be provided to the State

3.4.6 Customer Satisfaction Assessment

The contractor shall assess customer satisfaction from three (3) perspectives: 1) State and local district satisfaction, 2) provider satisfaction, and 3) client satisfaction:

- **State and local district satisfaction** evaluates contractor performance to identify areas for improvement. Factors to be evaluated include responsiveness to client issues and concerns and quality of contractor performance.

- **Provider satisfaction** is intended to 1) analyze the effectiveness of the Medicaid operations to respond to providers' issues, concerns, and problems; 2) evaluate providers' satisfaction with claims processing and payment and the usefulness of bulletins and manuals prepared by the contractor; and 3) to identify areas for improvement.

- **Client satisfaction** evaluates satisfaction from the client's perspective and concentrates on assessing clients' medical access and clarity of program policies, procedures, and regulations.

Customer satisfaction shall be determined through the utilization of the following techniques and tools:

- Customer surveys, which include written surveys and detailed written reports on survey results; surveys will concentrate on obtaining opinions from the following:

  Department employees
  Local district employees
  Medicaid providers
  Medicaid clients

- Focus group meetings to gather information on satisfaction with the contractor's performance and identify areas requiring improvement through face-to-face contact; written reports will be developed to capture information obtained through the focus groups

- Reviews of documentation submitted by contractors to ensure accuracy and timeliness; examples of documents to be reviewed include:

  Bulletins
  Manuals
  Reports

Memoranda

- Complaint log reviews to evaluate where providers have identified deficiencies within the Replacement Medicaid System operations

If areas needing improvement are identified, the contractor will provide a corrective action plan for implementation and follow-up upon Department approval.

As part of the Customer Satisfaction Assessment, the contractor shall be required to:

- Conduct Department surveys on an annual basis or as directed by the Department.

- Conduct provider surveys on an annual basis or as directed by the Department.

- Mail surveys to a statistically valid number of clients who received Medicaid services within the last year. Coordinate with EOMBs in the SUR operations.

- Conduct quarterly focus groups to obtain program feedback from providers, clients, and the Department.

- Develop and implement Department-approved corrective action plans to improve deficiencies identified through surveys and focus groups.

- Compile, and deliver to the Department for review, survey report, and focus group findings.

Table of Contents
Section 4

Section 4
Transition Issues - EMEVS

4.1 Introduction

In an effort to reduce the risk to the contractor and to the Department for the implementation of the Replacement Medicaid System, the Department has elected to extend the contracts of the incumbent Medicaid contractors. This approach will permit the incumbent contractors to focus on continuing operations of the current EMEVS and MMIS while the contractor selected in this procurement can then focus on the Implementation Phase of the Replacement Medicaid System, including the Medicaid data warehouse.

In Section 7.1, the RFP presents the current Medicaid systems in some detail. The Medicaid systems to be replaced by the Replacement Medicaid System are:

- Electronic Medicaid Eligibility Verification System (EMEVS) currently operated by Deluxe Electronic Payment Systems, Inc. (DEPS)

- Medicaid Management Information System (MMIS) currently operated by Computer Sciences Corporation (CSC)

- Several State-operated systems, some of which are components of the Welfare Management System (WMS) and some of which are standalone systems; all of the State-operated systems are currently operated by the Human Services Application Service Center (HSASC)

Continuation of the functions currently performed by the EMEVS is absolutely critical to the Department. The purpose of this section is to make the offerors aware of the issues involved in the transition from the EMEVS to the Replacement Medicaid System.

The Department's objectives are that the transition from the current EMEVS to the redesigned EMEVS components be:

- **Seamless** - EMEVS stakeholders, especially providers, must experience minimal impact from the transition to a new contractor and new system. The transition must be transparent to these stakeholders to the greatest extent possible. After transition, the contractor must preserve the level of

service to which the providers, clients, and system users have become accustomed.

- **Low risk** - The transition must be performed with minimum risk to the New York State Medicaid program. All program functions directly or indirectly supported by the current EMEVS must continue to operate with the same level of integrity and service now experienced by the Department. All applicable State and Federal requirements must be met.

- **Forward-looking -** The purpose of this RFP is to acquire and implement enhanced EMEVS functionality for the Department. The Replacement Medicaid System, with its new EMEVS components, will be functionally richer and support a higher level of service to providers than is currently provided.

4.2 EMEVS Functionality

The functions that are performed by the current EMEVS are described throughout this RFP. The most complete description can be found in Section 7.1.2.4. The critical functions are:

- Eligibility verification through audio response, point-of-service devices, personal computer dial-up, remote job entry, and CPU to CPU; this function is very critical since New York State employs day-specific eligibility for its clients

- Maintenance of the number of services subject to Utilization Thresholds used by clients and the number of services remaining; this function creates a service authorization that is used to permit payment of claims

- Maintenance of the Post and Clear function for selected laboratory and pharmacies

- Prospective DUR and pharmacy electronic claims capture

- Copay management

- Managed care enrollment in and by health plans

These are the functions that, at a minimum, must be a part of the "EMEVS Redesign." This does not imply that the functionality implemented on

November 1, 1999 is necessarily limited to these functions. It does mean, however, that if these functions are not implemented by November 1, 1999, the contractor will have failed to meet a critical date and will be liable for the damages incurred by the Department thorough the need to continue the EMEVS contract.

The requirements for the EMEVS Redesign components are in the following sections of the RFP:

- Eligibility verification, electronic claims capture, networking - Section 7.5
- Utilization Threshold, Post and Clear - Section 7.8
- Prospective DUR - Section 7.14

4.3 Design Drivers

The primary business drivers, or design issues, for the EMEVS are:

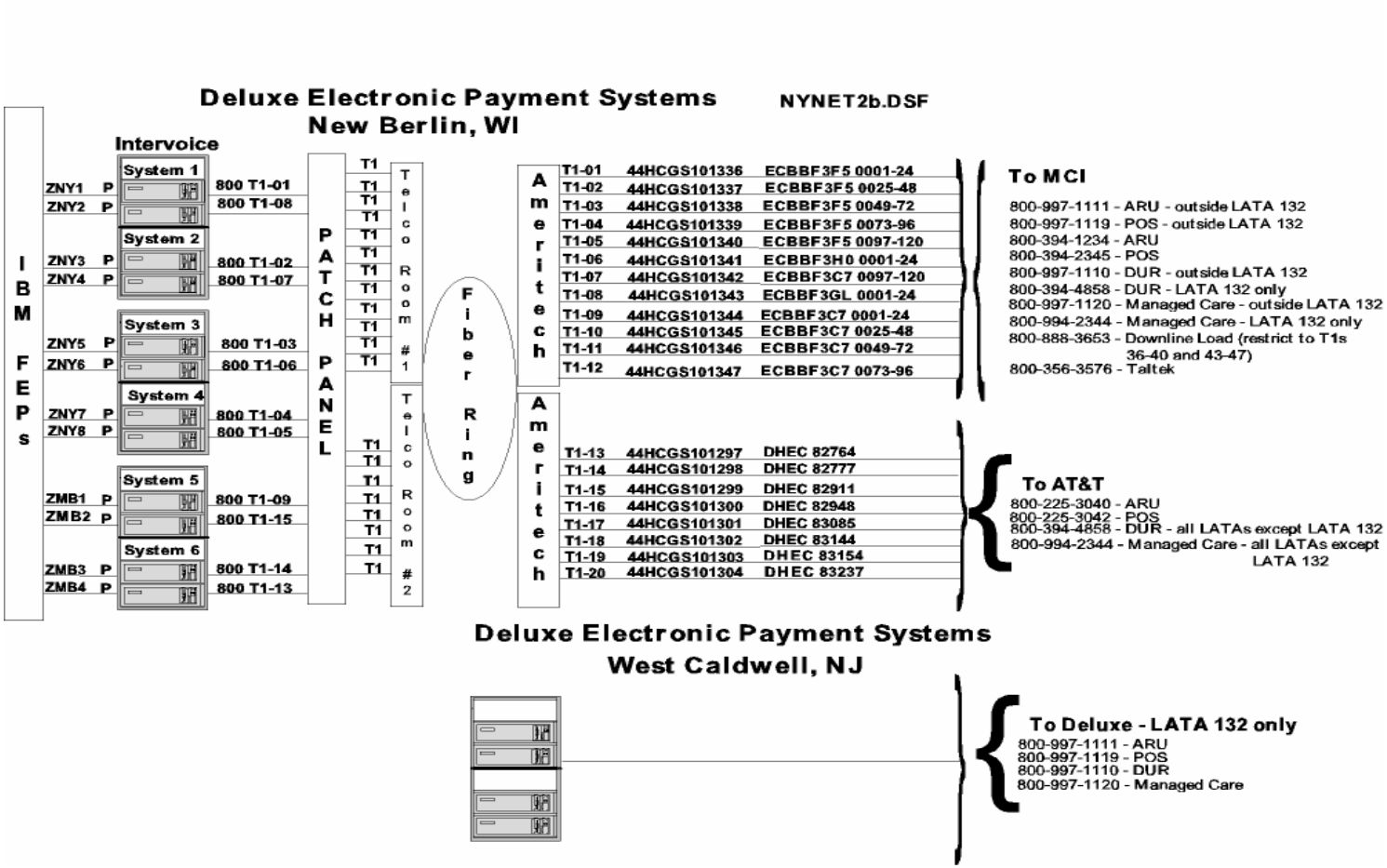
- The telecommunications network necessary to permit providers to access eligibility data
- The electronic data interchange required for transactions
- The client information needed to be responsive to all transactions
- The need for availability of other information
- The need to have the information available to providers twenty-four (24) hours per day, seven (7) days per week

4.3.1 Telecommunications Network

The current communications network is in serious need of upgrading. The data communications speeds are at 1200 baud, and the InterVoice units used for audio response are no longer supported by the manufacturer. A schematic diagram of the current EMEVS network is shown in Exhibit 4.1.

Exhibit 4.1
Current EMEVS Network

Exhibit 4.1
Current EMEVS Network



The current EMEVS contractor will be required to upgrade the network to improve data communication speeds and reduce data problems. There will be no change in the EMEVS software, and the network upgrade will be a stop-gap measure until the Replacement Medicaid System contractor can begin operations with the EMEVS Redesign.

By encouraging the Replacement Medicaid System contractor to utilize NYT, the Department is moving the network costs to the State and relieving the contractor of that cost. It will still be the contractor's responsibility, however, to ensure that the network is in place and to obtain common carriers if NYT does not support the system. A schematic diagram of NYT can be found on the World Wide Web at http://www.irm.state.ny.us/nyt/nyt.htm and is summarized in Exhibit 4.2.

4.3.2 Electronic Data Interchange (EDI)

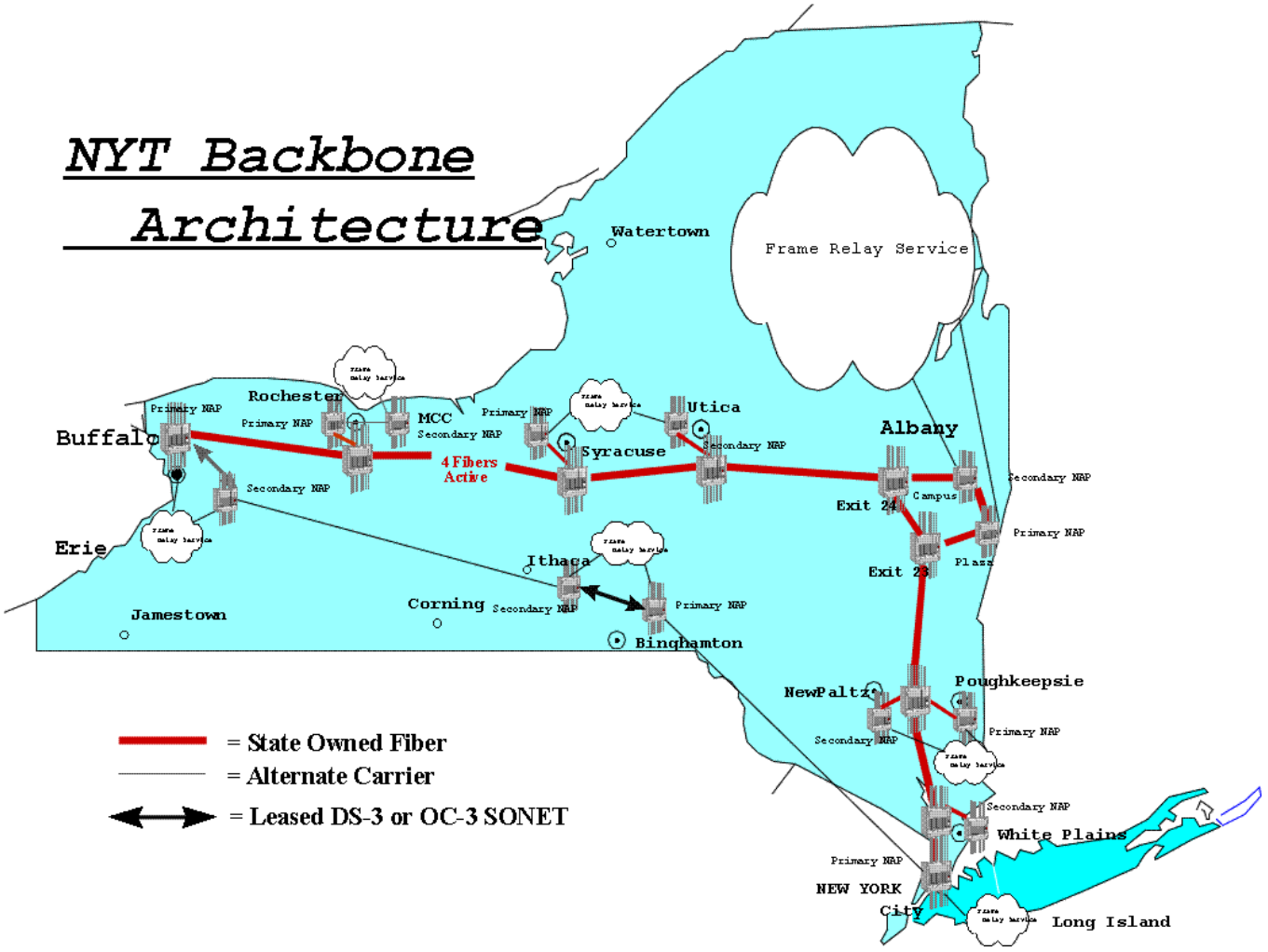
EMEVS functionality is based entirely on electronic data interchange with the providers. The Replacement Medicaid System components that comprise the EMEVS Redesign are the components most critical in the implementation of the EDI standards under the Health Insurance Portability and Accountability Act of 1996. As discussed throughout the RFP, the Department intends to fully comply with these EDI requirements when adopted by the Secretary of U.S. DHHS.

It will be important for the Replacement Medicaid System contractor to be knowledgeable with the standards when they are adopted in February 1998 and to implement those standards for operations by November 1999.

4.3.3 Client Eligibility Information

Equally important as the telecommunications network is that EMEVS provides the means for providers to inquire on the eligibility status of their patients and to inform the Department of intended services when those services may be limited for that client.

Exhibit 4.2
Schematic of NYT



While the MMIS and EMEVS derive the eligibility information from the same sources (the WMS and it subsystems plus related State-operated systems), the information is derived at different times (daily for the EMEVS and weekly for the MMIS). In addition, the EMEVS has edits on the eligibility input that the MMIS does not have. The combination of these conditions may result in different information in each system on a given client.

To ease the frustration caused by these "file synchronization" issues, the Department requires a single Client Eligibility Data Repository (Section 7.2) that will serve both the operational needs of the redesigned EMEVS components and the other Replacement Medicaid System components. Because the EMEVS-type functions are client-related, the development of the Client Eligibility Data Repository must occur simultaneously with the other EMEVS redesign components.

Another function of the current EMEVS is that it acts as a conduit for managed care enrollment. WMS is the primary enrollment vehicle as most managed care enrollment is accomplished by the LDSS. Health plans may also initiate client enrollment by sending a transaction to EMEVS. The enrollment information is then transmitted to WMS, where it is properly processed.

4.3.4 Other Information Requirements

In addition to the client information needed to properly operate the EMEVS Redesign components, information from the Provider and Formulary files is also needed. As shown in Exhibit 1.1, the Department is not requiring that the Provider Enrollment and Data Maintenance and Reference Data Maintenance components be implemented until the second contract year. However, because Provider and Formulary file information is required for the EMEVS Redesign components, the contractor should strongly consider implementing at least these elements as part of the EMEVS Redesign.

4.4 Data Conversion Considerations

Due to the importance of the EMEVS functionality to the Department, retention of transaction history is also important. This converted history includes:

- All available eligibility verification, Utilization Threshold, and Post and Clear transaction history
- All available ProDUR transaction history (this is the history used in the computation of alerts, not claims history)
- Conversion of all EMEVS report information
- Conversion of the VeriFone tracking file

In addition to the EMEVS transaction history, the Department requires a minimum of twenty-four (24) months of eligibility history on-line and eight (8) years of eligibility history in an archive file that can be retrieved within five (5) business days.

4.5 Incumbent Contractor Turnover Support

Significant features of the current EMEVS contractor's commitment for turnover are presented in this section. The entire turnover plan is available in the Procurement Library.

4.5.1 Training

The incumbent contractor's training effort will focus on providing the new contractor's management personnel with information about all operational aspects of the EMEVS. The training objective is to introduce the contractor's management team to the unique features of the EMEVS.

4.5.2 Documentation Update

The incumbent contractor will ensure that all documentation is in its prescribed format and is complete and accurate. Any required updates or additional copies will be provided.

4.5.3 Systems Hardware/Software

The incumbent contractor will transfer all system hardware and equipment, with title, leasing, or license rights to the new contractor or to the State. The incumbent contractor will transfer to the State all computer programs, manual procedures, operating plans, documentation, data, records, and other items related to the EMEVS.

4.5.4 Proprietary Software

The incumbent contractor has the requirement to exercise the option to assign or deliver proprietary software to the State or the new contractor. However, the Department expects that all proprietary software will have been replaced by the incumbent contractor.

4.5.5 Transfer Management and Personnel Responsibilities

The incumbent contractor's responsibilities at turnover will include:

- Maintain management and control of turnover assistance and cooperation with the contractor.
- Maintain constant staffing during the turnover period by encouraging or providing incentives to staff to remain.
- Arrange for transfer of employee records to the successor contractor.
- Provide access to employees by the State or successor contractor.

4.5.6 Supplies

The incumbent contractor will maintain no less than a two- (2-) month supply of all supplies during the turnover period.

THIS PAGE INTENTIONALLY LEFT BLANK

Table of Contents
Section 5

Section 5
Transition Issues - MMIS

5.1 Introduction

In an effort to reduce the risk to the contractor and the Department for the implementation of the Replacement Medicaid System, the Department has elected to extend the contracts of the incumbent Medicaid contractors. This approach will permit the incumbent contractors to focus on continuing operations of the current EMEVS and MMIS while the contractor selected in this procurement can then focus on the Implementation Phase of the Replacement Medicaid System, including the Medicaid data warehouse.

In Section 7.1, the RFP presents the current Medicaid systems in some detail. The Medicaid systems to be replaced by the Replacement Medicaid System are:

- Electronic Medicaid Eligibility Verification System (EMEVS) currently operated by Deluxe Electronic Payment Systems, Inc. (DEPS)

- Medicaid Management Information System (MMIS) currently operated by Computer Sciences Corporation (CSC)

- Several State-operated systems, some of which are components of the Welfare Management System (WMS) and some of which are standalone systems; all of the State-operated systems are currently operated by the Human Services Application Service Center (HSASC)

The Department's objectives are that the transition from the current MMIS to the Replacement Medicaid System be:

- **Seamless** - MMIS stakeholders should experience minimal impact from the transition to a new contractor and new system. The transition should be transparent to these stakeholders to the greatest extent possible. After transition, the contractor must preserve the level of service to which the providers, clients, and system users have become accustomed.

- **Low risk** - The transition must be performed with minimum risk to the New York State Medicaid program. All program functions directly or indirectly supported by the current MMIS must continue to operate with

the same level of integrity and service now experienced by the Department. All applicable State and Federal requirements must be met.

- **Forward-looking -** The purpose of this RFP is to acquire and implement enhanced claims processing and information retrieval functionality for the Department. The Replacement Medicaid System, with all of its components, will be functionally richer and support a higher level of service to all stakeholders than is currently provided.

5.2 Implementation Timing

As shown in Exhibit 1.1, the cutover to the full Replacement Medicaid System shall be on November 1, 2000. This date is critical for several reasons:

- The extension of the incumbent's contract expires on October 31, 2000. If the Replacement Medicaid System contractor is not ready for full operation, the contractor will have failed to meet a critical date and will be liable for the damages to the Department through the need to continue the MMIS contract.

- The entire functionality of the Replacement Medicaid System that is needed to achieve Federal certification as of November 1, 2000 must be operational. If HCFA does not certify the Replacement Medicaid System retroactive to November 1, 2000, the contractor shall be liable for the damages to the Department for lost Federal financial participation.

- To achieve a smooth transition from the current MMIS to the Replacement Medicaid System, the stakeholders must be kept focused. If the implementation date begins to slip, stakeholders will begin to lose focus and the implementation will be in jeopardy.

5.3 Design Drivers

The primary business drivers, or design issues, for the Replacement Medicaid System are:

- Efficient and accurate processing of fee-for-service claims and timely payment to providers
- Integration of managed care
- Integration of non-Title XIX programs
- Improvements in the business processes for selected Medicaid operations
- Compliance with new Federal requirements

5.3.1 Claims Processing

The Department recognizes that the current MMIS is one of the oldest in the country, and the inherent design limitations prevent the Department from implementing many of the needed initiatives. This factor is one of the major reasons for moving forward with the new Replacement Medicaid System.

However, offerors should also recognize that the current system is very efficient in the processing of claims and payment of providers. It is the Department's intent to use technology and good business process design to minimize the impact of a new system on providers.

5.3.2 Integration of Managed Care

New York State has had contracts with various health plans for some time. Recently, however, the Department has implemented an approved Section 1115 waiver to implement a mandatory managed care program. The current MMIS does process the encounter data it receives from the health plans. Due to its age, however, the fundamental architecture of the MMIS is not oriented to an extensive managed care program.

The Department expects the Replacement Medicaid System contractor to bring concepts and features from other states or from commercial systems to ensure that the fundamental architecture of the Replacement Medicaid System incorporates capitated programs as much as it does fee-for-service. Examples of features the Replacement Medicaid System must have are:

- Enrollment of clients in, and auto-assignment to, health plans
- Storage of information on health plans and their provider networks with as much detail as is available for fee-for-service providers
- Recognition that fee-for-service claims are being processed under a stop-loss agreement with a health plan and report the information accordingly
- Ability to accommodate fee-for-service claims for self-referral to out-of-plan services where permitted by Department and Federal policy

5.3.3 Integration of Non-Title XIX Programs

The Department will be making a significant investment in the Replacement Medicaid System. To achieve maximum benefit from that investment, the system shall be able to accommodate programs other than Title XIX. This may require:

- Sources of eligibility or enrollment information other than WMS
- Multiple benefit packages and different pricing models for each benefit package
- Financial management and reporting for different programs
- Statistical and programmatic reporting for multiple programs
- Enrollment of types of providers currently not recognized by the Medicaid program in New York State

5.3.4 Improvements in Business Processes

One of the primary reasons for the development of the Replacement Medicaid System is the recognition by the Department that the design of many of the current business processes is based on system limitations. The Department expects to work in partnership with the contractor to redesign fundamental business processes, not just design a new system around outdated processes. Among the business processes that need to be redesigned are:

- Capture and storage of rates for rate-based providers - There are many rate-setting entities, some of which are automated and some of which are not. The Department expects that the Replacement Medicaid System will interface with automated rate systems and provide an easy means of update for rate-setting entities that are not automated.

- Provider enrollment - Currently, provider enrollment and update of provider information is performed on a State-operated system, which is then transmitted weekly to the MMIS. The Department expects the contractor to develop new procedures for provider enrollment, including out-of-state provider enrollment, as it redesigns the provider data maintenance component.

- Reference file update - Most of the Reference files are State-operated, with the updated information being passed to the MMIS weekly. The Department expects that these processes will be improved and that the systems support will be an integral part of the Replacement Medicaid System. In addition, current processes update only those procedures, diagnoses, and formulary items applicable to the New York State Medicaid program. With the implementation of the managed care program and the inclusion of non-Title XIX programs, the need for a full update of the Reference files now exists.

In preparing proposals, offerors are encouraged to review Appendix J closely. This appendix captures the expressly stated business needs of the New York user community. To avoid being overly prescriptive, many of these needs are not expressly detailed in Section 7. However, all of these needs are considered to be inherent in those requirements.

5.3.5 Compliance With New Federal Requirements

Like the EMEVS Redesign components, all other Replacement Medicaid System components must be in compliance with the electronic data interchange standards set forth in the Health Insurance Portability and Accountability Act of 1996. Among these are standards for health care claims and remittance advices. A particularly onerous task will be the implementation of electronic attachments by February 2001.

In addition, the Balanced Budget Act of 1997 requires that all states submit data to HCFA under the Medicaid Statistical Information System (MSIS). New York State currently submits a paper version of the HCFA-2082. The

Replacement Medicaid System must permit the Department to comply with the MSIS requirement.

5.4 Data Conversion Considerations

The Department expects that the contractor will convert as much data to the Replacement Medicaid System as is needed to operate the New York State Medicaid program. This includes claims history, client eligibility history, provider demographic history, prior authorization/prior approval history, etc.

The major consideration in the conversion of historical data is the factor of multiple, probably overlapping and possibly conflicting sources of data. For example:

- Client eligibility data is available from the MMIS, the EMEVS, the WMS and its related subsystems, and State-operated systems.
- Provider data is available from the MMIS and EMEVS and the Provider file.
- Provider rate data is available from the MMIS from the Rate file and from the rate-setting entities.

The Department expects the Replacement Medicaid System contractor to develop and present a comprehensive conversion plan to ensure that all data conversion considerations have been addressed.

5.5 Incumbent Contractor Turnover Support

Significant features of the incumbent contractor's commitment for turnover are summarized in this section. The entire turnover plan is available in the Procurement Library. Not all of this turnover support will be required in the development and implementation of the Replacement Medicaid System. The responsibilities of the incumbent contractor described in the following paragraphs assume a takeover of the current system and will have to be adapted to the transition to a new system.

5.5.1 Training

The incumbent contractor will provide training to the contractor's management personnel in the operation and maintenance of the MMIS.

5.5.2 Resources

The incumbent contractor will be required to make the following resources available to the contractor during the transition:

- Access to the MMIS facilities at 800 North Pearl Street
- The detailed turnover plan
- Computer resources outside normal working hours
- Computer system time within the computer resources available
- Two (2) computer terminals for testing and training during normal working hours
- Space, desks, and reasonable office support (copiers, etc.) for contractor turnover staff
- Three (3) months' supply of claim form inventory

5.5.3 Documentation Update

The incumbent contractor shall ensure that documentation is updated and available during the transition period.

5.5.4 System Hardware/Software

The incumbent contractor shall transfer all system hardware and equipment, with title, leasing, or license rights thereto, to the contractor or to the Department. The incumbent contractor shall similarly transfer to the Department or to the contractor all nonproprietary system software, data files, application programs, and documentation.

5.5.5 Proprietary Software

The incumbent contractor shall exercise the options to assign or deliver proprietary software rights to the Department or contractor.

5.5.6 Transfer Management and Personnel Responsibilities

The incumbent contractor's responsibilities at turnover shall include:

- Maintain management and control of turnover assistance and cooperation with the contractor.
- Maintain constant staffing during the turnover period by encouraging and/or providing incentives to the staff to remain.
- Encourage experienced staff to become employees of the successor contractor.
- Arrange for transfer of employee records to the successor contractor.
- Provide access to employees by the Department or successor contractor.

5.5.7 Supplies

The incumbent contractor shall maintain no less than a two- (2-) month supply of all supplies during the turnover period.

Table of Contents
Section 6

Table of Contents
Section 6 (continued)

Table of Contents
Section 6 (continued)

Section 6
Scope of Work

6.1 Introduction

The contractor shall develop and implement a Replacement Medicaid System for New York State that meets the requirements defined in Section 7 of this RFP and validated by Department staff during joint application design (JAD) sessions. The selected contractor shall develop, implement, and operate a Medicaid data warehouse. The structure of the data warehouse and operations requirements are addressed in Section 8 (Medicaid Data Warehouse) of this RFP.

Upon implementation of the Replacement Medicaid System, the contractor will operate, maintain, and enhance the system for the contract period and perform contractor responsibilities described in Section 7 and in Section 6.3. The expected scope of work for the system development, implementation, operations, maintenance, and enhancement is described in this section of the RFP.

The Department encourages offerors to propose the best technical and operational solutions available to meet the needs of the New York State Medicaid program and other medical assistance programs.

The Replacement Medicaid System shall meet Federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual and other authoritative publications by HCFA. It is imperative that the New York State Replacement Medicaid System be complete, stable, and of high quality.

The scope of work under this RFP includes the following phases:

- Implementation Phase (Section 6.2)
- Operations Phase (Section 6.3)

Each of these phases are discussed in detail in the remainder of this section of the RFP.

6.2 Implementation Phase

During the Implementation Phase, the contractor will design and develop the Replacement Medicaid System in an incremental approach. An incremental approach means that the functional requirements of the Replacement Medicaid System have been organized into seventeen(17) functional areas. Each functional area will be subject to the System Development Life Cycle (SDLC) required by this scope of work. The contractor may elect to implement some components concurrently and some on an overlapping schedule. In any case, the schedule for implementing the components is as follows:

- EMEVS Redesign must be completed not later than October 31, 1999 and includes the following Replacement Medicaid System components:

  The Eligibility Verification System (EVS) and other elements of the Electronic Commerce component (Section 7.5)

  The Client Eligibility Data Repository (Section 7.2)

  The Utilization Threshold and Post and Clear components of Service Utilization Management (Section 7.8)

  The Prospective Drug Utilization Review (Section 7.14) and point-of-service drug claims capture (Section 7.5)

- The Medicaid data warehouse must be completed by February 28, 2000 (Section 8).

- All remaining components of the Replacement Medicaid System must be implemented no later than October 31, 2000.

The scope of work for the implementation of the entire Replacement Medicaid System, including the EMEVS redesign components and the Medicaid data warehouse component, are defined in the following sections:

- Section 6.2.1 - Implementation Phase Standards and Requirements

- Section 6.2.2 - Project Planning Task

- Section 6.2.3 - Joint Application Design (JAD) Task
- Section 6.2.4 - Technical Design Task
- Section 6.2.5 - Conversion and Interface Design Task
- Section 6.2.6 - System Construction Task
- Section 6.2.7 - System and Acceptance Testing Task
- Section 6.2.8 - Implementation Task
- Section 6.2.9 - Certification Task
- Section 6.2.10 - Medicaid Data Warehouse

6.2.1 Implementation Phase Standards and Requirements

The contractor must comply with the General System Requirements specified in Section 3.2 throughout the Implementation, Certification, and Operation Phases of the contract. In addition, the contractor must meet the following data processing design and development requirements and project management requirements.

6.2.1.1 Structured Design and Programming

All Replacement Medicaid System components shall be developed using structured design and programming concepts. To the greatest extent possible, the Department expects:

- Frequently used logic to be shared between programs to ensure that any modifications to such logic are automatically carried throughout the system
- On-line screens to be developed using consistent format and navigational rules to ensure a consistent "look and feel" for the Replacement Medicaid System

- Reports to be produced through auxiliary programs outside of mainline processing to ensure that report files can be easily sorted and modified without affecting existing processes

- Data elements used in the system to be well-documented, normalized to the extent possible, and consistent throughout all components of the Replacement Medicaid System, including the Medicaid data warehouse; and data element value definitions to be available in a Tables Manual

All transferred and newly developed source code shall be organized in a modular manner, be well-documented, and meet commonly accepted standards for structured applications.

The contractor may propose any design methodology, such as event-driven design or object-oriented programming, but it must use the system development life cycle (SDLC) as the development methodology.

6.2.1.2 Hardware

The contractor is responsible for any hardware platform that will support the requirements set forth in this RFP. However, the proposed hardware platform shall be easily upgradable and expandable if:

- Changes made to the architecture as a result of the JAD activities require additional processing capacity.

- Additional processing capacity is required to respond to changes to the New York State Medicaid program during the Implementation and Operations Phases of the contract.

The cost of the hardware and telecommunications platform is part of the Annual Administrative Fee. Where such upgrades are required, the contractor must demonstrate to the Department's satisfaction that adjustments to the Annual Administrative Fee are justified.

The contractor shall provide an interface to the New York backbone network (NYT) to provide user access to the Replacement Medicaid System and the Medicaid data warehouse.

6.2.1.3 Software

The contractor may propose the operating system and application languages to develop the new Replacement Medicaid System. However, the operating system and application languages shall be widely used and technically appropriate for the application. Any proposed proprietary software and application languages shall be identified in the proposal and are subject to Department approval.

The proposed system software shall allow State technical staff and consulting resources to browse development and test source libraries, procedure libraries, object repositories, record format libraries, test files, and other Replacement Medicaid System software regardless of platforms being used for development. It shall also enable these Department resources to access the same software development tools used by contractor staff to assist in the development of test data and the evaluation of test results and system changes.

The proposed software shall be easily migrated to a larger platform if the proposed platform is demonstrated to be insufficient to meet the performance standards and system requirements described in Section 7.

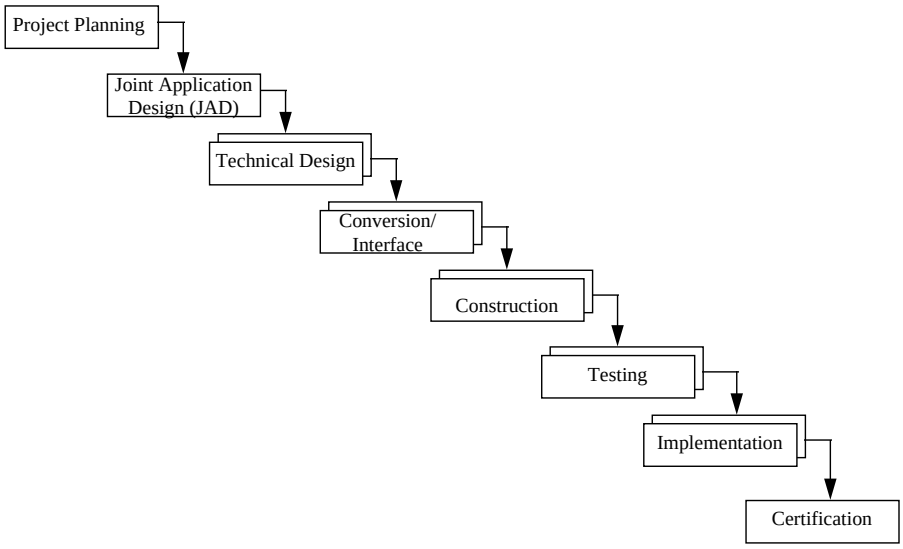
6.2.1.4 Documentation

Documentation, including all Implementation Phase deliverables and resulting system documentation (e.g., user documentation, operational procedures, and provider handbooks), shall be provided in hard copy and be stored in an electronic format. The electronic versions of the documentation shall be accessible to users on-line through a PC-accessible bulletin board, CD-ROM technology, Internet Web site, or other methods, at the Department's direction. Browse and search, such as hypertext markup language (HTML) capabilities shall be provided to permit users to easily locate specific information in the documentation. The contractor will maintain and update all documentation in accordance with Department-defined criteria. Specific documentation standards will be defined during the Project Planning Task.

6.2.1.5 Project Management Requirements

As mentioned previously, the contractor must use the system development life cycle (SDLC), sometimes known as the "waterfall" methodology, for organizing the development of the system. The methodology, including the tasks for the development of the Replacement Medicaid System, are as follows:

Tasks of the Implementation Phase



The Replacement Medicaid System shall be developed in components as described above. The Project Planning, Joint Application Design, and Certification Tasks shall be performed jointly and concurrently for all components.

The exception to this requirement to use the "waterfall" SDLC is the development of the Medicaid data warehouse. The implementation process is different for a data warehouse than it is for a transaction-based system. The details of this implementation approach are defined in Section 6.2.10.

The contractor shall define the work plan and schedule for each component. However, such work plan and schedule will consist of the tasks described above, and the detailed schedule shall conform to the schedule overview presented in Exhibit 1.1. The contractor shall use Microsoft Project to document the work plan and schedule. The contractor must provide up to five (5) licensed copies of Microsoft Project to the Department and must provide updated copies of the work plan as a part of the status reporting described in the next section.

6.2.1.6 Reporting and Approvals

Standard contractor requirements for reporting status and obtaining Department approvals include the following:

- Report progress against the work plan for each task through weekly written status reports and at weekly progress review meetings with the Department's Project Manager.

- Update the project work plan and task schedule biweekly.

- Deliver written status reports and updated work plans/schedules by 9:00 a.m. one (1) work day before the status meeting.

- Prepare an outline and provide sample contents for each deliverable, and obtain written approval from the Department before beginning work on the deliverable. Where the base deliverable contents are defined by Federal rules (e.g., State Medicaid Manual), those requirements should serve as the basis for the outline to be submitted for approval.

- Obtain written approval from the Department on each deliverable submitted for review.

- Revise deliverables, if required, using Department review findings to meet content and format requirements.

It is the intent of the Department to closely monitor the progress of the Replacement Medicaid System development activities. Most of the Implementation Phase tasks will be monitored through the work plan, schedule, and deliverables. The Construction Task for each Replacement Medicaid System component is a lengthy period with few milestones. To enable the Department to monitor that Task, the contractor must develop a **spending plan** for the Construction Task for each component. That spending plan shall consist of an estimate of the number of programmer/analyst hours by program/module. This information, along with the scheduled completion of each program/module will permit the Department to monitor progress during the Construction Task.

6.2.1.7 Location and Facility Requirements

The contractor shall establish the development and Replacement Medicaid System operations within thirty (30) miles of the State Capitol building in Albany, New York. During the Implementation Phase, the project planning; JAD sessions; structured walk-throughs; and conversion, system acceptance, and certification activities shall be performed at this site. At the Department's direction, some of these activities may be performed at Department facilities. The current MMIS facility at 800 North Pearl Street is **not** available for these activities.

In addition to the requirements for Contract Management Staff described in Section 3.1.2, the contractor shall provide adequate working space, conference space, and parking at the local development site to accomplish all of the Implementation Phase tasks in an efficient and professional manner. Specifically, a large, well-equipped conference room will be required to accommodate Department users, consultant staff, and contractor staff during the JAD sessions, System Construction walk-throughs, System Testing task, and other activities during the Implementation Phase.

In addition to the Department's requirement for work space described in Section 3.1, the contractor shall provide dedicated working space at the contractor's local facility for up to ten (10) Department and consultant personnel and three (3) OSC personnel. These personnel will be working on-site at the contractor's facility approximately fifty percent (50%) to one hundred percent (100%) of full-time, depending on the project task. The work space shall be equipped with thirteen (13) workstations and three (3) laser printers connected to the contractor's local area network. Minimum requirements for the Department's work area are as follows and are subject to Department approval:

- Two (2) private offices with locking doors, each with furniture and equipment appropriate for manager-level activities: file cabinet, desk, desk chair, two (2) additional chairs, bookcase, white board, phone, workstation, data line, LAN connection, and office supplies necessary to carry out project management and monitoring duties

- Eleven (11) partitioned work areas, each with furniture and equipment appropriate for professional staff: file cabinet, desk, desk chair, bookcase, white board, phone, workstation, data line, LAN connection, and office supplies necessary to carry out project monitoring activities

- One (1) dedicated conference room with space, table, and chairs for a minimum of twelve (12) people, a large white board, conference phone, (3) workstations, data line, LAN connection, (2) laser printers, and office supplies necessary to carry out project management and monitoring duties; the conference room shall be equipped with three (3) desks and chairs in a common work area for Department use

- One (1) dedicated facsimile machine with plain paper capability and automated to send or receive faxes unattended

- One (1) dedicated photocopy machine with sorting, collating, stapling, and automatic feed capabilities

This space shall be made available and maintained exclusively for Department use until the end of the Implementation Phase, which occurs upon Department approval of the systems documentation and Federal certification of the Replacement Medicaid System.

6.2.1.8 Contractor Responsibilities

The responsibilities of the contractor are identified for each of the tasks within the Implementation Phase. In addition, the contractor has overall responsibility for the timely and successful completion of each of the tasks. The contractor is responsible for clearly specifying and requesting information from the Department in a manner that does not delay any part of the schedule.

The Department's project team will review the contractor's proposed approach to assuming overall system development responsibilities and the specific responsibilities in each of the Implementation Phase tasks.

6.2.1.9 Contractor Commitment to Quality

The Department is making a significant investment in procuring a Replacement Medicaid System and the expanded fiscal agent services described in this RFP. The contractor selected will perform an essential role in New York State Medicaid program administration. To maintain continuous focus on the importance of delivery of quality systems and services, the contractor shall plan, implement, rigorously endorse, and constantly improve a quality assurance program.

The Department does not seek a textbook approach to quality management. Instead, the Department seeks contractor endorsement of the fundamental importance of quality imbedded in a living plan to introduce, promote, reinforce, and acknowledge quality in all contractor activities.

The offeror shall develop a Total Quality Management (TQM) Plan which shall be included as part of the technical proposal and refined early in the Implementation Phase to address the needs and specific opportunities for quality improvement throughout the contract period. The TQM Plan shall be submitted to the Department not later than the completion of the Project Planning Phase and shall reflect the Contractor's experience and resolve toward quality in systems design, testing, and implementation; process design and staff training; performance standards development and measurement; and customer satisfaction measurement and analysis.

As part of the contractor's commitment to quality, the Department requires that contractor staff involved in the Implementation Phase will remain part of the contractor's New York State team until Federal certification is completed. During the course of the contract, the Department reserves the right to approve or disapprove the contractor's and any subcontractor's staff assigned to this contract, to approve or disapprove any proposed changes to staff, or to require the removal or reassignment of any contractor employee or subcontractor employee found unacceptable by the Department.

6.2.1.10 Deliverables

Specific task deliverables will be proposed by the contractor based on the structured methodology used. Some deliverables for certain tasks, however, are listed and required. The contractor will propose for Department approval the format of the deliverables and documentation as a part of the completion of the Project Planning Task. The Department requires that the contractor deliver a minimum of four (4) printed copies of the deliverables and documentation and a minimum of two (2) copies on compact disk (CD) accessible in an on-line format such as Adobe Acrobat 3.0. The deliverables shall also be prepared using the Department's standard word processing software, which is currently Corel WordPerfect 6.1, and electronic copies in this format shall be delivered to the Department.

Each document will be reviewed by the Department's Project Team and will require formal approval from the Department. The contractor shall include at least fifteen (15) business days, per deliverable, in the project work plan for

the Project Management Team to review each deliverable and document their findings. Based on the review findings, the Department may approve or reject the document or specify conditional approval with a request that revisions be made to the deliverable. The contractor shall organize the deliverables and documentation so that the revisions specified by the Department may be accomplished by change pages, if possible, rather than document replacement.

Deliverables of low quality will be rejected by the Department and shall be rewritten and resubmitted by the contractor. Additional ten- (10-) business-day review periods shall be required whenever revisions are requested or a deliverable is rejected.

The contractor will be required to conduct a detailed walk-through of each deliverable to facilitate the Department's review and approval process.

6.2.1.11 Milestones

Project milestones are listed for each task. Each milestone denotes a checkpoint toward the operations start date. The dates for completion of project milestones will be finalized for purposes of performance standards and implementation checkpoints based on the contractor-proposed methodology and the Department-approved Work Plan and Schedule for the Implementation Phase.

The contractor's status reports shall provide information on progress toward meeting milestone dates. Damages may be assessed for failure to meet a milestone or the operations start date, as specified in Section 11 of this RFP.

6.2.1.12 Expected Scope of Work

The Department requires the contractor to accomplish the tasks described in Section 6.3.2 through 6.3.10 for the fixed price submitted in the contractor's Price Proposal. The system requirements listed in this RFP represent the Department's best assessment of processing needs at this time. It is the Department's intent, however, to refine the system requirements through the JAD sessions. The purpose of the JAD sessions will be to validate the requirements in this RFP, accept user input on the design of on-line screens, system reports, and system processes, and to finalize the design of the Replacement Medicaid System.

Without advance knowledge of the capabilities of the transfer base to be proposed by the successful offeror, the extent to which that transfer base can meet the requirements specified in this RFP without extensive modification is unknown. The contractor, by submitting a proposal in response to this RFP, is charged with presumptive knowledge of the level of effort to accomplish the tasks described in this RFP.

The Department recognizes that, with the passage of time between proposal submission and completion of JAD and with the dynamics of the program, changes may occur in the scope of the Replacement Medicaid System as presented in this RFP. Such changes may include additions, modifications, or deletions of requirements. It shall be a joint responsibility of the contractor and the Department to maintain requirements traceability and change control tracking documentation to help in assessment of whether a modification to the contract is necessary.

It is extremely important that the Medicaid data warehouse be developed and implemented concurrently with the EMEVS redesign portion of the Replacement Medicaid System implementation (see Exhibit 1.1). The Department expects that the Medicaid data warehouse will be included as an integral part of the Project Planning Task discussed in the next section.

6.2.2 Project Planning Task

The objectives of the Project Planning Task are to:

- Discuss, refine, and finalize the work plan required as part of the contractor's Technical Proposal.
- Develop the Detailed Implementation Schedule (DIS) for use in monitoring the remainder of the project and for submission to HCFA.
- Acquire hardware and software, install it at the contractor's facility, and provide full connectivity to the development host.
- Determine and implement system interfaces and organizational relationships between contractor and Department staff.
- Initiate project management control and reporting procedures.

- Define and install a correspondence tracking process, an issue tracking process, and a change control process.

- Begin initial planning and site development for fiscal agent operations support.

The Department expects the contractor to perform phase-limited planning. Project planning during this task includes detailed discussion of the overall implementation work plan and finalization of the detailed work plan for the Joint Application Design (JAD). For each component of the Replacement Medicaid System, the Technical Design, the Conversion and Interface Design, the System Construction, the System and Acceptance Testing, and the Implementation Tasks will be presented at a higher level, but with sufficient detail to enable the contractor and the Department to perform overall scheduling. Project Planning Task activities will include briefings, presentations, and training in the proposed system development life cycle methodology and any computer-aided software engineering (CASE) or other software development-aid tools proposed.

Desirable approaches to requirements definition include the use of a structured methodology and documentation of the Replacement Medicaid System requirements which is supported by a CASE tool or tool set to be used for systems analysis, systems design, and application generation. The contractor shall use an automated tool set to develop and maintain an integrated data dictionary, and screen and report layouts, at a minimum.

It is also highly desirable that the tool set be integrated across the life cycle or be capable of supporting upper CASE functions of analysis and design with a seamless interface to a lower CASE product. The tool set should support the project deliverables and the creation of screen and report layouts. The selected approach shall incorporate significant and continuous user involvement through JAD sessions.

The contractor will specify the approach, use of any CASE tools, and deliverables appropriate for the selected methodology. Use of any CASE tool outputs should be clearly defined in the deliverables for this task.

The Project Planning Task will result in a Final Work Plan and Schedule, reflecting the detailed work breakdown, staffing, deliverables, and schedule for the JAD. A complete, but less detailed work plan and schedule will reflect the remaining Implementation Phase activities, including planned deliverables. The Project Planning Task will continue throughout the

Implementation Phase to the extent that the contractor will be required to prepare a Final Work Plan and Schedule prior to the start of each task.

6.2.2.1 State Responsibilities

State responsibilities for the Project Planning Task are:

6.2.2.1.1 Provide information on State resources, project organization, and staffing.

6.2.2.1.2 Participate in detailed planning for the Joint Application Design Task activities and higher-level planning for subsequent Implementation Phase tasks.

6.2.2.1.3 Attend contractor-led briefings, presentations, or training sessions on the proposed system development methodology or software development tools.

6.2.2.1.4 Approve the contractor's finalized approach and selection of CASE tools or other planning, design, and development software.

6.2.2.1.5 Participate in project control and reporting planning efforts.

6.2.2.1.6 Provide all available relevant documentation on current claims processing, program policy, and anticipated changes.

6.2.2.1.7 Approve the contractor's work plan.

6.2.2.2 Contractor Responsibilities

Contractor responsibilities for the Project Planning Task are:

6.2.2.2.1 Produce the Final Work Plan and Schedule through joint detailed planning with the Department. The Final Work Plan and Schedule shall incorporate all State and contractor tasks and activities and provide a detailed plan describing plans and contingencies to ensure an on-time, on-budget implementation.

The Final Work Plan and Schedule will include an updated, approved project schedule, work plan, description of project deliverables, project resource requirements, project organization and staffing (including a staff loading chart for each task and for the entire phase), project interfaces, and project reporting approach. It shall address all milestones defined in this RFP with an expected date that the milestone will be met. A Gantt or PERT chart showing all tasks,

dependencies, and a critical path analysis shall be provided. The initial work plan will be at its lowest level of detail for the Joint Application Design Task and at a higher level of detail for subsequent Implementation Phase tasks. As each task ends, the next task work plan will be developed at the lowest level of detail until all activities are complete.

The Final Work Plan and Schedule shall be developed using Microsoft Project. The contractor will use this project management tool throughout the Implementation Phase. Copies of updated work plan files shall be provided to the Department through electronic media monthly.

6.2.2.2.2 Produce the Detailed Implementation Schedule (DIS) based on the approved Final Work Plan and Schedule, cost allocation data, and data on resource availability. Some of the information required for completion will be provided by the Department.

6.2.2.2.3 Maintain the DIS throughout the Implementation Phase. Provide the Department with updated work plans and schedules biweekly or when requested.

6.2.2.2.4 Finalize approach and selection of CASE tools or other planning, design, and development software. Provide orientation and training on approach and/or proposed tools to Department staff.

6.2.2.2.5 Initiate project management control software and reporting procedures.

6.2.2.2.6 Establish a contractor facility in New York State, within thirty (30) miles of the State Capitol in Albany within the first thirty (30) calendar days of the start of the Project Planning Task.

6.2.2.2.7 Provide complete State offices, partitioned work areas, and a conference room, as described in Section 6.2.1.6, within thirty (30) calendar days of the start of the Implementation Phase.

6.2.2.2.8 Install the contractor's LAN and establish the link to the Department as described in Section 7.5 within sixty (60) calendar days of the start of the Implementation Phase.

6.2.2.2.9 Establish and maintain a correspondence control system, an issue resolution tracking system, and a change control tracking system using PC-based database software. Update the databases by recording and tracking all correspondence initiated by either the Department or the contractor. The

system shall be accessible for joint use by both authorized Department and contractor staff.

6.2.2.3 Milestones

Completion of the Project Planning Task will be based upon Department approval of the following milestones:

6.2.2.3.1 Completion of all task deliverables, including Final Work Plan and Schedule, Detailed Implementation Schedule, and connectivity Implementation Plan

6.2.2.3.2 Installation of, and completion of Department training on, all project management and control software

6.2.2.3.3 Installation of, and completion of Department training on, any proposed CASE tools or other planning, design, and development software

6.2.2.3.4 Establishment of the contractor facility and completion of Department work space at that facility

6.2.2.3.5 Installation of all LAN hardware and software, and required linkage to the State mainframe and existing LAN

6.2.3 Joint Application Design Task

The objectives of the Joint Application Design (JAD) Task are to:

- Establish a development environment for use in the JAD Task. Install hardware and software, and establish telecommunications and connectivity to the proposed development host.

- Become familiar with New York State Medicaid and other special program policies, services, and administration, as well as user Replacement Medicaid System requirements, through JAD sessions with Department and State staff.

- Document, validate, and refine the requirements for the Replacement Medicaid System to ensure clear definition of all requirements from JAD sessions with State staff.

- Translate New York State program user needs into the most appropriate technical solutions through JAD sessions with State staff.

- Design a fully functional Replacement Medicaid System.

- Fully research and review current New York State Medicaid operational responsibilities, and identify areas and recommendations for improvement in those activities.

During this task, the contractor will perform requirements analysis activities to gain a detailed understanding of the New York State Medicaid program and system requirements and to validate and refine the Department's system requirements described in Section 7 of this RFP.

The Department requires a JAD approach that uses an independent, experienced facilitator knowledgeable in systems analysis, together with contractor business analysts and development staff. JAD sessions shall be focused in scope, be short in duration, and follow a sequential path. The system design documents resulting from the JAD will refine and provide the design solution for the system requirements presented in Section 7 and refined during the JAD sessions. Use of prototypes to demonstrate functionality is desired.

The Department will select and provide the JAD facilitator.

6.2.3.1 State Responsibilities

State responsibilities for the JAD Task are:

6.2.3.1.1 Interview and select the JAD facilitator.

6.2.3.1.2 Clarify, at the contractor's request, Medicaid program policy, regulations, and procedures.

6.2.3.1.3 Provide staff to participate in JAD or similar requirements sessions to define system and operational requirements.

6.2.3.1.4 Attend deliverable walk-throughs to enhance understanding and facilitate the approval process.

6.2.3.1.5 Review and approve (or request modification of) task deliverables.

6.2.3.2 Contractor Responsibilities

Contractor responsibilities for the JAD Task are:

6.2.3.2.1 Occupy and equip the contractor's New York State facility to support JAD sessions to validate and refine requirements.

6.2.3.2.2 Provide contractor support staff to document the proceedings of the JAD sessions and to assist the JAD facilitator.

6.2.3.2.3 Prepare a comprehensive and detailed statement of requirements for the Replacement Medicaid System for tracking those requirements throughout the development effort.

6.2.3.2.4 Design the Replacement Medicaid System by identifying functions, data, internal and external interfaces, system tables, and the processing architecture through the JAD sessions.

6.2.3.2.5 Produce the Business Design Deliverable in a format approved by the Department. The contractor will define the content of design deliverables in the Final Work Plan and Schedule. Specifically, the Business Design Deliverable shall include:

- A cross-walk or map of each functional requirement to a system component and process
- An overview of the system architecture and how the components are interfaced to meet RFP requirements
- An identification of all internal and external interfaces
- An identification and description of linkages across functions
- A description of system files and databases and processing architecture
- A general narrative of the entire Replacement Medicaid System and the flow of data through the system (including functions, features, and

processes) and a functionally based graphic representation of the entire system

- A detailed narrative of each component of the Replacement Medicaid System, describing functions, features, and processes, and a data flow diagram identifying all major inputs, processes, and outputs; narrative descriptions of processes shall be clear, concise, logical, and easily understood by nontechnical users

- Draft layouts for all inputs; a description of the process for conversion of non-electronic inputs to electronic format; a description of the editing for data integrity for each input

- Draft layouts for all outputs, including full mock-ups of all screens and windows and provide narrative descriptions of the navigation and drop-down features for each screen/window; full layouts shall be provided for each report; each report item/data element shall be defined; all field calculations shall be defined in detail

6.2.3.2.6 Conduct a thorough and comprehensive inventory and assessment of existing business processes of New York State Medicaid and current operations, including work flow, administrative processes, automation, and quality control. Include the results of the assessment and analysis in the Business Design Deliverable.

6.2.3.2.7 Conduct walk-throughs of all task deliverables to enhance Department understanding and facilitate the approval process.

6.2.3.2.8 Conduct overviews of selected deliverables when requested. These overviews will be conducted for Department executive management staff and for oversight agencies.

6.2.3.2.9 Revise task deliverables to reflect Department comments.

6.2.3.2.10 Establish a full development environment, with Department access, in preparation for the remaining tasks.

6.2.3.2.11 Install the base system, if the contractor proposes transfer of a system or components of multiple systems.

6.2.3.2.12 Provide Department access to the base system to facilitate user understanding of the system during the JAD Task.

6.2.3.3 Milestones

Completion of the Joint Application Design Task will be based upon Department approval of the following milestones:

6.2.3.3.1 Completion of all task deliverables, including the Replacement Medicaid System Business Design Deliverable

6.2.3.3.2 Establishment of a Department-accessible full development environment, including installation of the transfer base system(s) if the contractor proposes transfer of a system, or components of multiple systems

6.2.4 Technical Design Task

While the Planning Task and the JAD Task serve the design of the Replacement Medicaid System as a whole, the Department requires the contractor to implement the components of the system separately and as standalone functions to the extent possible. These components must serve the specific business processes for which they are designed. However, they are also intended to work together to provide a complete certifiable MMIS.

The Technical Design Task, and all subsequent tasks shall become part of the work plan and schedule for each of the Replacement Medicaid System components.

The objectives of the Technical Design Task are:

- Provide a detailed definition of each component of the New York State Replacement Medicaid System for Department approval.
- Provide specifications for contractor staff to make modifications of the transfer base or components of multiple systems (or to develop new functionality) to meet the needs of the New York State Medicaid program.
- Provide the earliest draft of the Replacement Medicaid System documentation.

In addition to the technical design of the Replacement Medicaid System components, the Technical Design Document will contain the redesign of business processes associated with the component.

6.2.4.1 State Responsibilities

The State responsibilities for the Technical Design Task are:

6.2.4.1.1 Provide technical assistance in designing external interfaces, such as those with the WMS.

6.2.4.1.2 Attend walk-throughs of the Technical Design to enhance understanding of the Replacement Medicaid System component and to facilitate the approval process.

6.2.4.1.3 Review and approve (or request modification of) the Technical Design Documents.

6.2.4.2 Contractor Responsibilities

6.2.4.2.1 Develop (and revise, as necessary) screen and window layouts, report and output layouts, file and record contents, processing logic, and interface specifications to meet the requirements of each component of the Replacement Medicaid System.

6.2.4.2.2 Prepare the draft Technical Design Document for each component of the Replacement Medicaid System.

6.2.4.2.3 Conduct walk-through sessions of the Technical Design Document for each component of the Replacement Medicaid System to enhance Department understanding and to facilitate the approval process. Ongoing presentation of the Technical Design Document elements and obtaining Department approval throughout the Technical Design Task will facilitate Department approval.

6.2.4.2.4 Prepare the final Technical Design Document for each component of the Replacement Medicaid System. The contractor will define the content of the design deliverables in the Final Work Plan and Schedule. Specifically, the Technical Design Document shall include:

- Data flow diagrams of the entire component showing all modules and functions and including all inputs, processes, interfaces, module interrelationships, and outputs. Graphical depiction of module relationships and logic pathways, such as in Jackson diagrams, are desirable.

- Narratives for all computer programs and modules that clearly identify the processes associated with each and the purpose of the program or module

- Detailed program logic descriptions and edit logic, including the sources of all input data, logic of each process, all editing criteria, all decision points and associated criteria, interactions with other modules, and all outputs

- Final layouts for all inputs to include input names and numbers; data element names, numbers, and sources for each input field; and examples of each input

- Final layouts for all outputs to include output names and numbers; data element names, numbers, and sources for each output field; and examples of each output

- Final layouts for all files (tables) to include file/table names and numbers; data element names, numbers, number of occurrences, length, and type; record names, numbers and length; and file/table keys and foreign keys to the file/table

- Detailed comprehensive data element dictionary; which must include data element names, numbers, descriptions and definitions; valid values with definitions; and sources for all identified data elements; development and maintenance of the data element dictionary with a CASE tool is desirable

6.2.4.3 Milestones

Completion of the Technical Design Task for each component of the Replacement Medicaid System will be based on the Department approval of the final Technical Design Document for that component.

6.2.5 Conversion and Interface Design Task

The Conversion and Interface Design Task will consist of the planning, development, testing, and coordination of all data and file conversions required to support the operation of the Replacement Medicaid System and each of its components. It will include the identification of all data elements that need to be converted, identification of the source of the data (manual file, automated file, or primary data collection), securing the data, development of data conversion requirements and exception processing procedures, development of conversion software and manual procedures, testing of conversion programs and procedures, and initial full file conversion processing.

As part of conversion activities, the contractor will be responsible for designing all system interfaces required in Section 7. Critical system interfaces include, but are not limited to, the interface with New York State's eligibility system (WMS); the provider licensing functions of the State Education Department; and the rates for rate-based providers from the Department and other rate-setting systems.

In this task, the contractor will demonstrate, through comprehensive testing of conversion processes, that data required to support processing will be available and accurate and that all system interfaces are operational. The Conversion and Interface Design Task may be performed concurrently with the JAD Task, with the System Construction Task, or overlapping both. The System and Acceptance Testing Task for a component will not be initiated until the System Conversion and Interface Design Task and the System Construction Task are complete for that component of the Replacement Medicaid System.

A minimum of one hundred eight (108) months of inpatient/nursing home claims history and seventy-two (72) months of all other claims history shall be converted. Twenty-four (24) months of that claims history shall be available on-line and used during claims processing. The entire claims history shall be available for reporting and processing claims over two years old. All claims needed to establish use of once-in-a-lifetime procedures and other benefit limitations shall also be converted and be available on-line.

The contractor will be required to convert ninety-six (96) months of client eligibility history from the existing EMEVS client file, from the WMS eligibility files, or both. The reference data may be built through a combination of conversion processes, file builds from commercial information (e.g., HCPCS, pharmacy pricing files, etc.), State or Federal databases (e.g., Medicare Fee Schedule), existing pricing files, or newly created pricing data. Provider files will be converted from the current provider file.

All additional support files, including third-party resource and prior authorization records, exception control files, and text files, as necessary for continuity of data and accuracy of processing, shall also be converted or initially loaded.

The contractor will be required to perform all manual, as well as automated, conversion tasks.

6.2.5.1 State Responsibilities

State responsibilities for the Conversion and Interface Design Task are to:

6.2.5.1.1 Assist in identifying sources of data.

6.2.5.1.2 Provide copies of all current files/tables, as requested, to support task activities.

6.2.5.1.3 Assist in clarifying, at the contractor's request, current data element definitions, record layouts, and file/table descriptions.

6.2.5.1.4 Provide information on other State and local systems with which the Replacement Medicaid System will interface.

6.2.5.1.5 Define system interfaces with other State systems and use of the State-owned networks.

6.2.5.1.6 Attend deliverable walk-throughs to enhance understanding and facilitate the approval process.

6.2.5.1.7 Monitor and validate conversion testing and exception processing actions.

6.2.5.1.8 Review and approve (or request modification of) task deliverables.

6.2.5.2 Contractor Responsibilities

Contractor responsibilities for the Conversion and Interface Design Task are to:

6.2.5.2.1 Identify data requirements and source(s) of data for all files/tables necessary to meet all functional specifications of the Replacement Medicaid System.

6.2.5.2.2 Receive existing files/data from the Department.

6.2.5.2.3 Obtain data from other sources when approved by the Department.

6.2.5.2.4 Prepare Conversion and Interface Design Task deliverables as defined in the approved Implementation Phase work plan. At a minimum, deliverables shall include a Conversion Plan, Conversion Test Results, preliminary converted files/data/tables, System Interface Plan, and System Interface Test Results.

6.2.5.2.5 Successfully conduct initial conversion of all data requiring conversion.

6.2.5.2.6 Design, develop, and test all system interfaces required for operations of Replacement Medicaid System components.

6.2.5.2.7 Review conversion results, and modify conversion programs as necessary.

6.2.5.2.8 Reconvert files/data to obtain successful initial conversion of all data for each Replacement Medicaid System component.

6.2.5.2.9 Conduct walk-throughs of all task deliverables to enhance Department understanding and facilitate the approval process.

6.2.5.2.10 Revise task deliverables to reflect Department comments and requirements.

6.2.5.3 Milestones

Completion of the Conversion and Interface Design Task for each component of the Replacement Medicaid System will be based on Department approval of the following milestones:

6.2.5.3.1 Completion of all task deliverables, including Conversion Plan, Conversion Test Results, System Interface Plan, and System Interface Test Results

6.2.5.3.2 Successful completion of all initial file/data conversions

6.2.5.3.3 Demonstrations, with production-quality data, that all system interfaces are operational

6.2.6 System Construction Task

The objectives of the System Construction Task are to:

- Develop, on the contractor's hardware, each component of the Replacement Medicaid System.

- Demonstrate, through structured walk-throughs, that completed application programs are ready for testing.

The Department plans to closely monitor contractor activity during the System Construction Task through the use of structured walk-throughs and progress metrics. The purpose of the walk-throughs will be to demonstrate

that completed application programs are likely to perform as desired by the Department. Walk-throughs will be scheduled weekly throughout the System Construction Task and will be attended by Department project personnel, appropriate user staff, the contractor's Implementation Manager, and the lead technical person responsible for the application development.

The Department will select the application programs to be presented in each walk-through based on a list of completed programs provided by the contractor. As part of the walk-throughs, the Department may request to see compiler listings or similar diagnostic output of compiled or translated source code.

Section 6.2.1.5 requires the contractor to submit a work plan that provides an estimate of the programmer/analyst hours by program/module and the anticipated completion date of each program/module. The Department will monitor progress during the System Construction Task through metrics based on the work plan. The Department will expect the contractor to report hours used and programs/modules completed during each biweekly reporting period.

6.2.6.1 State Responsibilities

State responsibilities for the System Construction Task are to:

6.2.6.1.1 Select completed programs to be presented during the structured walk-throughs.

6.2.6.1.2 Request compiler listings or similar diagnostic output to support walk-through presentations.

6.2.6.1.3 Attend deliverable walk-throughs to enhance understanding and facilitate the approval process.

6.2.6.1.4 Review and approve (or request modification of) task deliverables.

6.2.6.2 Contractor Responsibilities

Contractor responsibilities for the System Construction Task are to:

6.2.6.2.1 Update the Implementation Phase Work Plan and Schedule to provide detailed subtask-level listings to confirm the schedule and to document finalized staff loading at the major subtask level.

6.2.6.2.2 Maintain a software change control process to document discrepancies and their resolution and to manage changes to programs and libraries. This change control process should have been established in the JAD Task.

6.2.6.2.3 Coordinate with the Department on questions and problems relating to development and testing of the Replacement Medicaid System.

6.2.6.2.4 Prepare all task deliverables as established in the contractor's work plan. At a minimum, deliverables shall include updated systems design deliverables and Data Dictionary.

6.2.6.2.5 Provide compiler listings or similar diagnostic output of completed application programs as requested by the Department.

6.2.6.2.6 Conduct structured walk-throughs of completed application programs on a weekly basis throughout the System Construction Task.

6.2.6.2.7 Conduct walk-throughs of all task deliverables to enhance Department understanding and facilitate the approval process.

6.2.6.2.8 Revise task deliverables as necessary to obtain Department approval.

6.2.6.2.9 Develop, and submit to the Department, the spending plan for the System Construction Task. Provide weekly updates of actual hours and module completion.

6.2.6.3 Milestones

Completion of the System Construction Task for each component of the Replacement Medicaid System will be based upon Department approval of the following milestones:

6.2.6.3.1 Completion of all task deliverables, including updated systems design deliverables and a Data Dictionary

6.2.6.3.2 Approval of contractor certification of the Replacement Medicaid System component readiness for system testing

6.2.6.3.3 Establishment of a Department-accessible source code library that includes complete systems documentation, object repositories and current source code listings, and updated systems design documentation

6.2.6.3.4 Creation and update of the System Construction Task spending plan

6.2.7 System and Acceptance Testing Task

The objectives of the System and Acceptance Testing Task are to:

- Test all system changes and new features to ensure the Replacement Medicaid System components will appropriately process all transactions (and, in the case of the Claims and Encounter Processing component, pay all Medicaid and other medical program claims), make all types of updates, and produce required reports and other outputs.

- Demonstrate, through detailed system testing, that the contractor is ready to begin acceptance testing of the Replacement Medicaid System component.

- Demonstrate, through system and acceptance testing, that the component is ready for implementation.

The System and Acceptance Testing Task consists of two (2) distinct testing efforts: the integrated system testing and user acceptance testing. These testing efforts are designed to confirm that the Replacement Medicaid System, as installed by the contractor, meets Federal and Department specifications and performs all processes accurately and in a highly automated manner.

All Replacement Medicaid System components and modules shall be tested through integrated system testing. The contractor will be required to demonstrate test results for all components to the Department in walk-throughs. During the walk-throughs, the Department may identify further test cases or situations to be demonstrated by the contractor in order to ensure that each functional area is adequately tested.

User acceptance testing will be conducted only on a fully tested and operations-ready Replacement Medicaid System component, meaning acceptance of the System Test Results deliverable for that component. Acceptance testing will include individual tests of selected software features, such as on-line systems, SURS capabilities, third-party recovery capabilities, financial processes, and other areas to be determined by the Department. The Department and contractor will be jointly responsible for developing the acceptance test plan and test scenarios.

The Department will monitor system testing activities to confirm full operational readiness and perform additional validation testing. The contractor shall be prepared to make minor modifications to screens, reports, and processes throughout the system testing period, in order to ensure that the component is fully responsive to State users. Automated screen and report development tools and an automated data dictionary shall be utilized by the contractor in order to support refinements requested by the Department throughout the Implementation Phase.

6.2.7.1 State Responsibilities

State responsibilities during the System and Acceptance Testing Task are to:

6.2.7.1.1 Attend test result walk-throughs to assess the completeness and accuracy of the contractor's integrated system testing.

6.2.7.1.2 Work with the contractor to develop the User Acceptance Test Plan and test scenarios.

6.2.7.1.3 Perform acceptance tests and validate test results.

6.2.7.1.4 Inform the contractor of any problems/discrepancies.

6.2.7.1.5 Monitor contractor compliance with the User Acceptance Test Plan and schedule.

6.2.7.1.6 Use the contractor's change control process to document software discrepancies or performance problems.

6.2.7.1.7 Monitor contractor response and resolution of discrepancies or problems.

6.2.7.1.8 Direct the retesting activities after correction of any problems.

6.2.7.1.9 Document acceptance test results.

6.2.7.1.10 Attend deliverable walk-throughs to enhance understanding and facilitate the approval process.

6.2.7.1.11 Review and approve (or request modification of) task deliverables.

6.2.7.2 Contractor Responsibilities

Contractor responsibilities during the System and Acceptance Testing Task are to:

6.2.7.2.1 Thoroughly test the operational system component through unit testing, integrated system testing, and user acceptance testing activities.

6.2.7.2.2 Retest system components as necessary, or as directed by the Department.

6.2.7.2.3 Establish and maintain a region for acceptance testing distinct and separate from training, development, system testing, or production regions.

6.2.7.2.4 Prepare all task deliverables as established in the contractor's work plan. At a minimum, deliverables shall include a Detailed System Test Plan, Systems Test Results, User Acceptance Test Plan, and User Acceptance Test Resolutions.

6.2.7.2.5 Provide training to the acceptance testing team on preparing input data, using system component screens, understanding system component processes, and reviewing system component outputs.

6.2.7.2.6 Assist the Department in implementing the user acceptance test with respect to generation of test transactions, data, and files, as well as analysis of reasons for unanticipated processing results.

6.2.7.2.7 Provide operations staff to support acceptance test activities.

6.2.7.2.8 Initiate any batch job streams requested by the Department to support acceptance testing.

6.2.7.2.9 Provide senior systems analysts and other technical staff necessary to coordinate user acceptance test activities and assist the Department in the analysis of test results.

6.2.7.2.10 Provide timely responses to discrepancy notices.

6.2.7.2.11 Make minor modifications to screens, reports, and processes, as directed by the Department, during the Acceptance Testing Task.

6.2.7.2.12 Correct any problems resulting from incorrect computer program code, incorrect file/data conversion, incorrect or inadequate documentation, or any other failure to meet specifications or performance standards.

6.2.7.2.13 Conduct walk-throughs of test results from integrated system testing to demonstrate to Department personnel that all system functions have been completely and accurately tested.

6.2.7.2.14 Conduct walk-throughs of all task deliverables to enhance Department understanding and facilitate the approval process.

6.2.7.2.15 Revise task deliverables to reflect Department comments.

6.2.7.3 Milestones

Completion of the System and Acceptance Testing Task for each Replacement Medicaid System component will be based upon Department approval of the following milestones:

6.2.7.3.1 Completion of all task deliverables, including a Detailed System Test Plan, User Acceptance Test Plan, and User Acceptance Test Resolutions

6.2.7.3.2 Completion of the System Test Results, organized by functional area, special program area, or system interface, that demonstrate that the Replacement Medicaid System component has been fully tested by the contractor

6.2.7.3.3 Department approval of contractor's readiness to begin operations of the component

6.2.8 Implementation Task

During the Implementation Task, the contractor shall perform final file/data conversions, recruit and train operations staff, conduct provider and State staff training, and prepare for start of operations of the Replacement Medicaid System component.

The contractor will be responsible for final conversions. These include transaction history and in-process transactions for the cycles processed by the current MMIS or EMEVS systems, after the initial history conversion. The contractor will also be responsible for converting any files/data necessary to produce system reports, such as management and utilization reports, that incorporate data from MMIS/EMEVS operations prior to the operational date.

Once files/data (such as client, provider, and reference) are converted, the contractor will maintain those production files/data concurrently with the scheduled maintenance of files/data in the existing systems. The contractor will receive, and be responsible for processing, transactions received after a cutoff date to be approved by the Department.

The contractor shall provide continuity in staffing from the Implementation Task through the completion of the Certification Phase. The contractor will be required to retain key Implementation Phase staff on-site through the completion of the Certification Phase to assist with resolving any problems or issues encountered during the initial months of operations. The contractor will meet with the Department on a regular basis to discuss system performance and operational issues. The contractor's Implementation Phase staff will monitor the performance of the Replacement Medicaid System components and modify the components as needed, to resolve problems identified during the initial months of operations.

While the contractor will be expected to work with the incumbent contractor, the State will coordinate transfer of files and other materials.

6.2.8.1 State Responsibilities

State responsibilities during the Implementation Task include:

6.2.8.1.1 Coordinate and monitor final conversion activities.

6.2.8.1.2 Facilitate transfer of all required files/data to the contractor.

6.2.8.1.3 Facilitate transfer of archive files and records.

6.2.8.1.4 Approve contractor-prepared transition notices.

6.2.8.1.5 Provide staff time to attend training sessions conducted by the contractor for Department management, technical, administrative, and clerical personnel.

6.2.8.1.6 Provide policy specialists for initial fiscal agent provider training sessions to address policy-related questions.

6.2.8.1.7 Attend deliverable walk-throughs to enhance understanding and facilitate the approval process.

6.2.8.1.8 Review and approve (or request modification of) task deliverables.

6.2.8.1.9 Meet with the contractor on a regular, frequent basis to discuss post-implementation issues through certification.

6.2.8.2 Contractor Responsibilities

Contractor responsibilities for the Implementation Task for each component of the Replacement Medicaid System are:

6.2.8.2.1 Prepare all task deliverables as established in the contractor's work plan. At a minimum, deliverables shall include an updated Implementation Phase Work Plan, a Detailed Implementation Schedule (DIS), a plan for training State personnel, a Provider Training Plan, User Documentation, Provider Manuals, and Systems Operation Documentation.

6.2.8.2.2 Define contents of the User Documentation and provider handbooks. Where appropriate, develop quick reference guides for desktop use by providers and Replacement Medicaid System users.

6.2.8.2.3 Develop format and media for provider bulletins to announce upcoming changes in the Replacement Medicaid System.

6.2.8.2.4 Provide orientation for Department personnel and OSC staff on contractor organization, contractor functional responsibilities, and Replacement Medicaid System operations.

6.2.8.2.5 Conduct walk-throughs of all task deliverables to enhance Department and OSC understanding and facilitate the approval process.

6.2.8.2.6 Revise task deliverables to reflect resolution of issues found during testing and file/data conversions.

6.2.8.2.7 Set up a facility for fiscal agent operations, and recruit and train staff.

6.2.8.2.8 Define operational procedures for all fiscal agent functions.

6.2.8.2.9 Accept all current files/data from the Department or other appropriate source. Files/data may be magnetic tape, disk, diskette, or paper.

6.2.8.2.10 Conduct final file/data conversion, review results, and submit results to the Department.

6.2.8.2.11 Balance files/data to the control totals of systems being replaced.

6.2.8.2.12 Correct any problems identified during final file/data conversion, and reconvert files as necessary.

6.2.8.2.13 Conduct training of Department and OSC management and administrative, technical, and clerical personnel. Training shall include Replacement Medicaid System, LAN, and workstation training as requested by the Department.

6.2.8.2.14 Prepare a notice to providers, with Department approval, in which transition activities are identified, including pertinent information regarding the new contract, addresses, telephone numbers, training schedules, cutoff dates for claim submissions and enrollment changes, and all other transition activities, as necessary.

6.2.8.2.15 Conduct provider training sessions across the State on new billing procedures, forms, policies, and claims/encounter processing, with assistance from Department policy specialists.

6.2.8.2.16 Prepare, print, and distribute User Documentation and Provider Manuals.

6.2.8.2.17 Control and store all transition-period transactions until Department approval of the contractor's notice that the Replacement Medicaid System component is fully operational.

6.2.8.2.19 Retain Implementation Phase staff to provide post-implementation support during the initial months of operations through certification.

6.2.8.2.20 Monitor the performance of the Replacement Medicaid System component during the initial months of operations.

6.2.8.2.21 Modify the Replacement Medicaid System component, as needed, to resolve problems identified during the initial months of operations.

6.2.8.2.22 Meet with the Department on a frequent, regular basis to discuss post-implementation issues.

6.2.8.3 Milestones

Completion of the Implementation Task for each Replacement Medicaid System component will be based upon Department approval of the following milestones:

6.2.8.3.1 Completion of all task deliverables, including an updated Implementation Phase Work Plan, a Detailed Implementation Plan, a plan for training State personnel, a Provider Training Plan, User Documentation, Provider Manuals, and Systems Operation Documentation.

6.2.8.3.2 Completion of final file conversions.

6.2.8.3.3 Contractor demonstration that financial data and transaction inventory counts are being verified through routine balancing procedures.

6.2.8.3.4 Contractor demonstration that all transactions are being processed at production volumes and within timeliness requirements.

6.2.8.3.5 Contractor demonstration that system reports are being delivered to State users according to the performance requirements.

6.2.8.3.6 Completion and Department approval of all other Implementation Phase tasks.

6.2.9 Certification Task

The Certification Task encompasses the production and delivery of final systems documentation and preparation for, and obtaining of, Federal certification of the New York State Replacement Medicaid System. Certification is a joint responsibility of the contractor and the Department. The contractor shall ensure the Replacement Medicaid System meets all Federal requirements for certification and meets the performance requirements of the most recent System Performance Review standards. The Department is responsible for demonstrating to the Federal review team how certification criteria are met and State staff capability to effectively utilize the Replacement Medicaid System. The system documentation finalized during this phase will be used to support the certification process.

Like the Project Planning Task and the JAD Task, the Certification Task will be performed once for all Replacement Medicaid System components.

6.2.9.1 State Responsibilities

State responsibilities for the Certification Task are to:

6.2.9.1.1 Review and approve, or require correction of, the final Replacement Medicaid System documentation.

6.2.9.1.2 Assist in certification planning and review of contractor materials prepared for the certification review.

6.2.9.1.3 Meet with the Federal review team in a pre-visit briefing prior to the on-site review.

6.2.9.1.4 Prepare for presentations on system features and capabilities for the on-site review.

6.2.9.1.5 Participate in the Federal certification review, answering questions from the review team and following up on any missing items.

6.2.9.1.6 Meet with the Federal review team to discuss its findings.

6.2.9.1.7 Coordinate submission of any corrective action materials needed to finalize Federal approval.

6.2.9.2 Contractor Responsibilities

Contractor responsibilities during the Certification Task include:

6.2.9.2.1 Submit and obtain approval of the final Replacement Medicaid System documentation.

6.2.9.2.2 Participate in certification planning, and prepare and assemble review materials to demonstrate system compliance with certification and SPR criteria.

6.2.9.2.3 Assist the Department in developing certification presentation materials.

6.2.9.2.4 Provide copies of all system outputs needed to demonstrate full functionality back to the start of operations.

6.2.9.2.5 Participate, as necessary, during the Federal on-site certification review.

6.2.9.2.6 Assist the Department in locating material needed to answer review team questions.

6.2.9.2.7 Provide the additional materials needed to resolve any post-review corrective actions.

6.2.9.3 Milestones

Completion of the Certification Task will be based upon Department approval of the following milestones:

6.2.9.3.1 Department approval of Replacement Medicaid System documentation

6.2.9.3.2 Federal certification of the New York State Replacement Medicaid System.

6.2.10 Scope of Work for the Medicaid Data Warehouse

The scope of work for the Medicaid data warehouse defines the implementation and operational responsibilities for the Medicaid data warehouse. The contractor is fully and solely responsible for the design, development, programming, testing, implementation, installation, documentation, operation, and daily administration and maintenance of the data warehouse. The Department shall take responsibility for providing policy direction and guidance to the contractor in delivering the data warehouse, shall conduct the user acceptance test, and shall approve start of operations.

The development of the Medicaid data warehouse shall be subject to the Implementation Phase standards and requirements as outlined in Section 6.2.1. Any deviation from these standards must be approved in writing by the Department.

The Medicaid data warehouse will be developed concurrently with the EMEVS redesign portion of the Replacement Medicaid System implementation and before implementation of the remainder of the Replacement Medicaid System components. The data warehouse shall capture all of the data elements in the current Medicaid systems (see Section 7.1 for a description of all current systems). As new data elements are defined during the design, development, and implementation of the Replacement Medicaid System, such data elements shall be added to the Medicaid data warehouse.

The implementation of the Medicaid data warehouse shall be accomplished in five (5) stages, as defined in Sections 6.2.10.1 through 6.2.10.5. The development and implementation of the Medicaid data warehouse shall be accomplished concurrently with the implementation of the components of the Replacement Medicaid System that constitute the EMEVS redesign. The Medicaid data warehouse development must begin no later than November 1, 1998 and must be completed no later than February 28, 2000, including all five (5) stages described below.

6.2.10.1 Stage I - Business Assessment and Strategy Documents

The contractor must develop a Business Assessment and Strategy Document, identifying the subject matter information requirements for each user group. In addition to OMM, the OMC data warehouse and the data warehouse under development by the Medicaid Fraud Control Unit are users of the Medicaid data warehouse. These data warehouses will receive data that has been "scrubbed" according to the edit rules established in the Medicaid metadata on a periodic basis.

6.2.10.1.1 Task 1 - Define Business Drivers

In this task, the contractor shall work with the subject-matter experts and the client sponsors to identify and develop decision support strategies for the organization. This includes the information that must be available to them in order to evaluate, monitor, and measure their success in meeting their stated objectives.

This initial task of the Medicaid data warehouse implementation shall be performed as a part of the Joint Application Development (JAD) sessions as described in Section 6.2.3. Through the analysis of decision support strategies, the contractor shall assess the types and level of information required, such as service and budget forecasting, service- or provider-level analysis, program-level analysis, or benefit payments analysis. The understanding of the reporting needs will help to define the nature of the extract and display the needed capabilities. It will also help to define the data requirements.

Because this task will be performed in conjunction with the requirements validation and business design activities for the other components of the Replacement Medicaid System, the contractor will obtain a clear understanding of the business functions of the New York State Medicaid program and the information and analysis needs of those business functions. The information and analytical needs include more than the Department staff involved in the day-to-day program analysis. In addition to Department staff and such users as OMH, OMR/DD, and OASAS, Medicaid data warehouse users will include the Office of the State Comptroller, Division of Budget, Legislative staff, and other agencies such as the Office of Temporary and Disability Assistance.

Through this assessment of the information and analytical needs of all users and potential users of the Medicaid data warehouse, the contractor shall develop an understanding of:

- The information requirements and "drill-down" needs of Department executives and other users, such as Legislative staff (executive information system requirements)

- The program and budget analysis needs of Department and Division of Budget users (decision support requirements)

- The needs of other users of Medicaid data, such as the Medicaid Fraud Control Unit and the Office of Managed Care data warehouses

- The data elements needed and the source of the data elements to be included in the data warehouse

6.2.10.1.2 Task 2 - Define Extract, Transformation, and Population Processes

The purpose of this task is to gain an understanding of the source data for the data warehouse. With this understanding, the contractor will develop the process to populate the data warehouse.

The contractor shall assess the data available in the Replacement Medicaid System, including new data as well as data converted from the current MMIS, EMEVS, and State-operated systems. This assessment, along with the understanding of the business drivers obtained in Task 1, will allow the contractor to define the processes for the Medicaid data warehouse. These processes include:

- The method and frequency of the extract of data from the Replacement Medicaid System and other source systems

- The method for editing, or "scrubbing," the data based on business rules approved by the Department

- The method for transformation of the data to the data warehouse; for example, the transformation may require "tagging" of client, provider, and service data to the claims/encounter record; another area of special attention is the method of handling adjustments and voids, especially if

the claims processing methods were different between the MMIS and the Replacement Medicaid System

- The method and timing of the population of the database and processing of analytical and aggregation tables

While the expectation is that the source for the vast majority of the data elements for the Medicaid data warehouse will be the other components of the Replacement Medicaid System, other sources will likely be required for some of the data. For example, some users have expressed a need to have certain eligibility data, such as family size and income information. While such data is not required for the operational components of the Replacement Medicaid System, it will be required for the Medicaid data warehouse. Thus, as a minimum, WMS will be a source for some data in addition to the Replacement Medicaid System.

As the data elements and their sources are identified in Task 1, the analysis of those sources is performed in Task 2 in terms of:

- The extract of the data from the source systems, including coordination with those source systems for timing, format, and media

- The transformation of the data into the format needed for updating the Medicaid data warehouse database; this requires ensuring that the metadata is up-to-date, that the data is edited in accordance with approved business rules, and that it is in a form to facilitate the updating of the data warehouse

- The population of the Medicaid data warehouse on an approved schedule (monthly) with the data that has been extracted and transformed

6.2.10.1.3 Task 3 - Identify Candidate Technology Components

For this task, the contractor must develop an architecture of the technical components of the warehouse. Using this architecture, the contractor will select, subject to Department approval, the components (hardware, software, etc.) of the Medicaid data warehouse.

In accordance with Section 8.3.2 of this RFP, the Department requires that the hardware, software, and data storage for the Medicaid data warehouse be located at the contractor's New York State facility, regardless of the location

of the data center for operation of the remainder of the Replacement Medicaid System components. This task provides the definition of the Medicaid data warehouse platform.

Based on the results of Tasks 1 and 2, the contractor will determine the sizing for the Medicaid data warehouse platform in terms of computer power, amount of data storage, and the necessary software, both systems software and application software. The product of this task is the architecture schematic. The contractor will submit this schematic to the Department for approval of the platform components.

6.2.10.1.4 Deliverables

The contractor must complete the following deliverables for Stage I:

- Business Assessment and Strategy Report
- Platform Architecture Schematic

The Business Assessment and Strategy Report will be delivered simultaneously with the Replacement Medicaid System Business Design Deliverable. It will discuss the results of the analysis of the business drivers that dictate the nature of the information and the analysis. It will also define the extract, transformation, and population processes. Finally, it will present a work plan for the implementation of the Medicaid data warehouse. This work plan will be integrated with the work plan for the other Replacement Medicaid System components prepared in accordance with Section 6.2.2 (Project Planning Task).

The Platform Architecture Schematic will describe the technology components of the Medicaid data warehouse platform. It will also describe how access to the data warehouse will be accomplished for State and Local District users through NYT.

The Platform Architecture Schematic should provide sufficient detail to justify the selection of:

- The computer hardware
- The data storage hardware to provide sufficient storage space

- The operating systems, the database management system, and other systems software

- The applications software that will be leased/purchased rather than built; this includes the data warehouse (relational database) browsing tools, the data mining tools, the decision support system tools, and the executive information system tools

6.2.10.2 Stage II - Metadata Management Strategy

Metadata provides a road map of all the data in the warehouse and enables effective administration, change control, and distribution of the data supporting the warehouse components. This information can include business rules, data access rights, data sources, summarization and aggregation levels, data aliases, data transformation rules, and technical configurations.

The Department requires a metadata management architecture that will provide enterprise-wide data access and control of the Medicaid program metadata. Through this architecture, the Department will be able to manage the definition, transformation, and integration of data within a complex distributed technical environment. The metadata management architecture will accomplish this by focusing on providing tool integration, change controls, consistency, and a high level of availability of metadata. Each of the Department's logical data repositories would be managed through this metadata architecture.

Development and implementation of this strategy are necessary prerequisites to Stages III and IV of the Medicaid data warehouse implementation. The metadata management strategy must span the development life cycle of the data warehouse. During operations of the Medicaid data warehouse, the metadata will play an active role in the ongoing production processes.

The Department will allow the contractor to propose the tasks for this stage, but requires the following deliverables from Stage II:

- Metadata Requirements Analysis
- Metadata Logical Database Design
- Metadata Repository

6.2.10.3 Stage III - Detailed Medicaid Data Layer Development

The Detailed Medicaid layer is the most elemental unit of data storage in the data warehouse. It is the bottom layer depicted in Exhibit 8.6 and must display the following characteristics:

- Store the most elemental (atomic) level of data for the warehouse.
- Define the unit of analysis for the data warehouse.
- Determine the dimensions of the data warehouse.
- Support all Level I decision support activities.

A detail claim record per member per month is one (1) common unit of analysis used for data warehouses. This unit of analysis assumes a monthly update schedule for the Detailed Medicaid Data layer; members are providers and recipients. As the scheduled updates to the detail data occurs, the size of the Detailed Medicaid Data layer grows; therefore, the lowest level of detail or "grain" of the data warehouse will determine the size of the warehouse database at full load.

During this stage, the contractor shall document all data definitions and prepare data mappings to show how the Replacement Medicaid System data, and other source data, maps to the data warehouse database. The contractor must apply data validation rules and reasonableness checks to the data extracted from the Replacement Medicaid System before loading the data to the data warehouse.

The contractor shall be responsible for conducting design sessions with Department users. The conceptual designs from these design sessions shall be the input to the metadata model, logical data model, and physical database for the data warehouse. The contractor shall use the design sessions to develop:

- Mechanisms for the migration of Replacement Medicaid System data to the data warehouse platform, the mapping of Replacement Medicaid System data to the data warehouse database, and the transformation processes to be applied to Replacement Medicaid System data; data loading and storage processes shall be developed during the design sessions

- Processes for updating the data, data "roll-off" processes, and the refresh schedule

- Design-query functionality to access the data warehouse

Although the Department will allow the contractor to propose specific tasks for this stage, the following deliverables must be approved before this stage is considered complete:

- Detail Design Document of the data warehouse

- Logical database models (both metadata and data warehouse)

- Population of the Detailed Medicaid Data layer

6.2.10.4 Stage IV - Executive and Decision Support Systems

During this stage of the project, the contractor shall provide:

- User interface and decision support tools for Level II and III users

- Access to detail and summary data by Level I, II, and III users

- Population of the data warehouse library with predefined queries and reports

- Training for all users in the EIS and DSS

6.2.10.5 Stage V - Implementation

The Medicaid data warehouse must be thoroughly tested prior to implementation. This testing shall include both system testing by the contractor and user acceptance testing by the Department. In addition, all

users must be provided adequate training in the use of the Medicaid data warehouse.

6.2.10.5.1 System Test

The contractor shall develop a System Test Plan and submit the plan for Department approval. The contractor shall perform an integrated system test of the data warehouse and its decision support capabilities. The results of the integrated system test must be reviewed by the Department before the user acceptance test begins.

6.2.10.5.2 User Acceptance Test

After the Department has approved the results of the system test, the contractor shall support the user acceptance test (UAT) task. The Department will conduct the UAT to ensure that the data warehouse and all functionality meets the RFP requirements.

The Medicaid data warehouse shall have the full data load to support testing of all Level I, II, and III capabilities. As part of the testing process, the data refreshment of the data warehouse shall be in accordance with the update schedule approved by the Department.

6.2.10.5.3 Training

The contractor shall develop a Training Plan with separate training components for users at each level (Levels I, II, and III). The plan shall include training of State staff in the use of the query, analytical, and presentation tools. The plan shall be submitted to the Department for approval. Upon approval, the contractor shall develop materials and shall provide training to all designated user staff.

The materials shall include user guides for each level. It shall also include quick-reference handout materials with examples of queries and reports. Training shall be appropriate to the user's level of expertise and expected use of the data warehouse and its decision support capabilities.

6.3 Operations Phase

The contractor will operate, maintain, and enhance the Replacement Medicaid System for the contract period and perform the associated contractor responsibilities. The contractor will perform all functions necessary to operate a complete and certifiable system, ensure that transactions are processed in a timely manner, and providers are paid in an accurate and timely manner and in accordance with Federal and State policy.

The contractor's scope of work during the Operations Phase has been organized into three (3) tasks:

- Operations Task
- Evolution Task
- Turnover Task

6.3.1 Operations Task

The Operations Task will begin with the implementation and production operation of the first Replacement Medicaid System component. The State Responsibilities, Contractor Responsibilities, and Performance Standards for each component are described in Sections 7 and 8 of this RFP.

The Implementation Phase has been organized to permit the contractor to implement each component of the Replacement Medicaid System separately. Therefore, the operations of each component will be dependent on when it is implemented. This approach is designed to reduce overall risk. It is important to note, however, that it is the Department's intent that the components, while developed separately, will be subject to an overall strategy and architecture. Similarly, the components will be operated in a highly coordinated and seamless manner.

In addition to the operation of the Replacement Medicaid System, the contractor shall provide expert testimony in support of the pursuit of indictments and convictions of providers for Medicaid fraud. State prosecutors frequently require expert testimony about the operation of the Replacement Medicaid System and the validity of the data, including the Medicaid data warehouse.

The staff member(s) assigned to provide such testimony must have a thorough working knowledge of both the technology and the operations (including manual components) of the Replacement Medicaid System. The contractor shall provide sufficient staff to provide assistance to the Special Prosecutor and to testify at up to sixty (60) grand juries or trials per year. The majority of the grand juries or trials at which the contractor's staff will have to provide assistance are in New York City. The Contractor may have to provide assistance at more than one trial or grand jury in a day.

The contractor shall also provide key data entry services to the Department. These services will be in addition to the baseline key data entry services needed by the contractor to ensure that all transactions are entered into the Replacement Medicaid System. Such baseline requirements shall be met through the Annual Administrative Fee.

The Department may require the contractor to provide key data entry services on an ad hoc basis for special projects. During the first eleven (11) months of calendar year 1997, key data entry needs averaged 2.4 million key strokes (which includes 100% verification) and eighteen (18) different forms. The Department requires that such requests be met through the rate established in Pricing Schedule G in this RFP.

6.3.2 Evolution Task

The contractor shall be responsible for maintaining and modifying the Replacement Medicaid System throughout the term of the contract. All changes to the system and its operating environment may be classified as either **system maintenance** or as **system evolution**.

System maintenance will result from one (1) of two (2) conditions: 1) the need to make operational improvements or increase the operational efficiency or 2) the correction of a deficiency in the system, whether identified by the Department or by the contractor. Maintenance of the system is a fundamental contractor responsibility and is expected to be funded from the fixed administrative fee. Examples of maintenance include:

- Activities necessary to correct a deficiency within the operational Replacement Medicaid System, including deficiencies found after implementation of modifications. Correction of deficiencies is a part of the contractor's system warranty requirements and is expected to be performed without the use of Department-funded evolution staff. A

system deficiency may be defined as a condition in which the system is not performing (or not performing correctly) a function which is a part of the system as defined in Section 7 and further defined during JAD sessions.

- Activities necessary to ensure that the system meets HCFA certification requirements which exist at the completion of JAD sessions and re-certification requirements

- Activities necessary to ensure that all data files, programs, and documentation are current and that errors are found and corrected

- File maintenance activities for updates to all files

- Changes to system parameters

- Changes to JCL/scripts

- Changes to edit disposition parameters for established edit criteria

- Addition of new values or changes to existing values found within program tables

- Changes to application software resulting from changes in hardware, system software, or other technology improvements designed to improve efficiency of the system

System evolution (also called system modification) will result when the Department determines (or when the contractor determines with Department approval) that additional functionality is needed or an additional requirement must be met, which results in a change to existing file structures, data sets, or current processing logic. Examples of system modifications include:

- Implementation of system capabilities not specified in the RFP or not agreed to during the JAD sessions.

- Implementation of edits not defined in the operational Replacement Medicaid System accepted by the Department.

- Substantial changes to established reports, screens and windows, or electronic formats; addition of new data elements or report elements

- Introduction of a new input form or electronic input format.

All maintenance activity will be accomplished by the contractor within the accepted annual fixed administrative fee. All evolution activity will be accomplished within the evolution budget defined below.

6.3.2.1 Evolution Staffing Requirements

The following key contractor staff shall be an integral part of the overall evolution process:

- Systems Manager - This individual is responsible for the overall management of the Evolution Task. This individual must be full-time on-site at the Albany facility.

- Systems Administrator - This individual is responsible for the data processing and technical operations of the Replacement Medicaid System and its components. If the contractor's computer facility is located at the Albany facility, this individual must be full-time on-site in that facility. If the computer facility is located out of state, this individual must spend at least forty-percent (40%) of a full-time equivalent at the contractor's facility in Albany.

- Database Administrator - This individual is responsible for the maintenance and integrity of the data processed by and stored by the components of the Replacement Medicaid System. This individual is responsible for ensuring that data elements and their definitions are used consistently throughout the system. If the contractor's computer facility is located in Albany, this individual must be full-time on-site. If the computer facility is located out of state, this individual must spend at least twenty-five percent (25%) of a full-time equivalent at the contractor's facility in Albany.

The key personnel are described in Section 3.3 of this RFP. These personnel are funded by the annual administrative fee.

In addition to the key personnel, the contractor shall employ not less than seventy-five (75) full-time on-site programmer/analyst staff, including four (4) documentation specialists, as defined in the contractor's Pricing Schedules F.1 through F.5, to support system evolution activities.

The contractor shall determine the number of staff to provide for the following Evolution Task positions:

- **Senior System Analyst** - Must have more than ten (10) years of experience in systems development and maintenance. Experience in Medicaid systems and the technologies of the Replacement Medicaid System are required. A high level of analytical ability is also required.

- **Systems Analyst** - Must have at least one (1) year, and as many as nine (9) years, of experience in systems development and maintenance. Experience in either Medicaid or other health care payment systems is required. Must have training in the technologies used in the Replacement Medicaid System and must display analytical ability.

- **Programmer Analyst III** - Must have five (5) or more years of experience in systems development and maintenance along with experience in the technologies used in the Replacement Medicaid System. Training or experience in Medicaid systems is required.

- **Programmer Analyst II** - Must have at least two (2) years of experience in systems development and maintenance. Training in the technologies used in the Replacement Medicaid System is required. Experience in the technologies or in Medicaid systems is desired.

- **Programmer Analyst I** - This entry-level position must have some training in systems development and maintenance. The contractor shall ensure that staff in this position receives training on the Replacement Medicaid System technologies and in Medicaid during the first year of employment.

Staff assigned to the data warehouse must also have appropriate experience in data warehouse design, development and maintenance.

The Department requires that the contractor define the number of staff for each Evolution Task position in their proposal. To ensure adequate distribution of skills at each level, the following rules must be followed in determining the mix of staff:

- At least one (1) Senior System Analyst

- At least five (5) System Analysts

- A ratio of one (1) Programmer Analyst III to every ten (10) staff at the Programmer Analyst I and II levels

- A ratio of seventy percent (70%) Programmer Analyst II to thirty percent (30%) Programmer Analyst I

The Department may elect to purchase additional resources from the contractor during periods of intense evolution activities when all high-priority projects cannot be completed by the existing staff, or where the Department needs to acquire specific expertise. These resources shall be purchased from the contractor at rates specified in the contractor's proposal.

6.3.2.2 Data Warehouse User Support

The contractor shall maintain a high level of user support for the data warehouse. The contractor shall provide health care and system consultants to provide assistance with all user aspects of the data warehouse. User support staff shall be individuals who can provide analytical and technical support to all three (3) defined levels of Department users. It is especially critical that user support staff be capable of providing assistance to Level II and III users in constructing efficient and effective queries. User support staff shall have expertise in health care analysis and use of the data warehouse software tools.

User support staff shall serve as a liaison with the Replacement Medicaid System operations staff on routine data and file transfer issues. The user support staff will also provide ongoing training to data warehouse users.

To provide this level of support, the contractor shall employ:

- Ten (10) full-time, on-site user support staff during the first year of data warehouse operations; this year period shall begin with the implementation of the Medicaid data warehouse as defined in Section 6.2.10.5

- Six (6) full-time, on-site user support staff during the remainder of the contract period

These user support staff shall be in addition to the Evolution staff and shall have at least three (3) years of experience in query languages and analytical

reporting. In addition, these staff shall have experience in health care data analyses (Medicaid experience is desired).

The contractor and Department shall implement a process to initiate, prioritize, track, and document activities of the user support staff.

6.3.2.3 Evolution Activities and Milestones

System modifications to the Replacement Medicaid System, including the Medicaid data warehouse, may be initiated by the Department or by the contractor through the submission of an evolution request form. The contractor shall respond, in writing, to evolution requests submitted by the Department within five (5) business days of receipt. The response shall consist of an acknowledgment of the request and a preliminary assessment of the effort (number of hours) required to complete the change. All evolution requests will be prioritized and approved (or denied or modified) by the Department.

When the Department approves an evolution request, the contractor shall conduct the evolution project in accordance with the following system development life cycle (SDLC):

- Requirements Definition and Business Design - Results in a Business Design Document
- Technical Design - Results in a Technical Design Document
- System Construction - Includes system modification, system testing of modifications, and conversions of data, where necessary
- Verification and Validation - Includes acceptance testing of changes or such other techniques as the Department determines appropriate to accept the system modification for implementation and operation
- Implementation - The implementation of the system modification into the production version of the Replacement Medicaid System; this activity also includes updates to system documentation, operations manuals, user manuals, and provider manuals
- Post-Implementation Assessment - An assessment conducted by the contractor of each system modification approximately thirty (30) calendar

days after implementation to ensure that the modification is functioning properly; the contractor will report the results of this assessment to the Department

The Business Design document will specify the problem to be addressed, propose a design solution, specify the estimated level of effort and specify the schedule required to design , code, test, and implement the change. The Department will approve the request, assign a priority to it, and establish the expected completion date. At the completion of each step of the evolution SDLC, the Department will exercise the option to adjust priority, stop the project, put the project on hold, or authorize the contractor to proceed.

The evolution project shall not be considered complete until all systems and user documentation, including, where appropriate, the metadata, has been updated. Such updates must be completed within ten (10) business days of implementation of the evolution project.

The contractor shall prepare a weekly report that lists each outstanding evolution request; its priority and current status; its expected completion date; progress toward completion, including hours expended during the period; and an update of the estimated staff hours to complete it and specific personnel assigned. The report will be sorted by status and by priority.

The contractor shall also prepare a monthly report on evolution staffing and hours expended by project or administrative category.

6.3.2.4 State Responsibilities

The responsibilities of the Department for the Evolution Task are:

6.3.2.4.1 Prepare and submit to the contractor a written evolution request for State-initiated modifications.

6.3.2.4.2 Receive and review change requests from the contractor.

6.3.2.4.3 Determine priority for contractor completion of evolution requests and return requests with priority assigned.

6.3.2.4.4 Assist the contractor, as needed, in each step of the SDLC, including providing access to user staff for requirements definition.

6.3.2.4.5 Review and approve (or request modification of) each deliverable for each evolution project.

6.3.2.4.6 Monitor system modification activities.

6.3.2.4.7 Request additional resources, where needed.

6.3.2.4.8 Conduct verification and validation of system modifications.

6.3.2.4.9 Accept or reject a system modification for implementation and operation in the production environment.

6.3.2.4.10 Keep the contractor informed regarding proposed, pending, or implemented new policies and programs or modifications thereto.

6.3.2.5 Contractor Responsibilities

6.3.2.5.1 Receive evolution requests from the State.

6.3.2.5.2 Submit an evolution request for contractor-proposed changes.

6.3.2.5.3 Conduct the evolution project in accordance with the evolution SDLC and in accordance with the Department-assigned priority.

6.3.2.5.4 Submit required deliverables to the Department for approval.

6.3.2.5.5 Conduct thorough system testing of all changes before submission to the Department for verification and validation.

6.3.2.5.6 Implement system modifications following Department approval.

6.3.2.5.7 Conduct the post-implementation assessment of each system modification and report the results to the Department.

6.3.2.5.8 Provide a weekly report to the Department on all modification activities, including, for each outstanding evolution request, its expected completion date, progress towards completion (including hours expended to date and hours expended during the reporting period), estimated staff hours to completion, and specific personnel assigned, sorted by status and priority.

6.3.2.5.9 Prepare changes to systems documentation, operations and user manuals, and provider manuals for maintenance and evolution activities within thirty (30)

calendar days of Department approval of a corrective action plan for a deficiency or of implementation of a modification.

6.3.3 Medicaid Data Warehouse Operations

The contractor will be responsible for operating the Medicaid data warehouse in compliance with this RFP and the contract. As with the implementation, operations will occur in stages. Stage III operations will begin upon approval by the Department of all deliverables for Stage II. Stage IV operations will begin upon approval by the Department of all Stage III deliverables.

Throughout the life of the contract, the contractor shall provide periodic reports on system performance and usage.

6.3.3.1 Update and Maintenance of Documentation

All systems and user documentation, including the metadata repository documentation, must be updated and maintained by the contractor throughout the life of the contract. During operations, documentation shall be updated within thirty (30) calendar days of a change to the data warehouse. Evolution activities for the Medicaid data warehouse will be subject to the requirements established in Section 6.3.2 of this RFP.

6.3.3.2 User Support

The contractor shall maintain a high level of user support. The contractor shall provide health care and system consultants to provide assistance with all aspects of the data warehouse use. User support staff shall be individuals who can provide analytical and technical support to all three (3) defined levels of Department users. It is especially critical that user support staff be capable of providing assistance to Level II and III users in constructing efficient and effective queries. User support staff shall have expertise in health care analysis and use of the data warehouse software tools.

User support staff shall also provide liaison services to the Replacement Medicaid System operations staff on routine data and file transfer issues. The user support staff will also provide ongoing training to data warehouse users.

After satisfactory completion of Stage IV, the contractor will be required to maintain a minimum of ten (10) full-time user support staff on-site at sites selected by the Department during the first year of operations. Thereafter, the

contractor will be required to maintain a minimum of six (6) full-time user support staff on-site at sites selected by the Department through the end of the contract period. The staffing requirements are defined in Section 6.3.2.2.

6.3.3.3 Medicaid Data Warehouse Evolution

Evolution of the Medicaid data warehouse shall be governed by the rules stated in Section 6.3.2 of the RFP.

6.3.3.4 Data Warehouse Operations Staffing Requirements

In addition to the key personnel identified in Section 3.3, the Contractor shall have staff to assist end users in accessing the data. The Department requires that the contractor provide:

- Ten (10) full-time on-site user support staff during the first year of data warehouse operations
- Six (6) full-time on-site user support staff during the remainder of the contract period

These user support staff shall have at least three (3) years of experience in query languages and analytical reporting.

6.3.4 Turnover Task

The contractor shall provide full support and assistance in the transition of fiscal agent operations and operations of the Replacement Medicaid System to a successor contractor or to the Department.

6.3.4.1 Turnover Plan

No later than one (1) year from the start of full operations of all components the Replacement Medicaid System, the contractor shall provide a Turnover Plan to the Department. The plan shall include:

- Proposed approach to turnover

- Turnover work plan, including detailed tasks and subtasks
- Schedule for turnover
- Documentation update procedures during turnover

The Turnover Plan shall be updated annually thereafter prior to the start of the next year of operations.

6.3.4.2 Replacement Medicaid System Requirements Statement

Along with the Turnover Plan, the contractor shall submit a statement of the resources that would be required by the Department or a successor contractor to take over operation of the Replacement Medicaid System. The Requirements Statement shall include:

- An inventory of all application software used to perform the functions of all components of the Replacement Medicaid System
- An inventory of all hardware, system software, and other technical environment resources required to operate all components of the Replacement Medicaid System
- The number and type of personnel required to perform the functions under the contract, including both data processing staff and administrative support staff

This statement shall be based on the contractor's experience in the operations of the Replacement Medicaid System and shall include actual contractor resources devoted to the operation of the system and other functions. This Resource Statement shall be updated annually and shall be submitted on the same schedule as the Turnover Plan and updates.

6.3.4.3 State Responsibilities

The responsibilities of the Department for the Turnover Task are:

6.3.4.3.1 Review and approve the Turnover Plan.

6.3.4.3.2 Review and approve the Resource Statement.

6.3.4.3.3 Request turnover services be initiated by the contractor.

6.3.4.3.4 Make Department staff or successor contractor staff available to be trained in the operation of the Replacement Medicaid System.

6.3.4.4 Contractor Responsibilities

6.3.4.4.1 Prepare and submit the Turnover Plan annually in accordance with the schedule specified above.

6.3.4.4.2 Prepare and submit the Resource Statement annually in accordance with the schedule specified above.

6.3.4.4.3 As requested, but no less frequently than annually, the contractor shall transfer to the Department or its agent, a current copy of the operational Replacement Medicaid System, including all documentation, programs, tables, files, software, and procedures required to operate and maintain the system. The material shall be provided on a medium as approved by the Department.

6.3.4.4.4 As requested, begin training staff or designated agents in the operation and support activities of the Replacement Medicaid System. Such training shall be completed at least three (3) months prior to the end of the contract or any extension thereof. Such training shall include computer operations, fiscal agent operations, and other manual functions.

6.3.4.4.5 Beginning with the submission of the initial Turnover Plan and Resource Statement, the contractor shall designate a staff person as Turnover Coordinator. This individual shall have a data processing background and shall serve part-time in this capacity until the Department initiates a request for turnover activity. This individual shall not be included in the Evolution staff count. At the time the Department requests that the contractor initiate turnover activity, this individual shall become a full-time Turnover Coordinator until termination of the contract.

6.3.4.5 Data Warehouse Turnover Task

Upon notice of nonrenewal or termination of the contract, the contractor shall provide support to the Department to complete a low-risk and orderly transition to the Department or its successor contractor according to the turnover provisions described in this RFP.

THIS PAGE INTENTIONALLY LEFT BLANK

Table of Contents
Section 7

Table of Contents
Section 7 (continued)

Table of Contents
Section 7 (continued)

Table of Contents
Section 7 (continued)

Table of Contents
Section 7 (continued)

Table of Contents
Section 7 (continued)

Table of Contents
Section 7 (continued)

Section 7
Replacement Operations Phase Requirements

The New York State Replacement Medicaid System must receive, enter, process, adjudicate to payment or denial, and report fee-for-service claim transactions for eligible clients under the New York State Medicaid program and included New York State Medical Assistance programs. The system must also receive enter, process, and store encounter transactions for the eligible managed care population of New York State, as defined by the Office of Managed Care (OMC). The system must ensure the accuracy, reasonableness, and integrity of the claims/encounter processing function. As a part of these fundamental functions, the Replacement Medicaid System must receive, respond to, and store eligibility verification and related transactions. The resulting system must be certifiable in accordance with the criteria set forth by HCFA to meet the requirements of a certified Medicaid Management Information System (MMIS).

7.1 Overview

This section provides a summary of the current New York State MMIS, the current EMEVS, and other systems comprising the New York State Medicaid systems. This section also provides an introduction to the remainder of Section 7, which provides the requirements for the Replacement Medicaid System.

7.1.1 New York State Medicaid Management Information System (MMIS)

The functions and capabilities of the current New York State MMIS are summarized in the following paragraphs. Each of the current subsystems are briefly described. More detail is available in the MMIS documentation in the Procurement Library. The names of the volumes, as listed in Appendix C, correspond to the names of the subsystems described below.

The New York State MMIS contains highly customized functionality designed to meet New York-specific laws, regulations, and policies. The contractor will be required to meet or exceed all of the functionality of the current systems in addition to the new requirements specified in Sections 7.2 through 7.17.

7.1.1.1 Audit Trace Function

The on-line audit trace function allows the Internal Audit department to accurately and efficiently measure the microfilm image processing and on-line pend error rate. This function will interface with the Kodak IMT-250 Microfilm Retrieval Unit. Through this process, the Internal Audit department can verify the accuracy of the pended claim information and microfilm retrieval. Auditors are able to record corrections and notes on each record, enhancing the accuracy of the audit process.

7.1.1.2 Claims Daily Processing

The Claims Daily Subsystem runs the daily claims processing cycles for the MMIS. Daily cycles are processed twice per week (Wednesday and Friday), but the system has the capability of processing more cycles per week when and if it becomes necessary.

More than 40,000 paper claim forms are received daily from providers and are manually screened for completeness (note: providers receive paper claim forms through the **Automated Forms Reorder Subsystem**). If errors (e.g., missing provider or recipient ID, missing names and addresses, or signatures) are detected, claims are rejected and are returned to the provider with an explanatory letter. Paper claims that are accepted in the prescreening step are batched by form type, microfilmed and stamped with the Claim Reference Number (CRN), and key-entered. In the Non-Electronic Media Front-End System (NON-EMC), the paper claims are reformatted, and the batches are balanced. Out-of-balance batches are returned to Data Entry for correction.

Claims received through various electronic media (tape or diskette) are manually checked by comparing the information on the transmittal form to the information on the magnetic media (dollar amounts, total number of records, and total number of invoices). Magnetic media in error is returned to the provider for correction. Valid magnetic media claims are reformatted and assigned a CRN. (See **Electronic Magnetic Media Subsystem.**) Medicaid Encounter Data (MED) is also accepted from managed care plans through the electronic front-end.

Prior approval forms and tapes are submitted by the State as input to the daily automated cycle. These transactions are processed to update the Prior Approval Master file.
Previously pended claims are released into the daily cycle. These include:

- Global transactions that release a certain range of pends according to selected criteria

- Claim Correction Forms (CCF) transactions where corrections were received on paper from providers

- Transactions/corrections submitted by the fiscal agent or the State through the **On-line Pend Resolution System** or the **Criteria-Based Pend Resolution System**

The pend transactions are processed through the **Pend Processing Subsystem** where the pend resolution transactions are matched to claims, then released to daily processing.

All inputs are processed by the Daily Extract module to extract the information needed to correctly process the claim. Extracts are made from:

- Provider file

- Provider License file

- Rate file

- Recipient file

- Procedure file

- Diagnosis file

- Prior Approval file

- Formulary file

- Patient Participation file

The extract output files are sorted into claim class and CRN sequence, and the CRNs of various extracts are matched and merged and used in the Claims Daily Adjudication Process.

Pre-edits common to most of the claims are performed first. Then a series of logic edit modules are called. These modules apply specific edits to each claim type and price the claim. Error conditions that are detected are assigned

an Edit Result Code, which is processed against the Edit Status Table to assign the final claims daily status of each claim: pay, pend, deny. The output of the daily process is approved, pended, and denied claim files.

The Daily Pend file is processed by an automatic pend router which determines if the claim will be pended internally to the fiscal agent (possible data entry errors), to the State (manual pricing/medical reviews), or to the provider (provider errors).

The Daily Approved Claims file is merged with the Week-to-Date Claims file to serve as input to claims weekly processing.

7.1.1.3 Weekly Claims Processing

The weekly processing cycle begins on Wednesday and ends on Saturday. After the second Claims Daily Cycle is complete, the weekly processing cycle begins with "Weekly Teen" processing which groups claims by history classes (provider types with similar data elements and editing criteria are grouped together) and processed as follows:

- Claims edited for duplication, frequency, combination, and service limitation.
- Adjustments or voids to previously paid claims are made.
- Retroactive adjustments to rate-based claims are performed.
- History files are updated with prior cycle-approved claims. Paid claims are placed on history in the cycle after they are approved.

Claims that receive a pend status in weekly processing are reviewed by the State.

The approved claims payment amounts are totaled by provider for the cycle. The amount paid to the provider is calculated based on the total amount for claims increased or decreased by other financial transactions (e.g., retroactive rate adjustments, recoupments, etc.) When the final payment is calculated, the provider accounting record is updated and a check is printed. The check is collated with the remittance statement and either mailed to the provider or prepared for pickup at one of several Contractor pickup locations around the State.

Files output by the Claims Weekly process are used in monthly processing and other subsystems. These files include:

- Lombardi Bad Debt/Charity Pools
- Malpractice Insurance Pool
- Major Public Hospital Add-on Reporting
- Bank Reconciliation

Files containing approved and denied activity records are created and utilized by **MARS**, **SURS**, and by the State for reporting and analysis. Accounting and Claims Status files are provided to the **On-Line Subsystem**.

7.1.1.4 On-Line MMIS

The On-Line Subsystem was developed for use by the fiscal agent Customer Relations Staff and by State users. The Customer Relations Staff use the information as they respond to provider inquiries.

The On-Line Subsystem is CICS-based and provides access to some twenty-two (22) sets of screens:

- Provider Identification
- Provider Category of Service
- Provider Specialty
- Provider Accounting
- Provider Rate
- Claim Status
- Inpatient/DRG Claim Status
- Diagnosis

- Procedure
- Recipient Verification
- Recipient Information
- Prior Approval
- Formulary
- Prepaid Capitation
- Patient Participation
- Reorder Forms
- Third-Party
- Service Intensity Weight
- Service Authorization
- Restricted Recipient
- Scope of Benefits
- License Verification

Recipient information is subject to both user and terminal-ID security.

7.1.1.5 Master Files Subsystem

The Master Files Subsystem performs two (2) major functions:
1) comprehensive editing of input data from the State and controlled updating of master files to ensure the most current and accurate data and 2) matching of claim data against the various master files for the extracts needed in **Claims Daily Processing**. The fiscal agent maintains the following master files:

- Recipient
- Recipient Restriction/Exception

- Provider Master file
- Provider Rate file
- Lombardi Bad Debt/Charity Pool and Malpractice Pool
- Prepaid Capitation Plan (PCP)
- Third-Party
- Long-Term Care (Patient Participation)
- Procedure
- Diagnosis
- Formulary
- Service Intensity Weight
- Case Payment Group
- Temporary Medicaid Authorization
- Scope of Benefits
- License Verification
- Service Authorization

Each of the files are organized using indexed VSAM format and generally contains both base and date-related segments. The data-related segments contain variable information such as recipient eligibility status or pricing information. The master files support:

- Claims adjudication
- MAR and SUR reporting
- On-line inquiry

7.1.1.6 Management and Administrative Reporting Subsystem (MARS)

The New York State MARS was developed using the guidelines of the MMIS General Systems Design (MMIS-GSD), but was tailored to meet the needs of New York State users.

The primary inputs to MARS are:

- Adjudicated Claims file
- Pend file
- Recipient Master file
- Provider Master file
- Procedure, Diagnosis, and Formulary Master files

The Weekly Adjudicated Claims file is processed to produce extract records which are sorted and merged to a monthly extract file. The monthly extract is processed to summarize the data into report groupings. The summarized files are used to generate or update history files for use in the various reporting modules.

To ensure consistent reporting, the MARS design incorporates a number of key design components that are commonly employed throughout the subsystem:

- **Table-Driven Structure** - MARS uses a table-driven structured COBOL reporting system to ease maintenance and improve comparability among MARS reports
- **Common Matrices** - MARS uses common matrices for all detail and summary reporting, facilitating the comparability of MARS to SURS and to On-Line. These matrices include the MARS Detailed Category of

Service (DETCAT) Matrix, the MARS Shares Funding Matrix, and the MARS Report Crosswalk Matrix.

- **Common Extraction Process** - MARS uses a weekly extraction process called MARS Distribute to create MAR data. Data from each adjudicated claim record is used to assign a MAR Detailed Category of Service and MAR Recipient Aid Category, along with determining other various data element values and derivations pertinent to MARS reporting. The processed records are written to various extract files to meet specific reporting needs. These weekly extract files are merged to monthly extract files for report processing

- **Automated Control Procedures** - MARS uses control procedures throughout processing to ensure system and data integrity. The control files are used for balancing of inputs to outputs.

MARS constructs history files containing data summarized to a level allowing optimum processing efficiency and maximum reporting flexibility for providing historical information. Each history file contains the minimum data necessary to produce predefined reports that reflect historical comparisons of data covering a two-year period.

The MARS reports are listed in Appendix F.

7.1.1.7 Surveillance and Utilization Review Subsystem (SURS)

SURS consists of the SURS Exception Processing, Claim Detail Special Reporting (CDSR), Provider Summary, On-Line SURS Provider, On-Line SURS Rate-Based Provider, and On-Line SURS Recipient modules.

7.1.1.7.1 SURS Exception Processing

Recipient exception processing runs on a monthly schedule. Provider exception processing runs on a monthly schedule from March through November with an annual provider run in December. Providers and recipients are referred to as “participants”; the processing for both are performed through common modules, producing reports and data files based on user-defined parameters. The exception processing modules are:

- Participant Profiling
- Peer Class Grouping
- Management Summary Processing
- Frequency Distribution Processing
- Exception Processing
- Exclusion and Forced Exception Processing
- Summary Profile Reporting
- Recipient Interfiled Reporting

7.1.1.7.2 Claim Detail Special Reporting (CDSR)

CDSR is a highly flexible report generator that is run against either the SUR Claim history file containing twelve (12) months of history or the Special Interest file which is created by selecting specific claims through the Claim Detail Reporting. A maximum of seventy (70) sets of selection criteria, each with a maximum of twenty-five (25) selection records are available to the user.

The user can select special report output or micro data file output. The data file output can be downloaded to a personal computer for further manipulation.

7.1.1.7.3 Provider Summary System

The Provider Summary System provides quarterly reports regarding services provided to recipients of the New York State Medicaid program by the providers enrolled in the program. This system generates a series of eight (8) reports, each with some reporting flexibility:

- Provider Summary Report

- Visits Services Report
- Ping-Pong Intersect Report
- Ordered Services Report
- Service Code Analysis Report
- Service Location Analysis Report
- Unique Transportation Report
- Cross-Reference Reports

7.1.1.7.4 On-Line SURS Provider System

The interactive portion of this system is composed of restricted-access CICS query and selection screens which allow the user to obtain data from the screen or queue up criteria for weekly batch reports. There are three information retrieval functions:

- **Provider Information -** A screen showing provider demographic information is initially displayed with a provider ID input. The user is given the option of branching to one (1) of eight (8) other three- (3-) month summary screens: Rendered Services, Payment Sources, Service Indicators, Inpatient Utilization, Institutional Care, Clinic Specialties, Ordered Services, and Enrollment Status.

- **Batch Request** - The Batch Selection Reports provide a means of analyzing providers as a group instead of on an individual basis. Five (5) entry screens allow user input of the utilization and demographic characteristics to be analyzed concurrently.

- **Claim Detail Request** - Claim detail reports can be generated based on the following criteria: Provider ID, From Date, To Date, Category of Service, Subcategory of Service, and User ID.

7.1.1.7.5 On-Line SURS Rate-Based Provider System

The weekly Adjudicated Claim file is used to maintain a Provider Rate Paid History file and create four (4) inquiry rate paid summary VSAM files. Only rate-based providers are maintained on the history file.

Two (2) reports are generated monthly detailing rate-based Medicaid activity for the most recent twenty-four (24) months: Rate Paid Provider Payments Report and Rate Paid Provider Summary Report.

The on-line portion of this SURS component offers the following query options:

- Rate Paid Provider Category of Service (COS) Payments
- Rate Paid Provider County/COS Summary
- Rate Paid Provider County/Rate Code Summary
- Rate Paid Provider/DRG Rate Code Summary
- Rate Paid Provider Projection Data

7.1.1.8 On-Line Pend Resolution Subsystem

This subsystem supports the resolution of claims that have been placed in a pend status by the claims processing subsystem. The fiscal agent performs pend resolution of data correction or CCF returns from the provider. The State performs pend resolution for manual pricing and medical review.

Pend resolution is performed on an on-line workstation consisting of a 3270 terminal and a Kodak IMT 250/350 Microimage Terminal. This workstation links the on-line pend worksheet to the microfilm image of the paper claim.

7.1.1.9 On-Line MARS/SURS Subsystem

The On-Line MARS/SURS Subsystem (OLMS) is a user-oriented facility designed to provide inquiry and reporting capabilities. There are seven (7) information categories included in OLMS:

- Recipient
- Provider
- Weekly Shares Report
- Request for Weekly Shares Batch Report
- Financial Funding
- Rate Paid Provider Inquiry
- Rate Paid Provider Projection

7.1.1.10 Electronic Media Claims Entry Subsystem

This front end accepts claims on tape, diskette, and dial-up electronic media. Claims are reformatted and balanced and are then entered into the Daily Claims Processing stream.

Electronic claims are submitted by providers either sending information directly via dedicated lines or by dialing into the MMIS Electronic Gateway, a UNIX-based communication server. Submitters can use a menu-driven interface to both send and receive information. Electronic claims are reformatted and processed in the same manner as tape or diskette media claims. Processing results are routed back to the submitter either directly via the dedicated lines or to the UNIX front-end submitter directory where they are downloaded the next time the user dials in.

7.1.1.11 Lombardi/Malpractice File Update Subsystem

This process is used to calculate the Medicaid contribution to pools established to provide funds to inpatient hospitals for financial relief needed because of bad debt expense, cost of charitable services performed by the hospitals, allowance for primary health care services, and the cost of malpractice insurance premiums. The pools are funded by Blue Cross, and other third party payors, as well as Medicaid.

7.1.1.12 Automated Forms Reorder Subsystem

The Automated Forms Reorder Subsystem is a collection of programs and manual processes designed to support the process of providing a supply of paper claim forms to providers. Newly enrolled providers are initially supplied with all necessary manuals and claim forms. The automated portion generates orders based on the rate of claim submission by the provider. There is a manual intervention mechanism which allows Provider Relations staff to generate orders based on provider phone calls.

7.1.1.13 Medicaid Override Application System (MOAS)

The New York State Medicaid program has established upper limits on the amount of certain services that a client can receive in a given time period. By requiring the provider to access the EMEVS for eligibility and the Utilization Threshold status, the EMEVS can capture the provider/recipient/ service encounters as they occur. The EMEVS will check to see if the threshold has been exceeded and, if not, will inform the provider that the service is approved. It then sends a service authorization transaction to the MMIS.

To provide special consideration for a client when it is needed, the Department has established the Medicaid Override Application System. Providers submit the Threshold Override Applications (TOA) to the fiscal agent, which renders clerical and medical decisions based on guidelines established by the Department.

Four on-line functions have been developed to support the processing of TOA forms submitted by providers:

- On-Line Application Entry Function
- On-Line Application Verification Function
- On-Line Application Medical/Professional Review Function
- On-Line MOAS Inquiry Function

In addition, batch processes perform file maintenance, generate letters to providers and recipients, and produce required reports.

7.1.1.14 Provider-Assisted Claim Entry System (PACES)

The New York State Medicaid program mandated electronic submission by providers required to submit the Version 4 claim format (inpatient hospitals, dental clinics, outpatient clinics, and free-standing clinics). PACES was developed to assist providers to create, edit, delete, track, and submit claims electronically. Claims can be submitted via diskette or through the MMIS Electronic Gateway.

7.1.2 Electronic Medicaid Eligibility Verification System (EMEVS)

The functions and capabilities of the current New York State EMEVS are summarized in the following paragraphs. More detail is available in the EMEVS documentation in the Procurement Library. It is important to note that the issuance of recipient identification cards is no longer a responsibility of the EMEVS contractor and will not be a responsibility of the contractor selected under this procurement.

The EMEVS Provider Manual offers a good overview of the system, although from a provider perspective. More technical details of the EMEVS are documented in other manuals in the Procurement Library as listed in Appendix C. Because system components are not documented in separate volumes like the MMIS, in the following sections more specific references have been made to materials in the Procurement Library.

7.1.2.1 Recipient Subsystem

The EMEVS is a client-driven system that was designed as a front-end to the MMIS. The update and maintenance of the Recipient Master file is an important part of the system. The EMEVS Recipient Master is updated daily from the WMS and its subsystems, unlike the MMIS Recipient Master, which is updated weekly.

The EMEVS Recipient Master file contains all the information relevant to an individual recipient, including demographic, Medicaid administrative, Medicare and third party insurance, restrictions, and Medicaid eligibility data. It is organized into variable length records consisting of the following sections:

- Common Data Section
- Medicaid Data Section
- Eligibility Section
- Insurance Section
- Restriction Section
- Medicare Section
- Deleted Recipient Section
- Head-of-Household Plastic Cross-Reference Segment
- Head-of-Household Temporary Cross-Reference Segment
- Head-of-Household Child in Transition Cross-Reference Segment
- Head-of-Household On-Line Cross-Reference Segment

The Head-of-Household segments and the Case update process were used when the issuance of identification cards was a responsibility of the EMEVS contractor. These components are no longer used. The details of the file components are located in Section 1.5 of the EMEVS Subsystems Manual.

7.1.2.2 Case Subsystem

The purpose of the Case Subsystem was to perform a daily update to the Case Master file, which was used to relate all recipients associated with a specific case. This Master file was used in the production of identification cards.

While the production of identification cards is no longer required, the ability to relate individuals to cases is still an important informational component of the Replacement Medicaid System's Client Eligibility Data Repository.

7.1.2.3 Provider Subsystem

The Provider Master file contains the demographic, statistical, and administrative information for providers enrolled in the Medicaid program. This file is updated daily by the Provider file system operated by the State. This source system is the same system that updates the MMIS Provider Master file weekly. The details of provider data elements are identified in Section 3.4 of the EMEVS Subsystems Manual.

7.1.2.4 On-Line System

The functionality of the EMEVS is in the On-Line System. The current system is described in terms of access methods and the functionality. There are five (5) types of EMEVS transactions, which correspond to the VeriFone TRANZ 330 transaction types:

- 1 - Service authorization and eligibility inquiry
- 2 - Eligibility inquiry only
- 3 - Service authorization confirmation only
- 4 - Service authorization cancellation
- 6 - Dispensing validation system request

7.1.2.4.1 Access Methods

The most common access methods for eligibility verification, Utilization Threshold, and Post and Clear are the Audio Response Unit (voice) and the VeriFone point-of-service terminal devices. The other access methods available are:

- PC to host link - This PC dial-up method is recommended for providers and billing services who have up to two-thousand (2,000) transactions per month. EMEVS software is available but not required. Responses are immediate.
- Remote job entry (RJE) - This method is available only to laboratory, transportation, and home health providers who want to use a direct file

transmission to the EMEVS host. Files are limited to five-thousand (5,000) transactions per batch cycle. Response turnaround with this method is twenty-four (24) to forty-eight (48) hours.

- CPU to CPU link - A method for large volume providers or value-added networks (VANs) who want to link their computer system to the EMEVS computer system over a dedicated communication line. Responses are immediate.

The only access methods available for the pharmacy claims capture and Prospective DUR features are the PC to host and CPU to CPU links.

7.1.2.4.2 Eligibility Verification

New York State uses day-specific eligibility and, therefore, providers must use the EMEVS for eligibility verification to ensure payment of claims. Through any of the access methods discussed in the previous section, the provider can get the following eligibility verification responses:

- The eligibility status for a Medicaid client for a specific date
- The county with financial responsibility for the client, which is used to identify the contact office for prior approval or prior authorization
- Any Medicare, third-party insurance, or managed care plan coverage that a client may have for the specific date
- Any limitations on coverage that may exist for the client that needs to be addressed in the Utilization Threshold or Post and Clear programs
- Status of copay for the service
- Restricted recipient information

Twenty-four (24) months of eligibility history are available.

7.1.2.4.3 Dispensing Validation System Request (DVS)

This type of transaction allows suppliers of predesignated enteral nutrition products, prescription footwear items, and certain medical/surgical supplies and equipment to request a prior approval number. If approved, the prior approval number is used in claims processing to approve the claim for payment.

7.1.2.4.4 Utilization Threshold (UT)

New York State has placed benefit limitations on certain services, which the EMEVS tracks for each client. If, based on the provider type and the specialty entered, an EMEVS transaction is subject to a limitation and if the number of units of service (including the units included in the present request) exceeds that limitation, the EMEVS responds with a partial approval or denial of eligibility for the service.

If the Utilization Threshold (UT) for the client has not been reached, the EMEVS authorizes the service and generates a Service Authorization, which is transmitted to the MMIS. Lack of a Service Authorization during claims processing will cause a claim from that provider for that recipient for that service to be pended for a specific number of days. If no service authorization is received within that time frame, the claim is denied.

Providers may request an increase in the threshold for a client based on medical necessity. This increase is requested through the Medicaid Override Application System (see Section 7.1.1.13).

7.1.2.4.5 Post and Clear

To limit utilization of laboratory and drug prescriptions, New York State developed the Post and Clear component of the EMEVS. Providers who are allowed to order laboratory services or to prescribe drugs are required to identify this service in a service authorization transaction. This creates a "posted" service authorization that is transmitted to the MMIS allowing the ordering provider's claim to be paid.

When the dispensing provider (freestanding laboratory or designated pharmacy) submits a service authorization transaction through the EMEVS for a corresponding service for the client, a successful match to the "posted" service authorization creates a "clearing" service authorization. This

authorization is transmitted to the MMIS, allowing the dispensing provider's claim to be paid.

7.1.2.4.6 Prospective Drug Utilization Review/Electronic Claims Capture

New York State has implemented an electronic drug claims capture with prospective drug utilization review (ProDUR) component in the EMEVS. The electronic data interchange standards are based on the National Council for Prescription Drug Programs (NCPDP) version 3.2.

The ProDUR edits performed through the EMEVS are:

- Therapeutic duplication
- Drug-to-drug interactions
- Drug-to-disease contraindications
- Drug pregnancy alert
- Pediatric precautions
- Lactation precautions
- Geriatric precautions
- High-dose alert
- Low-dose alert

The ProDUR component of the EMEVS uses only ProDUR transaction history (not claims history) in order to ensure a more complete dispensing history (providers may not have claimed some dispensed drugs for reimbursement). Because of this history, drug-to-disease alerts are based on analysis of the active drugs in that history. Similarly, pregnancy, pediatric, lactation, and geriatric alerts are based on age, or age and sex.

If there are no alerts or the alerts are resolved, the provider may elect to have the EMEVS capture the drug claim and perform most edits (eligibility, provider, drug coverage, drug price, claim completeness). However, all pharmacies must have ProDUR approval for claims to be paid. The captured

claim is sent to the MMIS for batch processing, where history-related edits are performed. Although the claim is not adjudicated interactively, the EMEVS is able to advise the provider with an estimated ninety-eight percent (98%) certainty whether the claim is payable.

7.1.2.5 Verification Subsystem

The Verification Subsystem provides an interface between the On-Line System and EMEVS batch processing. All transactions received on-line during a cycle period are stored on log files. These log files provide the input to the Verification Subsystem at the start of each batch cycle.

The Verification Subsystem performs four basic functions:

- Edits all transactions entered through the On-Line System
- Routes transactions to the appropriate Subsystem
- Maintains historical files
- Provides statistical reports

The details of the Verification Subsystem are documented in Section 4 of the EMEVS Subsystems Manual/

7.1.2.6 Terminal Management Subsystem

New York State has approximately 15,000 VeriFone TRANZ-330 devices in use by providers for EMEVS transactions. The Terminal Management Subsystem (TMS) is used to perform and track the order, deployment, and recall, of these point-of-service devices.

TMS batch processing is documented in Section 5 of the EMEVS Subsystem Manual which is included in the Procurement Library. The TMS User Guide provides documentation of the on-line component. The on-line screens used by the operators when providers call to order a terminal or to report a problem is documented in the TMS/Voice Center User Guide. The reports produced on terminal deployment are documented in the Terminal Management System Internal Reports document.

7.1.2.7 Parameter Master Update/Build Subsystem

The Parameter Master file establishes the standards and limitations for processing and reporting information from and about the State, the counties, the providers, and the recipients in the New York State Medicaid program. The subsystem is documented in Section 8 of the EMEVS Subsystems Manual located in the Procurement Library.

7.1.2.8 Reporting Subsystem

The documentation of the Reporting Subsystem in the EMEVS Subsystems Manual provides technical specifications for the production of standard reports. The description of the report layouts are provided in the EMEVS User Guide. Both documents are in the Procurement Library.

7.1.2.9 Activity Update Subsystem

This process updates an Activity Master file with summary statistics on the cycle activity in the EMEVS. The information is used in reporting. The details of the Activity Master file and the update processes are documented in Section 10 of the EMEVS Subsystems Manual located in the Procurement Library.

7.1.2.10 Edits Subsystem

Section 11 of the EMEVS Subsystems Manual in the Procurement Library presents the processing specifications for the editing of system records prior to processing. The editing routines are:

- Recipient Transmission Pre-Edit
- Recipient Edit
- Provider Edit
- Tape Supplier Number (TSN) Pre-Edit
- Photo Pre-Edit
- Photo Edit
- Transmission/Transaction Summary Processing

The transmission edit process is used to edit records transmitted by New York State, either by tape or by communications line.

7.1.2.11 Utilization Threshold Subsystem

The Utilization Threshold (UT) Subsystem documented in Section 12 of the EMEVS Subsystem Manual located in the Procurement Library is used to prepare and generate the UT Ranking Reports. Users are provided an access method to request reports. The information is extracted from the historical verification file and the reports are printed to satisfy the requests.

7.1.2.12 Drug Utilization Review Data Preparation Subsystem

The DUR data preparation subsystem is the process to receive and process the First Data Bank drug tape and populate the DB2 tables used for Prospective DUR processing. This process is documented in Section 13 of the EMEVS Subsystems Manual in the Procurement Library.

7.1.2.13 Electronic Claims Capture (ECC) Subsystem

This subsystem, documented in Section 14 of the EMEVS Subsystems Manual located in the Procurement Library, updates the drug ECC master file on a daily basis. Claims are released from this file to the MMIS for processing.

7.1.2.14 Formulary Subsystem

The EMEVS formulary file is recreated weekly. The process for recreation and the documentation of the EMEVS formulary file is documented in Section 15 of the EMEVS Subsystem Manual in the Procurement Library.

7.1.2.15 On-Line Microfiche

When the EMEVS was first developed, the Department received all of the reports on microfiche as well as on paper. Under the DEPS contract, these reports were maintained on report image files with on-line access.

These reports exist from the beginning of the contract. It is important that this information be retained. The contractor shall migrate these reports to the new system.

7.1.2.16 Other DB2 Tables

A number of DB2 tables are maintained with statistical and analytical information available. Department users can access this information through queries. It is mandatory to migrate this information to the new system to maintain continuous information on the system. The data elements in these tables are presented in Appendix H.

7.1.3 State-Operated Medicaid Systems

There are a number of Medicaid systems operated and maintained by the Human Services Application Service Center (HSASC). While it is the Department's intent to replace nearly all of these systems and place the operational functionality with the contractor, the Replacement Medicaid System must meet or exceed the functionality of these systems while enhancing that functionality as described in the remainder of this section. These systems are briefly described in the following paragraphs.

7.1.3.1 Client Eligibility-Related Systems

The Welfare Management System (WMS) described in Section 1.2.1 is the New York State eligibility determination system that supports the activities of the LDSSs and the Office of Temporary and Disability Assistance in the determination of Medicaid eligibility for clients. There are two (2) separate, but similar systems: one (1) services New York City and the other services the Upstate local districts. The WMS subsystems, Medicaid systems, and attendant processes are important for the collection of client eligibility information for transfer to the MMIS and EMEVS:

- MABEL - MA Budget Eligibility Logic
- Restriction/Exception - Lock-in to a designated provider
- Principal Provider - Information on recipients in residential care facilities (long-term care facilities), including the provider ID and the patient contribution
- Pay-in - Processing of payments from medically needy clients who elect to pre-pay their spenddown obligation
- Third-Party Resources - Insurance codes and claiming addresses for recipients with other insurance resources
- Prepaid Capitation Program - Information on a client's enrollment in an HMO or other managed care plan.
- Client Notice System (CNS)
- State Data Exchange (SDX) - SSI eligibility (New York State is a Section 1634 state)
- Electronic Eligibility Decision Support System (EEDSS)
- Growing Up Healthy (GUPH)

Some of these are WMS subsystems that produce their own input to the MMIS and the EMEVS, while other information is passed from the WMS to the Interim Recipient Eligibility File (IREF). The CNS, SDX, EEDSS, and GUPH are transparent to the MMIS and EMEVS; information required by the MMIS and EMEVS is passed through the WMS. The IREF gathers and

consolidates the client's eligibility and other information, and creates the Fiscal Agent Master file to transmit the information to MMIS weekly. WMS eligibility information is transmitted to the EMEVS daily. Other informational files, such as Principal Provider or Third-Party Resource, are transmitted to the EMEVS weekly.

7.1.3.2 Provider File System

The Provider File System is operated by HSASC and has two (2) principal components: the Provider enrollment component and the Rate file component.

Providers who are newly enrolling in the Medicaid program or who are changing their information on the file submit paper enrollment applications and documentation to the Department. The Department updates the file through key data entry and batch updating. A Provider file is generated weekly for MMIS and daily for the EMEVS.

There are a number of rate-setting entities, both within and outside of the Department. Each entity calculates the provider-specific rates under its jurisdiction. Until recently, all rates were input to the Rate file manually. Updates of statewide inpatient rates were recently automated. A Rate file is produced weekly for transmittal to the MMIS.

7.1.3.3 Reference File Systems

There are a number of reference files that are maintained by HSASC. These files are:

- Diagnosis file - All ICD-9-CM diagnosis codes applicable to the New York State Medicaid program are transcribed from the Federal Register publications to input documents for key data entry.

- Formulary file - This file of legend drugs, over-the-counter items, medical/surgical supplies, orthotics and prosthetics, DME items, hearing aids, and audiological services is updated with a file from the current updating contractor, Medispan. The Medispan input is processed by HSASC and sent to two (2) different entities for review. Selected items are retained and used to update the formulary file. The file also carries

local formulary items created by the Department to meet New York State-specific Medicaid initiatives.

- Procedure file - This reference file contains the codes, derived from CPT-4, applicable to the New York State Medicaid Program. These New York State-specific procedure codes are grouped by provider type to improve claims processing efficiency. For services that are subject to a fee schedule (as opposed to rate-based providers), the fee is also carried on this file.

Each of these files are transmitted to the MMIS weekly to update the MMIS master files. The formulary file is also transmitted to the EMEVS to support ProDUR and drug claim capture.

7.1.3.4 Prior Approval File

Department staff enter prior approval requests for medical services, evaluate the requests, and enter the approval/denial of the requests on a Prior Approval file system operated by HSASC. Recently, however, prior approval processing for some DME services was removed from this process and was implemented in the EMEVS. This system is also used by local districts and the fiscal agent contractor (on behalf of New York City) to enter Transportation and Personal Care authorizations. The file is transmitted to the MMIS weekly.

7.1.3.5 Other State-Operated Systems

The Provider Accounting file is used to show the last ten (10) checks issued to a provider and calendar year-to-date payments. The information is transmitted weekly from the MMIS to HSASC, which updates a file used as part of the Voice Interactive Processing System (VIPS) to permit providers to call and review the payment information. VIPS is operated under a contract with Teleswift Corporation, which maintains a 900 number for providers to call. The State receives considerable revenue from this 900 service.

The Lombardi file maintains information on the Medicaid contributions to the Public Goods Pool. The MMIS calculates some of the contribution amounts and sends reports to the Department. Department staff make additional calculations, make actual payments to the Pool, and update the Lombardi file system operated by HSASC, which is then forwarded to the MMIS as a full file replacement.

7.1.4 Overview of the Replacement Medicaid System

The Replacement Medicaid System requirements are presented here to assist offerors in gaining an understanding of the needs of the New York State Medicaid program for the replacement system. All requirements are subject to further definition and finalization during the implementation development life cycle, as described in Section 6.

This section presents a description of each functional area of the Replacement Medicaid System. The business objective, system requirements, performance standards, and operational responsibilities are described for each of those functions. The functional areas that comprise the system are:

7.2 Client Eligibility Data Repository
7.3 Provider Enrollment and Data Maintenance
7.4 Reference Data Maintenance
7.5 Electronic Commerce
7.6 Claims and Encounter Processing
7.7 Financial Management
7.8 Service Utilization Management
7.9 Third-Party Resources
7.10 The Child/Teen Health Plan (EPSDT)
7.11 Managed Care Support
7.12 Drug Rebate
7.13 Surveillance and Utilization Review (SUR)
7.14 Prospective Drug Utilization Review (ProDUR)
7.15 Retrospective Drug Utilization Review (RetroDUR)
7.16 Systems Operations and Integrated Test Facility
7.17 Management and Administrative Reporting (MAR)

Section 8 describes the Medicaid data warehouse function components, including the system design and development requirements for the Medicaid data warehouse.

Each of the other sixteen (16) functional areas is defined in terms of:

- Overview description of the functional area
- Business objectives of the functional area

- System requirements
- Performance standards
- State responsibilities
- Contractor responsibilities

The system requirements are defined in terms of the capabilities that the New York State Replacement Medicaid System must meet. **In general, it is the intent of the Department that the Replacement Medicaid System must, at a minimum, meet or exceed all of the functionality of the current MMIS and EMEVS, as described in the previous sections. It is the intent of the Department to move forward, not backward, in capability.** In addition, the system must improve on that functionality to provide the Department with the flexibility to edit fee-for-service claims more effectively, prevent payments inconsistent with State and Federal policy, provide the needed automated solutions to the mandatory managed care program, perform Medicaid business functions more efficiently and effectively, and incorporate new Medicaid programs and policies as they evolve. It is also the intent of the Department that the Replacement Medicaid System support payments for services funded by non-Medicaid programs.

The Department expects offerors to propose a set of automated and business solutions to address the needs of the New York State Medicaid program. The system requirements are deliberately defined at a capabilities level to permit offerors maximum flexibility in providing creative solutions. The system requirements are defined in this section in terms of:

- Inputs
- Processing requirements
- Outputs
- Interfaces

Throughout Section 7, references will be made to terms and acronyms. To the extent possible, the terms and acronyms are defined in Appendix B. However, certain terms which are used in the description of system capabilities for the Replacement Medicaid System are presented in Exhibit 7.1 below.

Exhibit 7.1
Key Words for Definitions of System Capabilities

Accept	An automated process of adding or changing data
Attribute	See Data Element
Assign	An automated process to provide a unique identifier
Column	See Data Element
Conduct	Performance of an activity; may be manual, automated, or a combination
Cross-Reference	Requires an automated linkage between attributes
Database	A relational database, which is the logical storage of data elements; in such a database, the data elements are stored in tables and the relationship of the data elements and tables is defined in the database management system (DBMS)
Data Element	The smallest unit of data; sets of related data elements are stored in records or tables
Edit	An automated process to evaluate the correctness of a transaction
File	The logical storage of a related set of data elements (records)
Generate	Automated process to produce a report or other output
Identify	Requires a flag, indicator, or field used for automated processing
Maintain	Automated process to store data
Monitor	Provides manual or automated oversight of a process
Record	A related set of data elements; multiple records constitute a file
Report	Media for providing information (e.g. paper, diskette, electronically) as determined by the Department
Row	See Record
Table	See File
Track	An automated process to monitor and report based on defined criteria
Update	An automated process of changing existing data

7.2 Client Eligibility Data Repository

7.2.1 Overview

The Medicaid eligibility determination process in New York State is generally the responsibility of the local departments of social services (LDSS). OMM's Bureau of Medicaid Eligibility is the central location that establishes and promulgates the eligibility policy and supervises the local offices.

The State of New York has a total of fifty-eight (58) local social services districts, including fifty-seven (57) "upstate" and New York City. Local social services districts have responsibility for application registration and eligibility determination.

The Welfare Management System (WMS) is used to enter client data and assist in the eligibility determination process. Local social services eligibility workers schedule face-to-face meetings with clients. Some eligibility workers enter the information into WMS during the interview. Others write down the information on paper and pass it to data entry operators who enter the information into the WMS. Eligibility data is entered into the WMS via on-line screens and is processed by two (2) separate, but similar, systems, one for the upstate districts and another for New York City. The local social services districts also update client demographic and financial information and perform undercare maintenance as well as eligibility redeterminations.

Several mechanisms are used to transfer eligibility data from the WMS to the MMIS and the EMEVS. Most eligibility data is transferred through the Interim Recipient Eligibility File (IREF) and other State-operated systems. Some data, however, is transferred directly from the WMS to the MMIS and the EMEVS. The desired system solution would collapse these component processes into a single update process. In addition, the eligibility data used by the MMIS (which is updated weekly) and the eligibility data used by the EMEVS (which is updated daily) shall be combined into a single Medicaid eligibility repository, or database, to be used by all Medicaid systems functions which require client eligibility data.

The repository should be constructed such that all information on Medicaid eligibility could be gathered in the single database, such as demographic information, eligibility segments, third-party resources, utilization limit status, copayment status, restricted client information, and Medicare eligibility and Buy-In status. The single database shall be updated daily by the WMS (and all of its subsystems) or its successor. The database will be accessed for both the Medicaid transaction processing function and the eligibility verification and related functions. It will also serve the needs of other Medicaid and managed care systems, including reporting and data warehouses.

Medicaid identification cards are currently issued under a separate contract under the Office of Temporary and Disability Assistance (OTDA).

7.2.2 Business Objectives

The business objectives of the Client Eligibility Data Repository function are to:

- Maintain identification of all individuals eligible for medical benefits under Medicaid or other New York State medical assistance and public health programs, such as those provided by the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMR/DD), and the Office of Alcohol and Substance Abuse Services (OASAS).

- Accept updates of the client eligibility data at least daily to include new eligibles, reinstated eligibles, and changes to existing client data.

- Maintain and ensure positive control over the client eligibility data required to process claims and meet State and Federal reporting requirements.

- Accept on-line updates of certain client eligibility data, such as restricted recipient or TPR, subject to State-defined security restrictions.

- Maintain multiple levels of security restrictions to protect the privacy of clients (e.g., higher security restriction for AIDS patients).

7.2.3 System Requirements

The current MMIS Recipient Master file update process is documented in the Master file volumes of the MMIS documentation; the EMEVS update process is documented in the EMEVS Subsystem Manual. These documents are in the Procurement Library. The New York State Replacement Medicaid System shall meet or exceed the current capabilities and shall provide the following additional system capabilities in order to meet the Department's objectives.

7.2.3.1 Inputs

The Client Eligibility Data Repository shall accept the following inputs:

7.2.3.1.1 Daily client eligibility data from the WMS

7.2.3.1.2 Third-party resource information, on-line and from the WMS

7.2.3.1.3 Restricted recipient information

7.2.3.1.4 Prepaid capitation plan information from the WMS

7.2.3.1.5 Principal provider information from the WMS

7.2.3.1.6 Client eligibility budget information from the Medical Assistance Budget Eligibility Logic (MABEL)

7.2.3.1.7 Payments made by clients in lieu of spenddown from Pay-In processing

7.2.3.1.8 Client notices from the Client Notice System

7.2.3.1.9 Information from Services/Medicaid Assistance Interface (SERMA)

7.2.3.1.10 Information from the Electronic Eligibility Decision Support System

7.2.3.1.11 Information from the Growing Up Health subsystem

7.2.3.1.12 Information from the Ambulatory Prenatal Care Program (APCP)

7.2.3.1.13 Prior approval information from the Prior Approval System

7.2.3.1.14 Medicare benefit criteria, including carrier information through the Beneficiary Data Exchange (BENDEX) with HCFA

7.2.3.1.15 Buy-In eligibility via data exchange with HCFA

7.2.3.1.16 Copayment status from the Claims function

7.2.3.1.17 Utilization limits from the Office of Medicaid Management

7.2.3.1.18 Scope of Benefits file from OMC

7.2.3.2 Processing Requirements

The processing requirements for the Client Eligibility Data Repository shall include the following:

7.2.3.2.1 Maintain current and historical day-specific eligibility data for basic program eligibility, special program eligibility, Medicare/Buy-In coverage, and other client data required to support claims processing, eligibility verification, and reporting, including the minimum data set prescribed by Part 11 of the State Medicaid Manual.

7.2.3.2.2 Accommodate the National Recipient Identification number (currently under development by HCFA).

7.2.3.2.3 Maintain on-line access to client eligibility data through the client ID number, the social security number, and the National Recipient Identification number, as well as the ability to conduct searches for recipients by name.

7.2.3.2.4 Accept changes to selected recipient data elements through on-line update, limiting access under Department-approved security procedures.

7.2.3.2.5 Maintain a minimum of twenty-four (24) months of historical eligibility information on-line. Maintain eight (8) years of historical eligibility information in an archive file that can be accessed within five (5) business days.

7.2.3.2.6 Apply edits on inputs from the WMS, its subsystems, or other sources of client demographic and eligibility information to ensure consistency and validity.

7.2.3.2.7 Maintain client restriction data to support the claims processing functions.

7.2.3.2.8 Maintain data element descriptors which are identical to, or that are cross-referenced to, those used by the WMS.

7.2.3.2.9 Maintain edit logic to ensure the integrity of data accepted from the WMS.

7.2.3.2.10 Cross reference current and prior client identification numbers and case number, including any old MMIS numbers.

7.2.3.2.11 Maintain reason codes for all eligibility transactions.

7.2.3.2.12 Provide a purge function to move inactive records to an archive file after eight (8) years. Permit on-request access to the archive file within ten (10) business days of the request.

7.2.3.2.13 Identify clients who are enrolled in the Managed Care program, with effective dates and other information required by the Department.

7.2.3.2.14 Identify managed care enrollees to the plan or plans in which they are enrolled.

7.2.3.2.15 Process the Scope of Benefits file information so that it is available to eligibility verification inquiries.

7.2.3.2.16 Identify recipients of special or State-funded programs, such as waiver, case-management, OMR, OMH, OASAS, and other medical assistance programs, with effective dates and other data required by the State, and identify potential or actual overlaps in program eligibility periods (such as when a recipient switches from/to Medicaid and State-funded programs).

7.2.3.2.17 Maintain a process to periodically reconcile client demographic, financial, and eligibility information between the Client Eligibility Data Repository and the WMS, and other sources of client eligibility information.

7.2.3.2.18 Maintain indicators for Qualified Medicare Beneficiary (QMB), Qualified Disabled Working Individual (QDWI), Specified Low Income Medicare Beneficiary (SLIMB) individuals, Qualifying Individuals 1 (QI1), and Qualifying Individuals 2 (QI2); perform Medicare Buy-in processing to automatically track and pay Part A and/or B premiums for these individuals.

7.2.3.3 Outputs

The New York State Replacement Medicaid System shall meet the following information requirements:

7.2.3.3.1 Reports to meet all Federal and State reporting requirements

7.2.3.3.2 Control reports of daily file updates and monthly file reconciliation

7.2.3.3.3 Results of monthly file reconciliation

7.2.3.3.4 Data transfer to the Medicaid data warehouse

7.2.3.3.5 Operational reports for management of the automated eligibility verification system

7.2.3.3.6 Mailing labels and letters for changes in service packages or eligibility resulting from legislation, as requested by the Department

7.2.3.3.7 Inquiry screens that display client basic demographic data, client historical eligibility segments, client restriction data, client Medicare and Buy-In data, etc.

7.2.3.4 Interfaces

The Replacement Medicaid System shall exchange data with the following systems and entities:

7.2.3.4.1 Support a two- (2-) way interface to the WMS.

7.2.3.4.2 Support interfaces with State agencies, local districts, providers, health plans, and other entities that transmit data to the Medicaid eligibility repository.

7.2.4 Performance Standards

The contractor shall meet the following performance standards during operation of the Replacement Medicaid System:

7.2.4.1 Update the Client Eligibility Data Repository at least daily on a schedule approved by the Department.

7.2.5 State Responsibilities

The Department will perform the following responsibilities in connection with the Client Eligibility Data Repository:

7.2.5.1 Provide guidance to the local social services districts regarding which individuals are eligible to receive medical assistance benefits and determine benefit limitations and applicable periods.

7.2.5.2 Arrange for the contractor to have inquiry access to the WMS and other eligibility sources to obtain client data.

7.2.5.3 Assist in the correction of errors and discrepancies resulting from the client update process between the WMS and the Replacement Medicaid System.

7.2.6 Contractor Responsibilities

In operating the Client Eligibility Data Repository component of the Replacement Medicaid System, the contractor shall:

7.2.6.1 Maintain the Client Eligibility Data Repository: the database containing client data from the WMS plus additional data specific to the Medicaid program.

7.2.6.2 Promptly notify the Department of any discrepancies or errors identified by the MMIS in the WMS files, including discrepancies in client data and evidence of unsuccessful file transfers.

7.2.6.3 Produce error reports for each eligibility transaction that fails one (1) or more edits and deliver them to the Department; notify the Department of the need to resolve edits if the contractor cannot resolve them.

7.2.6.4 Process and apply daily updates to the Client Eligibility Data Repository from the WMS and other eligibility sources.

7.2.6.5 Purge inactive client records from the Client Eligibility Data Repository to an archive file after eight (8) years.

7.2.6.6 Transmit updates of Medicaid-specific data fields to the WMS as necessary.

7.2.6.7 Maintain appropriate controls and audit trails to ensure that the most current client data is used during each claims processing cycle.

7.2.6.8 Provide on-line inquiry to the Client Eligibility Data Repository through PC-based workstations. Provide on-line inquiry capability to the local districts.

7.2.6.9 Produce mailing labels with various select-and-sort options, such as aid category, program type, date of birth, county, census tract, and ZIP code.

7.2.6.10 Generate and mail letters to clients as requested by the Department.

7.3 Provider Enrollment and Data Maintenance

7.3.1 Overview

The Provider Enrollment and Data Maintenance function acts as the primary liaison between providers and the New York State Medicaid program. This function is crucial to ensuring that New York State's provider community understands the responsibilities and rights associated with becoming a Medicaid provider and continued status as a Medicaid provider. Specifically, the Provider Enrollment and Data Maintenance function in New York State includes:

- Provider enrollment
- Provider certification and verification
- Provider data table maintenance
- Provider rate maintenance
- Technical assistance and training
- Provider manual development and maintenance

Currently, the Department is responsible for Provider Enrollment and Data Maintenance functions. Under this RFP, the contractor will perform these functions.

Provider Enrollment

The contractor is responsible for guiding providers through the enrollment process. The contractor's Replacement Medicaid System shall provide a provider enrollment tracking system. Once the provider is enrolled, the contractor is responsible for updating provider records and ensuring that provider recertification requirements are met in a timely fashion.

Provider Certification and Verification

In New York State, pharmacies, physicians, and other practitioners are licensed by the State Education Department (SED). Institutional and most other provider types are licensed or certified by units of the Department of Health, except for ICFs/MR which are certified by OMR/DD. Certain providers are certified by OMH and OASAS; and durable medical equipment suppliers must have a business license or permit from the Department of State. The contractor will be responsible for developing an automated interface to communicate with these organizations to obtain license and certification information.

Provider Table Maintenance

The contractor shall maintain comprehensive current and historical information about providers enrolled in the New York State Medicaid program. A Provider Master file is maintained to support electronic commerce, claims and encounter processing, prior authorization processing, management reporting, and utilization review reporting and activities. Provider data will be entered directly into the Replacement Medicaid System using a series of on-line screens with editing capabilities, making the information immediately available to claims processing.

Provider Rate Maintenance

A number of provider types in New York State are reimbursed on the basis of provider-specific rates. These rates are developed by a number of agencies, including the Department of Health, OMH, OMR/DD, and OASAS. The contractor shall develop an automated interface with each of the rate-setting agencies to capture and post new rates, with effective dates, to the Replacement Medicaid System database as soon as they are finalized. For rate-setting agencies with no rate-setting system, the Replacement Medicaid System shall have an on-line update process to enter and update provider-specific rates.

Technical Assistance and Training

Providing technical assistance and training to providers will be a fundamental, ongoing responsibility of the contractor. The contractor shall strive to resolve all provider issues as efficiently as possible to minimize Department intervention and to foster and maintain a harmonious working relationship with the provider community. Technical assistance activities primarily refer to researching and responding to provider inquiries in a timely fashion. Providers may have questions about billing, the status of a particular claim or adjustment, electronic claims submission, electronic funds transfer, client eligibility categories, prior authorization requirements, TPR requirements, etc. If the contractor cannot provide an immediate answer to the provider, the contractor is expected to research the question and make a return call to the provider with an answer.

Each year, the contractor will be required to conduct provider training sessions and to tailor these sessions to the needs of the new provider as well as providers that are experienced in billing for Medicaid services. Contractor staff must provide on-site assistance to a provider whenever requested.

The Department requires that electronic media options be made available to providers for claims and encounter submission. The contractor will be responsible for provider outreach, developing training materials, conducting training seminars, and assisting providers in the installation and maintenance of the electronic claims submission tools.

The contractor must engage in a variety of activities to encourage increased enrollment and participation of providers in the Medicaid program. Activities required include: making presentations regarding the Replacement Medicaid System to provider groups and organizations, promoting favorable publicity for the Replacement Medicaid System and for the program in the news media, and establishing and actively participating on Provider Advisory Committees. As a part of this activity, the contractor shall maintain adequate regional representation.

The current contractor maintains seven (7) regional offices: Rochester, Yorktown Heights, Binghamton, Medford, Buffalo, Utica, and New York City. Except for the staff in New York City, each regional representative works from home.

When the Replacement Medicaid System is operational, the contractor shall maintain a New York City office, as specified in Section 3.1.1 and shall provide sufficient regional representation to provide on-site assistance to

providers who may be experience difficulty in billing or who may have recently replaced staff. The contractor staff should also attend professional association meetings.

Provider Manual Development and Maintenance

The contractor shall provide an increased emphasis on communication with providers through professionally-developed and -published provider manuals and bulletins. The contractor is responsible for the development and maintenance of the provider manual and bulletins. The Department must approve all manuals and updates prior to release.

The contractor shall develop and maintain a separate provider manual for each provider type. These manuals must be updated annually or as requested by the Department. The manuals shall document procedures for billing, encounter submission, eligibility verification, Utilization Threshold and Post and Clear transactions, submission of prior approval/authorization requests, and other provider procedures.

The contractor shall prepare and publish monthly bulletins that are sent to providers to advise them of changes in the program or procedures.

Provider and Service Categorization

New York State uses a number of data elements to categorize providers and the services they are authorized to perform. The significant data elements used for this purpose are provider type, provider category of service, and provider specialty. These data elements are not only important for claims processing (MMIS) but are important in the method used by EMEVS to apply Utilization Thresholds. It is important to note that service codes (procedure, drug, and provider rate s) must also be tied to the provider category of service.

Because of the importance of provider category of service, the Department requires the Replacement Medicaid System to have the flexibility to quickly add, delete, or change provider categories of service and adjust both claims processing/payment and Utilization Threshold processing accordingly.

7.3.2 Business Objectives

The purpose of the Provider Enrollment and Data Maintenance function is to encourage enrollment into the New York State Medicaid program by making

enrollment an efficient process and by effective and cooperative provider relations.

The objectives of the New York State Provider Enrollment and Data Maintenance function are to:

- Encourage and facilitate the participation of qualified providers in the New York State Medicaid program by making enrollment and rate updating an efficient process.
- Ensure that providers are qualified to render specific services under the New York State Medicaid program by screening applicants for State licensure and certification; by Federal participation requirements, by specialty board certification, if appropriate; and by visit to the provider by a review team, if necessary.
- Allow for enrollment of health plans and the providers in their networks (and document the association) even if the providers are not enrolled in fee-for-service Medicaid.
- Allow for enrollment of providers who participate in programs other than Title XIX, even if those providers are not enrolled in Medicaid.
- Allow for enrollment of providers, even if the fee-for-service program does not cover the services of that provider type (e.g., provider types covered by Medicare, but not New York State Medicaid).
- Process provider applications and changes in a timely manner.
- Maintain control over all data pertaining to provider enrollment.
- Maintain all demographic information to support claims processing and information management functions.
- Maintain provider-specific rates to support claims processing.

7.3.3 System Requirements

The MMIS Master file volumes document the MMIS Provider file and Rate file update process. The EMEVS Subsystem Manual contains the corresponding update process for the EMEVS. These documents are

available in the Procurement Library. The Replacement Medicaid System shall meet or exceed these capabilities and shall provide the following additional system capabilities in order to meet the Department's objectives.

7.3.3.1 Inputs

The inputs to the Provider Enrollment and Data Maintenance function include:

7.3.3.1.1 Provider application and enrollment forms, including those for non-Title XIX providers

7.3.3.1.2 Provider data update forms

7.3.3.2 Processing Requirements

The Provider Enrollment and Data Maintenance function shall have the capabilities to:

7.3.3.2.1 Accept and maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual. Accept and maintain the data necessary to make the New York State provider data repository consistent with the National Provider file.

7.3.3.2.2 Maintain a unique identifying number for each provider enrolled in the New York State Medicaid program or enrolled to provide State-funded services. The Department intends to migrate the provider file so that a provider enrolled to perform multiple categories of service would have one (1) identification number. This transition should be made as the National Provider File and National Provider Identifier are implemented.

7.3.3.2.3 Provide an automated tracking and reporting system for provider enrollment applications (from receipt to final disposition). The system shall include tracking and reporting on application status, provider agreements, and certifications.

7.3.3.2.4 Provide an on-line automated tracking and reporting system for written, telephone, and electronic provider inquiries. The system shall be used to log and track all provider inquiries. At a minimum, the tracking system shall include the date and subject of the inquiry; the provider number, provider type, and provider name; the form of the inquiry (e.g., telephone); the date and form of response from the contractor; the respondent; and relevant comments, including what the respondent told the provider.

7.3.3.2.5 Provide on-line access to, and update of, the Provider Master file/database. Display the staff ID, update source, and date of the last change on all on-line screens.

7.3.3.2.6 Provide on-line access to the provider records using provider ID number, National Provider Identifier, provider Medicare number, Universal Provider ID Number (UPIN), social security number, tax ID number, and provider name.

7.3.3.2.7 Provide the capability to maintain multiple provider types, provider categories of service, and provider specialties for a single provider and to process claims using this data.

7.3.3.2.8 Provide the capability to provide services to clients in different programs. Provide the capability to identify provider qualifications for each program separately.

7.3.3.2.9 Provide the capability to maintain multiple addresses and service locations for a provider.

7.3.3.2.10 Maintain thirty-six (36) months of historical data on-line (e.g., authorized levels of care, certifications, associated dates, etc.). Maintain five (5) years of historical eligibility information in an archive file that can be accessed within five (5) business days.

7.3.3.2.11 Maintain and display on-line the status and status date of providers applying to submit claims electronically.

7.3.3.2.12 Identify the methods/media for which a provider is certified to submit claims electronically.

7.3.3.2.13 Maintain all data necessary to support the electronic transfer of provider payments (e.g., electronic funds transfer [EFT]).

7.3.3.2.14 Maintain all necessary information to track, consolidate, and report 1099 information.

7.3.3.2.15 Maintain and display on-line inquiry to summary information regarding provider month-to-date and year-to-date (current and prior year) claims submittal and payment data (including paid, denied, and pended claims).

7.3.3.2.16 Maintain, and display on-line, year-to-date claims submittal and payment data (including other insurance payment data) for calendar, State fiscal, and Federal fiscal year (current and prior).

7.3.3.2.17 Accept group provider numbers, and relate and cross-reference individual providers to their groups as well as a group to its individual member providers. This facility will be used to meet Federal requirements for matching physicians to groups. It shall also be used to relate individual providers to their groups (e.g., individual pharmacies to chains, optical establishments with opticians or optometrists).

7.3.3.2.18 Provide the capability to display on-line individual providers associated with a group and the groups to which an individual provider belongs.

7.3.3.2.19 Provide the capability to identify and cross-reference multiple practice locations and practice types for a single provider.

7.3.3.2.20 Maintain a cross-reference of inactive or old provider numbers to the current active number for that provider.

7.3.3.2.21 Maintain a cross-reference of current Medicaid provider number to prior Medicaid provider numbers, Medicare provider number, UPIN, and National Provider Identifier number.

7.3.3.2.22 Maintain a cross-reference of Medicaid-Medicare provider numbers to support crossover claims processing. The system shall accommodate the cross-referencing of multiple Medicare numbers to one (1) Medicaid provider number.

7.3.3.2.23 Maintain a cross-reference of at least two (2) inactive or old Drug Enforcement Agency (DEA) numbers to the currently active DEA number.

7.3.3.2.24 Provide a mechanism to identify providers as enrolled for special programs, such as waiver programs or non-Medicaid programs.

7.3.3.2.25 Identify all provider types and specialties for which a provider is enrolled, including effective dates, status codes, and limitations. Maintain at least twelve (12) segments with effective dates and status codes.

7.3.3.2.26 Capture and store the license number or certification number issued by the agency responsible for that provider's licensure or certification. Also capture and store license or certification type.

7.3.3.2.27 Provide electronic access to provider manuals, provider manual revisions, provider bulletins, enrollment applications, State Medicaid rules, and other instructions and forms via the Internet.

7.3.3.2.28 Provide the capability for non-Medicaid programs to enroll, approve, and certify providers to participate in their designated program only.

7.3.3.2.29 Provide the capability to terminate or pend providers who meet specific State or Federal criteria for termination from the program.

7.3.3.2.30 Edit all terminal-entered data for presence, format, and consistency with other data in the update transaction and on the Provider Master file.

7.3.3.2.31 Maintain provider-specific rates and effective dates as required by the New York State Medicaid program. Maintain historical rates for at least eight (8) years.

7.3.3.2.32 Provide the capability to perform mass updates to provider rate information, in accordance with Department-defined criteria.

7.3.3.2.33 Provide the capability to accept retroactive rate changes to the Provider file.

7.3.3.2.34 Provide the capability to request, on-line, mailing labels (and ZIP code summaries for mailing) and provider listings by provider type, specialty, county, ZIP code, and program participation. Include the capability to unduplicate labels for multiple providers practicing in one (1) clinic or group. Display on-line the results of user-entered selection criteria and allow the user to request a hard-copy printout, generate mailing labels, and/or receive an electronic file.

7.3.3.2.35 Purge inactive provider records in accordance with Department criteria.

7.3.3.3 Outputs

The New York State Replacement Medicaid System shall meet the following information requirements:

7.3.3.3.1 Reports to meet all Federal and State requirements

7.3.3.3.2 List of providers to be deactivated/purged due to inactivity, as defined by the Department

7.3.3.3.3 Reports required to support rate-setting, such as inpatient, nursing facility, etc.

7.3.3.3.4 Quarterly-enrolled provider report by County, specialty, ZIP code, and status

7.3.3.3.5 Quarterly alpha-enrolled provider report

7.3.3.3.6 Quarterly numeric provider report by category of service

7.3.3.3.7 Provider mailing labels

7.3.3.3.8 Audit trail reports of adds and changes to provider file data

7.3.3.3.9 Provider acceptance letters and notification of change letters

7.3.3.4 System Interfaces

The New York State Replacement Medicaid System shall exchange data with the following systems and entities:

7.3.3.4.1 Maintain an interface with the HCFA Clinical Laboratory Improvement Amendments (CLIA) database (OSCAR) for information regarding laboratory certifications.

7.3.3.4.2 Maintain an automated interface with the State Education Department, OMR, OMH, OASAS, OHSM, and the Department to transfer licensure information.

7.3.3.4.3 Maintain an automated interface with the DOH Wadsworth Laboratory for information on the certification and rates for independent laboratories.

7.3.3.4.4 Accept and process data from other accreditation agencies for exchange of provider information, as directed from the Department.

7.3.3.4.5 Provide electronic access to listings of procedure codes, coverage of procedure codes, and fee schedules via the Internet.

7.3.3.4.6 Maintain required interfaces to support EFT.

7.3.3.4.7 Maintain an interface with the existing rate-setting systems to support the capture of rate information.

7.3.3.4.8 Maintain an interface with managed care plans to receive updates to provider networks.

7.3.4 Performance Standards

The contractor shall meet the following performance standards during operation of the Replacement Medicaid System:

7.3.4.1 Mail provider enrollment packets within two (2) business days of the contractor's receipt of request. The contractor shall maintain a log, by date, of all requests made and enrollment packets sent by date. The log will be used to monitor compliance with this standard. The contractor shall prepare and submit a monthly report summarizing information maintained in this log.

7.3.4.2 Process to completion ninety-eight percent (98%) of all clean provider applications and updates within five (5) business days of receipt. Process to completion the remaining two percent (2%) within ten (10) business days of receipt. For "non-clean" applications (e.g., the applications are missing information), the provider shall be notified of what is required to complete the application within two (2) business days of determining that information is missing. The contractor shall complete processing of "non-clean" applications within five (5) business days of receipt of the requested information. The contractor shall maintain a log to support the monitoring of compliance with this standard and shall prepare and submit a monthly report summarizing the information maintained on this log.

7.3.4.3 Send notification letters of acceptance/rejection as New York State Medicaid providers, subject to approval by the Department, within one (1) business day of determination.

7.3.4.4 Staff provider relations hotline toll-free phone lines from 7:30 a.m. to 6:00 p.m., Eastern time, Monday through Friday (excluding Department-approved contractor holidays).

7.3.4.5 Maintain a sufficient number of telephone lines and personnel to staff the lines so that no more than ten percent (10%) of incoming calls ring busy and no more than ten percent (10%) remain on hold for more than two (2) minutes.

7.3.4.6 Respond to all requests or questions via telephone within two (2) business days. Requests of an unusual nature requiring significant research must be answered as expeditiously as possible. The contractor must send the requesting party, within two (2) business days of receipt of the request, an acknowledgment, including an estimate of how long it will take to answer the question or to provide the requested information.

7.3.4.7 Respond to ninety-eight percent (98%) of all written provider correspondence (inquiries) with a written response within ten (10) business days of receipt of the provider's correspondence by the contractor. Respond to the remaining two percent (2%) within fifteen (15) business days of receipt by the contractor.

7.3.4.8 Provide toll-free lines for providers to access the electronic bulletin board. The bulletin board must be available twenty-two (22) hours a day and compatible with a wide range of computer configurations, modem speeds, and communications protocols (to be determined by the Department).

7.3.4.9 Respond to legislative or executive-level (e.g., Governor) inquiries within three (3) business days of receipt of the inquiry by the contractor. Submit all responses to the Department for approval.

7.3.4.10 Mail, or post electronic mail for, claim forms and other billing documents to providers within two (2) business days of request for the forms. Perform automated claim form distribution in accordance with a schedule established by the Department.

7.3.4.11 Prepare, and send to the Department for approval, drafts of provider manuals and revisions within ten (10) business days of the Department request.

7.3.4.12 Mail provider manual revisions and provider bulletins within eight (8) business days of approval by the Department, or sooner, as requested.

7.3.4.13 Develop and submit to the Department an annual provider training plan within ten (10) business days of the beginning of the contract year.

7.3.4.14 Update and distribute approved revisions to the Operating Procedures Manual within thirty (30) calendar days of Department approval.

7.3.4.15 Maintain, at a minimum, a ninety-five percent (95%) accuracy rate for processing provider applications and entering provider information into the Replacement Medicaid System.

7.3.4.16 Update all manuals, including Provider Manuals, internal procedure manuals, and Operating Procedures Manuals, every quarter to include information sent to providers in the provider bulletins and to reflect changes made during the quarter.

7.3.5 State Responsibilities

The Department will perform the following responsibilities in connection with the Provider Enrollment and Data Maintenance function:

7.3.5.1 Review and approve provider enrollment criteria.

7.3.5.2 Establish eligibility requirements for all new providers.

7.3.5.3 Establish, review, and approve policies, standards, and procedures concerning provider enrollment, provider eligibility, provider relations, payments, and related issues.

7.3.5.4 Conduct appeals for provider terminations.

7.3.5.5 Maintain, and revise as necessary, all provider agreements to conform with all applicable Federal and State statutes, rules, and regulations.

7.3.5.6 Monitor the provider communications and relations function and contractor timeliness in performing provider communications functions, including provider inquiries and call management.

7.3.5.7 Provide the contractor with all Department-approved, provider-specific payment rate updates, including mass or paper updates.

7.3.5.8 Determine service restrictions to be placed on individual providers, and complete and submit an update request form to the contractor.

7.3.5.9 Review and approve all provider communications material, with an option to write any material, and approve distribution to the provider community.

7.3.5.10 Review and approve the contractor's training plan and training materials.

7.3.6 Contractor Responsibilities

In operating the Provider Enrollment and Data Maintenance component of the Replacement Medicaid System, the contractor shall:

7.3.6.1 Establish and maintain electronic bulletin boards and an Internet site, with appropriate security mechanisms, to facilitate posting and transmission of training schedules, notices, policy changes, remittance statements, etc., for secure access by providers.

7.3.6.2 Perform enrollment activities for all provider types, including those specifically associated with managed care programs. The contractor must maintain knowledge of all applicable Federal and State provider enrollment and certification regulations and develop and establish detailed guidelines and procedures to ensure proper enrollments of all provider types.

7.3.6.3 Designate staff resources to establish and perform regular and ongoing QA procedures. The QA process shall be conducted, at a minimum, on a monthly basis and shall include comprehensive reviews of a statistically valid sample of provider enrollments to ensure the accurate enrollment of providers into the Replacement Medicaid System, including a full second-party review of enrollments, reviewing new and ongoing enrollment activities, and performing file reviews.

7.3.6.4 Perform targeted provider recruitment, enrollment, and training as needed, by provider type, to encourage participation and increase access to care.

7.3.6.5 Receive requests for enrollment and mail all enrollment packets to providers.

7.3.6.6 Process and track, using an automated tracking system, all provider enrollment applications, including reviewing returned packets for completeness and obtaining missing information. Enroll providers eligible to provide medical assistance services, in accordance with Federal and State statues, rules, and regulations.

7.3.6.7 Verify required licenses and certifications, including specialty credentials.

7.3.6.8 Maintain regular communication with the applicable State agencies to perform certification and licensure verification. Verify certification for out-of-state providers.

7.3.6.9 Notify each provider applicant of acceptance/rejection as a New York State Medicaid provider, and send accepted providers start-up packets containing all information, manuals, and forms for participation in the program and for billing the State for Medicaid services provided to eligible clients.

7.3.6.10 Maintain a hard-copy file on all approved, denied, and terminated providers. The file for approved providers should contain certification applications, provider agreements, and all correspondence relating to certification or enrollment or resulting in provider data updates. Files for denied providers will include applications and documentation regarding the reason for the denial. Files for terminated providers will include documentation on reasons for termination. Subsequent updates or additions to the file shall be date-stamped and initialed by contractor staff who updated the file. This file may be maintained on a State-approved micromedia format.

7.3.6.11 Recertify providers on a recurring basis, as appropriate, by provider type. Validate credentials for physicians requesting specialty enrollment through the Accreditation Council for Graduate Medical Education.

7.3.6.12 Update the provider data set on a daily basis to reflect changes brought to the attention of the contractor by the Department, providers, or its own staff. Maintain an on-line audit trail of all changes.

7.3.6.13 Support the capture of rate information either directly or through interfaces with existing rate-setting systems.

7.3.6.14 Establish methods to edit and verify the accuracy of provider data entered into the Replacement Medicaid System.

7.3.6.15 Periodically purge inactive provider records to an archive file on a schedule and using criteria specified by the Department.

7.3.6.16 Annually develop and submit to the Department for approval a provider training plan at the beginning of each contract year, and update the plan as necessary.

7.3.6.17 Educate providers across the State, at no charge to the providers, about the New York State medical assistance programs, the claims processing system,

proper billing, and prior authorization procedures through workshops, training sessions, presentations at professional association meetings, and individual training as needed or as required by the Department.

7.3.6.18 Develop, distribute, and evaluate provider training questionnaires from all training sessions, and provide the Department with a summary of the provider responses.

7.3.6.19 Maintain, and submit to the Department, a listing of all providers (by provider type) that participate in training sessions.

7.3.6.20 Maintain and staff sufficient toll-free and toll-bearing lines for provider inquiries to meet performance expectations.

7.3.6.21 Supply and staff toll-free telephone lines for provider inquiries about enrollment, billing, or claim payment. Staff that perform this function should be specialized to respond to the specific needs of particular provider types or specialties. While cross-training is also necessary, specialists with a more thorough understanding of a specific provider type or specialty's needs will provide more knowledgeable and accurate information to providers.

7.3.6.22 Maintain an automated system for tracking and reporting written and telephone inquiries that ensures retrieval of the date and nature of the inquiry and the date and nature of the reply.

7.3.6.23 Provide the Department with monthly reports on all calls placed by providers to the Provider Relations toll-free line and local calls and the timeliness of written correspondence for the prior month's activity. The reports must include information on busy rates, number of calls, calls abandoned, calls unanswered, and other information to monitor contractor responsiveness, as required by the Department.

7.3.6.24 Develop a comprehensive, internal training plan for all provider staff. This training plan should address the issue of staff turnover and how the contractor proposes to train and support positions where turnover is common. The plan should also include ongoing training activities or processes to ensure that all staff keep policy knowledge current.

7.3.6.25 Train all contractor provider relations staff in billing procedures, current New York State Medicaid policy, and telephone inquiries. Ensure that all contractor staff are trained to interpret policies and procedures in a consistent manner. Provide a mechanism for staff to consult with the Department to clarify policy or to refer issues for resolution.

7.3.6.26 Provide a sufficient number of regional field representatives to provide adequate coverage to furnish on-site assistance to providers with billing difficulties, to attend provider association meetings, and to provide on-going training. The field representatives assigned to New York City shall be permanent staff located in New York City.

7.3.6.27 Ensure that provider field representatives and provider communications/ relations staff are sensitive to provider training and inquiry needs. Field representatives must provide on-site support to a provider when requested.

7.3.6.28 Supply providers with NDC codes, HCPCS codes, fee schedules, anesthesia base units, and diagnosis codes through an Internet Web site.

7.3.6.29 Monitor all undeliverable mail to providers, and verify that future mail is sent to correct address.

7.3.6.30 Provide the capability to process claims from out-of-state providers.

7.3.6.31 Identify and communicate leads on potential fraud and abuse cases to Quality Assurance and Audit (QA&A).

7.3.6.32 Identify the need for establishing reciprocal arrangements with other states to monitor care given to New York State Medicaid clients in out-of-state facilities, establish such arrangements, and monitor the arrangements.

7.3.6.33 Perform reciprocal care monitoring activities for other states requesting such arrangements and as directed by the Department.

7.3.6.34 Participate in monthly meetings (or more frequently) with the Department.

7.3.6.35 Develop, and make available, at no charge to providers, software, including future updates, for providers to submit electronic media claims (EMC) data via PC, electronic transfer, diskette, or magnetic media. EMC software and software updates shall also be available on the bulletin board system and/or an Internet Web site for downloading to approved providers.

7.3.6.36 Supply all providers with the most current provider manual materials through continual updates as well as replacement manuals when necessary.

7.3.6.37 Produce and mail provider manuals and revisions to provider manuals.

7.3.6.38 Print and distribute to providers, at no charge, all claim forms unique to the New York State Medicaid program, all prior authorization forms, all consent forms (e.g., sterilization, hysterectomy), and other State-specific attachments. Maintain an inventory control system on all forms.

7.3.6.39 Provide copies of billing manuals and provider bulletins to the Department, all provider associations, local district offices, and other entities as specified by the Department.

7.3.6.40 Schedule and distribute all regularly recurring reports and rosters, including MARS.

7.3.6.41 Research any questions or concerns by providers regarding their annual 1099.

7.4 Reference Data Maintenance

7.4.1 Overview

The Reference Data Maintenance business area's primary function is to provide a repository of current and historical pricing, prepayment utilization review, and code validation information to be used to process Medicaid claims and encounter transactions. The Reference Data Maintenance function collects and maintains the information used to define and enforce State policy as it relates to covered services, prior authorization requirements, medical policy, service restrictions, and reimbursement. Other business areas, such as Claims/Encounter Processing, Prior Authorization, Third-Party Resources, and Utilization Management, access the Reference files during system processing to retrieve stored data used to make pricing determinations, post edits, or secure other Reference data. The Replacement Medicaid System shall provide the capability for entry directly into the Replacement Medicaid System Reference files, making the information immediately available to claims processing.

Data stored on the Reference files includes information regarding:

- Pricing for HCPCS procedure codes, National Drug Codes (NDCs), diagnosis-related groupings (DRGs), and Department-specific service codes

- Pricing for provider rate s, where appropriate

- ICD-9 procedure and diagnosis codes
- Lab fee schedules
- Edit criteria
- Edit dispositions (pay, pend, claim correction, and deny)
- Error and remittance text information and explanation of benefits (EOBs)

The pricing data in this section is primarily for providers reimbursed on fee schedules or on calculated prices, such as DRGs. A significant element of provider reimbursement in New York State is the reimbursement of rate-based providers. While specific requirements to capture and maintain provider rates are included in Section 7.3, all requirements for fee schedule prices in Section 7.4 are equally applicable to provider-specific rates.

In the Replacement Medicaid System, Reference data will be updated via batch processes and on-line updates. Typically, batch updates will be performed on the following schedule: monthly for NDCs; in accordance with the schedule approved by the Department for State-specific codes; and annually for HCPCS procedure codes, ICD-9 procedure codes, and diagnosis codes. Edits and error disposition files are updated on an as-needed basis. Most updates will be received via tape from sources contracted by the Department or from Federal entities (e.g., HCFA). At times, on-line updates will be performed. Changes occurring in the Replacement Medicaid System will be tracked through audit trails that provide a before-and-after image of changes occurring in the system. By reviewing audit trails, changes can be validated to ensure accuracy.

7.4.2 Business Objectives

The purpose of the Reference Data Maintenance function is to provide access to timely, accurate pricing and code information in order to accurately process claims in accordance with State policy. Specific objectives are:

- Provide an updating facility for procedure, diagnosis, and formulary codes, prices, and other related information.
- Provide a means of readily obtaining listings of this information by specific selection criteria.
- Provide a fee schedule file for those providers reimbursed on the basis of a fee schedule. On request, provide the fee schedule file to managed care organizations subject to Department approval.
- Maintain the data necessary to support the processing of fee-for-service claims in accordance with 42 CFR Part 447 and State requirements.
- Provide current and historical rates for those providers reimbursed through provider-specific rates.

7.4.3 System Requirements

The current process of updating the MMIS Reference file is documented in the Master files volumes. These procedure, diagnosis, and formulary files are limited to codes that correspond to services covered under the New York State Medicaid program. In support of the mandatory Managed Care program, the data needs to be expanded to support the full range of HCPCS procedure codes, ICD-9-CM diagnosis and procedure codes, and a complete formulary file with all NDC, universal product (UPC), and health-related information (HRI) codes. In addition, New York-specific codes need to be maintained.

7.4.3.1 Inputs

The inputs to the Reference Data Maintenance function are:

7.4.3.1.1 Department-approved updates for procedure, drug, DRG, diagnosis, edit criteria, and edit disposition files

7.4.3.1.2 Drug updating service for drug codes and prices

7.4.3.1.3 HCFA - HCPCS updates and the annual Medicare Fee Schedule Database

7.4.3.1.4 Diagnosis and procedure updates

7.4.3.1.5 Lab fee schedule updates from the Wadsworth Center

7.4.3.1.6 Provider-specific rates from each rate-setting agency

7.4.3.2 Processing Requirements

The Reference Data Maintenance function must comply with the following requirements in order to support the Replacement Medicaid System processing functions. It must be able to:

7.4.3.2.1 Accept and maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual.

7.4.3.2.2 Maintain a procedure data set that contains five- (5-) character HCPCS codes for medical-surgical, dental, and other professional services; two- (2-) character HCPCS modifiers; ICD-9-CM surgical, obstetrical, and miscellaneous diagnostic and therapeutic procedure codes; ADA dental codes; and New York State-specific codes for other medical services.

7.4.3.2.3 Maintain a diagnosis data set of medical diagnosis codes utilizing the three- (3-), four- (4-), and five- (5-) character ICD-9-CM coding system, which can maintain relationship edits for each diagnosis code.

7.4.3.2.4 Maintain a DRG data set by peer group, facility, and effective date.

7.4.3.2.5 Maintain a drug data set of the eleven- (11-) digit NDC, which can accommodate updates from an updating service.

7.4.3.2.6 Maintain a provider rate data set for use in processing claims that use provider rate s for billing (hospital, ambulatory surgical centers, home health agencies, nursing homes, and others, as defined).

7.4.3.2.8 Maintain current and historical pricing data to be used in claims processing. The pricing segments must be date-specific.

7.4.3.2.9 Accept on-line and batch updates to all Reference files.

7.4.3.2.10 Maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the potential implementation of ICD-10.

7.4.3.2.11 Maintain flexibility to accommodate multiple reimbursement methodologies, including DRG, per diem, and peer group level of care for inpatient hospital care and case-mix-based payment structure for long-term care facilities.

7.4.3.2.12 Provide capabilities to identify, carry, and use separate pricing methodologies or rates for other medical assistance program (e.g., OMR, OMH, OASAS) claims.

7.4.3.2.13 Maintain on-line access to all Reference files with inquiry by the appropriate code, depending on the file being accessed.

7.4.3.2.14 Maintain an Edit Criteria table to provide a user-controlled method of implementing service frequency, quantity limitations, and service conflicts for selected procedures and diagnoses, with on-line update capability.

7.4.3.2.15 Maintain a user-controlled Claim Edit Disposition data set with disposition information for each edit used in claims processing, including the disposition (pay, pend, claim correction form, deny) by submission medium (paper and electronic) within claim type, by recipient table (e.g. NYC, upstate, OMH/OMR). For each error, maintain the description of the error, the related remittance Explanation of Payment (EOP) and EOB codes, and edit recycle times and frequency, with on-line update capability for all parameters and information.

7.4.3.2.16 Maintain on-line audit trails of changes made to Reference files. The audit trails must provide the data element changed, before-and-after images of the change, the date of the change, and the individual who made the change.

7.4.3.2.17 Generate reports to support the Reference Data Maintenance function.

7.4.3.2.18 Maintain up to seventy-two (72) months of pricing history by date segment.

7.4.3.3 Outputs

The Replacement Medicaid System must provide the following outputs:

7.4.3.3.1 Fee schedule to be used by providers and others, on State-requested media (e.g., paper, electronic bulletin boards, the Internet, etc.)

7.4.3.3.2 Pricing data listing on State-specified media using selection parameters specified by the Department

7.4.3.3.3 Listings of the procedure, diagnosis, drug, DRG, revenue code, provider rates, and other files based on variable, user-defined select and sort criteria, with all pertinent record contents on one (1) listing

7.4.3.3.4 Audit trail reports showing the before-and-after image of changed data, the ID of the person making the change, and the change date

7.4.3.3.5 Inquiry screens that display all relevant pricing data and restrictive limitations for claims processing and all pertinent data for claims processing and report generation

7.4.3.4 Interfaces

The Reference Data Maintenance function interfaces with:

7.4.3.4.1 Drug updating service

7.4.3.4.2 HCPCS annual updates from HCFA

7.4.3.4.3 ICD-9 updating service

7.4.3.4.4 Medicare lab fee schedules from the Wadsworth Center

7.4.3.4.5 Lab fee schedules from the Wadsworth Center

7.4.4 Performance Standards

This subsection presents the performance standards for the Reference Data Maintenance business function.

7.4.4.1 Process the annual HCPCS procedure code tape update within five (5) business days of receipt.

7.4.4.2 Process monthly NDC drug file updates within two (2) business days of receipt.

7.4.4.3 Manually update DRGs within two (2) business days of receipt.

7.4.4.4 Correctly apply updates to the Reference tables within two (2) business days of the update processing.

7.4.4.5 Manually update ICD-9 procedure and diagnosis codes within five (5) business days of receipt.

7.4.4.6 Manually update limits and restrictions associated with NDC file updates within two (2) business days of receipt.

7.4.4.7 Generate, and disseminate to providers, a bulletin outlining all HCPCS procedure code changes thirty (30) calendar days in advance of the effective date of the HCPCS codes.

7.4.4.8 Provide listings of the Reference files (i.e., HCPCS procedures, modifiers, formulary, diagnoses) to the Department within seven (7) calendar days of receipt of the request.

7.4.4.9 Ensure that new and revised copies of edits are sent to the Department within five (5) business days of the update.

7.4.4.10 Support State rate-setting activities by providing copies of the pricing file and other files specified by the Department on electronic or paper media within five (5) business days of the date of the request.

7.4.5 State Responsibilities

State operations responsibilities for the Reference Data Maintenance business function are presented below.

7.4.5.1 Determine and interpret policy and administrative rules related to covered services, allowed charges, and changes in codes.

7.4.5.2 Establish and approve all policies governing procedure code, revenue code, or rate code usage and new medical procedures.

7.4.5.3 Establish all rates, fees, and other pricing instructions, and authorize all pricing updates.

7.4.5.4 Identify procedures that require prior authorization/prior approval and all services that are covered under the New York State Medicaid program or other State-funded programs.

7.4.5.5 Perform on-line updates to Reference files.

7.4.5.6 Approve any additions, corrections, changes, or deletions to Reference data elements.

7.4.5.7 Provide the operational and policy parameters used by the contractor to design or modify edits.

7.4.5.8 Specify the benefit limitation and service conflict criteria to be applied during claims processing.

7.4.5.9 Authorize any revisions to the edit hierarchy.

7.4.5.10 Review and approve all EOB messages to ensure clarity in interpretation.

7.4.5.11 Define alternate pricing methodologies to be implemented in the future.

7.4.5.12 Respond to inquiries from the contractor regarding discrepancies in Reference data information.

7.4.5.13 Define and interpret for the contractor the detailed policies and payment objectives related to the use of DRG pricing and any other reimbursement methodologies.

7.4.5.14 Validate Reference data integrity on an ongoing basis.

7.4.5.15 Request and approve mass updates (i.e., regular and irregular updates) to files as necessary.

7.4.5.16 Select or approve contractors providing Reference data updates to the Replacement Medicaid System.

7.4.5.17 Forward copies of proposed policy changes or new policies to the contractor.

7.4.6 Contractor Responsibilities

Contractor operations responsibilities for the Reference Data Maintenance business function are presented below.

7.4.6.1 Operate the Reference Data Maintenance function of the Replacement Medicaid System.

7.4.6.2 Provide current and historical information to be used in claims processing.

7.4.6.3 Maintain appropriate controls and audit trails to ensure that only the most appropriate Reference data is used in claims processing.

7.4.6.4 Manipulate automated files to update fee schedules.

7.4.6.5 Accommodate retroactive rate changes in an automated fashion and Medicaid policy changes as they relate to rate appeals, medical procedures, and limitations.

7.4.6.6 Provide authorized Department personnel with on-line inquiry and update capabilities to all Reference data.

7.4.6.7 Maintain the Reference data that supports claims edits and pricing logic in accordance with State policy. The application of these policies is subject to change; therefore, the system must be flexible enough to accommodate the edits and pricing methodologies listed in this RFP as well as future changes to the processing and pricing.

7.4.6.8 Review proposed policy changes and new policies, and identify and develop proposed edits to address the policy changes or additions for Department review. Proposed edits shall be written and presented in a manner easily understood by non-technical users.

7.4.6.9 Provide technical assistance to the Department in developing new edits required to respond to State or Federal audit findings, quality assurance findings, and other Department areas of concern, including providing analysis

of options and recommendations for the most effective means of implementing the desired solution.

7.4.6.10 Purchase the Department's selected DRG grouper and code editor each year and update the Department-defined schedule.

7.4.6.11 Modify the DRG grouper logic and code editor to conform with Department-defined criteria.

7.4.6.12 Maintain historical versions of the DRG grouper in order to be able to process claims up to six (6) years old.

7.4.6.13 Enter into an agreement with the carrier(s) and intermediary(ies) to ensure conformance of local procedure codes to overall HCPCS structure. The contractor shall immediately notify the Department of any non-compliance, as specified by the Department.

7.4.6.14 Obtain and update the diagnosis file with the annual Commission on Professional and Hospital Activities (CPHA) updates.

7.4.6.15 Contract with the Department's selected drug pricing updating service (currently Medispan) for monthly updates of the Drug file.

7.4.6.16 Perform batch updates of Reference information from other update services (e.g., HCPCS, ICD-9).

7.4.6.17 Perform mass updates to the Reference data, as specified by the Department.

7.4.6.18 Identify, and advise the Department of, proposed changes to edits to enhance processing and efficiency.

7.4.6.19 Ensure that only authorized personnel can submit changes to the Reference data. The security procedures shall be documented and approved by the Department.

7.4.6.20 Provide training to the Department in the use of the Reference data functions initially and on an ongoing basis as prescribed by the Department.

7.4.6.21 Specify the benefit limitation and service conflict criteria to be applied through the use of the edit criteria files, the UT process, and the Post and Clear process.

7.4.6.22 Perform updates to Federal MAC, DESI/IRS, and Rebate files in accordance with Federal effective dates, unless directed otherwise by the Department.

7.4.6.23 Update pricing information and other Reference data in accordance with Department procedures.

7.4.6.24 Submit status reports weekly describing changes occurring in the system, including the reason behind the change.

7.4.6.25 Develop and update a work plan that delineates planned activities in relation to the Reference Data Maintenance function.

7.4.6.26 Respond to Department requests for research of claims payment problems within one (1) week of request. Responses to Department requests must include an accurate diagnosis of the problem, a description of how it will be fixed, and a time estimate for fixing the problem.

7.4.6.27 Perform batch updates of Reference tables from other update services (e.g., HCPCS, NDCs, ICD-9, DRGs, DUR) on a schedule determined by the State.

7.4.6.28 Coordinate with the provider assistance unit on a weekly basis to identify newly-discovered Reference data problems that are causing file inaccuracies. Once identified and confirmed, update the Reference data to correct the problem within ten (10) business days.

7.4.6.29 Update and deliver resolution manuals.

7.4.6.30 Develop a work plan for major Reference data update projects that delineates planned activities in relation to the Reference Data Maintenance function. The work plan should delineate daily activities related to non-routine HCPCS and DRG maintenance. Work plans should be updated monthly to show progress toward existing activities and defining new projects. Work plan updates must be submitted to the Department on a monthly basis for review and comment.

7.4.6.31 Develop a quality control process to ensure integrity of the Reference data (e.g., claims price correctly and edits post according to specifications).

7.4.6.32 Ensure modifiers are correctly identified and linked to appropriate codes.

7.4.6.33 Provide definition for all modifiers, including how the system processes the modifiers to all relevant contractor and State staff as determined by the Department.

7.4.6.34 Purge inactive records on a schedule to be defined by the Department.

7.5 Electronic Commerce

7.5.1 Overview

The current New York State Medicaid systems are composed of the Medicaid Management Information System (MMIS) and the Electronic Medicaid Eligibility Verification System (EMEVS). The MMIS is a claims processing engine and reporting system supported by data maintenance systems operated on the HSASC data center. The EMEVS is a "front-end" processing system, focused primarily on client-related data, which performs the following functions:

- Eligibility verification by providers through point-of-service (POS) devices similar to credit card verification terminals; through PC-based communications on a dial-up basis; through remote job entry (RJE); through CPU to CPU; and through the audio response unit (ARU), a voice response system
- UT, Post and Clear, and DME service authorizations
- Copayment management, including incrementing and decrementing copayment amounts based on claims processing
- Prospective Drug Utilization Review and electronic claims capture
- Managed care enrollment, allowing Local Districts an alternative to direct data entry to WMS utilizing the EMEVS system and contractor developed software

- Client restrictions

- Client third-party coverage, including Medicare

It is the intent of the Department, through the Replacement Medicaid System, to continue and enhance the electronic commerce features currently found in the EMEVS. Functional components of the EMEVS are addressed in other functional areas. For example, the prior authorization and service authorization components are addressed in Section 7.8, Service Utilization Management is addressed in Section 7.13, Prospective Drug Utilization Review is addressed in Section 7.14, and Third-Party Resources is addressed in Section 7.9. These electronic transactions must be in compliance with the EDI and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as described in Section 3.2.2.1 of this RFP.

The Department also intends to expand the capabilities of electronic commerce with providers and other external entities through the use of the Internet. The contractor shall establish a New York State Medicaid Web site with appropriate security protection.

The Electronic Commerce function is intended to be a focal point to support the electronic communications and business needs of all other functional areas. The Department encourages the contractor to access and use the features of the New York State communications infrastructure, known as NYT (pronounced “net”). Through this infrastructure, the contractor can establish toll-free lines as needed and utilize the connectivity with State agencies and local districts to provide access to the Replacement Medicaid System and the Medicaid data warehouse. Information for NYT is included in the Procurement Library. A description of the NYT can be found at the Web site http://www.irm.state.ny.us/nyt/nyt.htm.

7.5.2 Business Objectives

The objectives of the Electronic Commerce function are to:

- Ensure the compliance with the electronic data interchange (EDI) standards, as determined under provisions of HIPAA.

- Support the Department’s requirements for electronic transaction processing, including claims-related transactions; encounter data; and

coordination of benefits with other payors and carriers, including Medicare cross-overs.

- Support the Department's requirements for electronic banking, including electronic funds transfer and compliance with the Federal Cash Management Improvement Act.

- Support Department's requirements for electronic eligibility verification, including use of POS terminal devices, PC-based dial-up, host-to-host, and audio response.

- Support the Department's requirements for on-line services and information publishing.

7.5.3 System Requirements

The New York State Replacement Medicaid System shall provide the following system capabilities in order to meet the Department's objectives.

7.5.3.1 Inputs

The Electronic Commerce component shall accept the following inputs:

7.5.3.1.1 The Client Eligibility Data Repository to provide eligibility and other client-related data

7.5.3.1.2 Access to other Replacement Medicaid System component files for information on third-party resources, prior authorizations, managed care enrollment, and service restrictions

7.5.3.1.3 Eligibility verification transactions via voice, POS devices, PCs, host-to-host, RJE, audio response, or other media approved by the Department

7.5.3.1.4 Inquiries by providers or other authorized external entities on the status of claims, payments, service authorizations, or other information to which the inquiring entity is authorized

7.5.3.1.5 Claims and other electronic transactions submitted in accordance with approved EDI standards

7.5.3.2 Processing Requirements

The EMEVS documentation, especially the On-Line System Manual and the Subsystem Manual, are important to the understanding of the current system and are available in the Procurement Library. The New York State Replacement Medicaid System shall meet and enhance the EMEVS capabilities to meet the Department's objectives.

7.5.3.2.1 Provide interactive eligibility information to providers through a variety of automated telecommunications media, including personal computers, POS terminal devices at the provider's place of business, remote job entry, or CPU to CPU that meets the following capabilities:

- Provide a sophisticated, menu-driven design, allowing use of shortcut key sequences.
- Provide information to providers regarding eligibility status for the date queried; third-party payors (including Medicare) who shall be billed prior to Medicaid; client participation in a managed care program or restricted to a certain provider(s); program and service restrictions information; prior authorization/service authorization information; benefit exhaustion information, including services or service limitations requiring PA; spenddown information; information on last checkwrite amount and date; and number and amount of pended claims.
- Track and identify transaction statistics by type, including inquirer ID, inquiries made, duration, and errors or incomplete calls.
- Provide a back-up system to ensure that no system downtime (due to hardware or software problems) occurs.
- Permit telecommunications directly with the provider's computer or through value-added networks (service bureaus, switches, billing service, etc.)

7.5.3.2.2 Provide an audio response unit (ARU) system that meets all requirements specified in 7.5.3.2.1.

7.5.3.2.3 Support the telecommunications component of all UT, Post and Clear, and other service authorization elements of Service Utilization Management (Section 7.8).

7.5.3.2.4 Support the telecommunications component for Prospective Drug Utilization Review (ProDUR) as specified in Section 7.14.

7.5.3.2.5 Provide, at no charge, application software, communication lines, and troubleshooting assistance to requesting providers, as necessary, for performing EVS/POS transactions on provider PCs, computer systems, and POS terminals. The EVS shall be compatible, to the extent possible, with existing provider information systems and existing telecommunications switching systems in use by providers.

7.5.3.2.6 Make available, for state issue or provider purchase or lease, POS terminals and optional printers suitable for EVS inquiry only and for both EVS and electronic claims capture and submission, at no greater than a fair and competitive price. Providers shall be responsible for site preparation, wiring, installation, installation services, and telecommunication arrangements. Maintain systematic tracking of terminal location, active status, and removal from service.

7.5.3.2.7 Verify that the EVS user is an authorized provider by Medicaid ID or by license/certification number or other authorized user, and allow access to data by Medicaid client ID number, social security number, or client name and date of birth, either through terminal entry or from information encoded on a client ID card and read by a POS terminal. Appropriate safeguards shall be in place to protect the confidentiality of eligibility information and to conform to all State and Federal confidentiality laws, and to ensure that State data security standards are met.

7.5.3.2.8 Assign a unique inquiry verification number to each ARU/EVS inquiry, to be used as a reference number by the provider and to maintain an audit trail of the transaction.

7.5.3.2.9 Maintain easily accessible records of all EVS inquiries made, information requested, and information conveyed.

7.5.3.2.10 Produce EVS manuals, quick-reference cards, provider bulletins, updates, and other documentation to providers and State staff in both electronic and paper media.

7.5.3.2.11 The EVS shall have sufficient communication capabilities to accommodate all providers requesting utilization of the system.

7.5.3.2.12 POS hardware and software shall support on-line, real-time adjudication of pharmacy and HCFA-1500 claims and shall support Pro-DUR claim editing at the direction of the Department.

7.5.3.2.13 Accept electronic submission of all claims types from providers, of the appropriate claim type and format for the submitting provider, through direct links to the Replacement Medicaid System.

7.5.3.2.14 Provide a means, via electronic claims management (ECM), of transmitting and receiving claim correction form (CCF) data for pended claims. Pended claims for which a CCF is not returned within a specified period may be reprocessed and denied based on Department-approved criteria.

7.5.3.2.15 Send electronic claim receipt files to providers that submit claims electronically.

7.5.3.2.16 Utilize client information transmitted during the EVS process as input to the claims submission record.

7.5.3.2.17 Perform logic and consistency editing to screen the submitted electronic claim before acceptance by the Replacement Medicaid System, including:

- Logical dates of service (e.g., valid dates, not future dates)
- Service consistency with place of service/type of service
- Number of services performed is consistent with the span of time

7.5.3.2.18 Notify the provider (on-line) shortly after ECM transmission if the claim(s) submitted is acceptable for further processing and if services are covered under the State plan; if errors are found, notify the provider as to the claim(s) in error and the nature of the errors, and accept for further processing claims without errors.

7.5.3.2.19 Provide on-line error messages to providers which are clearly understood when miskeying of entered data occurs.

7.5.3.2.20 Capture pharmacy and HCFA-1500 claims submitted at the point of service and process on-line and in real time.

7.5.3.2.21 Provide access to select screens/windows by local districts via the NYT.

7.5.3.3 Outputs

The Electronic Commerce component of the Replacement Medicaid System shall produce the following outputs:

7.5.3.3.1 Reports equivalent to all current EMEVS reports, including:

- Operational reports about the number of inquiries received during the month; average waiting time for inquiries, by hour segment and by day; number of abandoned calls; and average time per call
- Records of what information is conveyed, and to whom, daily with weekly and monthly summaries
- System downtime
- Response time
- Counts and types of inquiries by provider type, region, and individual providers

7.5.3.3.2 ECM outputs, to include:

- Formatted claim records for input into the claims processing cycle
- Statistics of ECM claim submissions, by claim type, provider type, individual provider, and geographical area
- Reports of unsuccessful transmissions and claim errors or rejections

7.5.3.3.3 Formatted transactions for input to the appropriate Replacement Medicaid System application component

7.5.3.3.4 Service authorizations for use in claims processing

7.5.3.4 Interfaces

The Electronic Commerce component of the Replacement Medicaid System shall provide exchange data with the following systems and entities:

7.5.3.4.1 Provide a wide variety of electronic commerce data and information exchanges with providers.

7.5.3.4.2 Provide access to authorized data by local districts and State agencies.

7.5.3.4.3 Exchange data with Medicare carriers/intermediaries and other health care payors.

7.5.4 Performance Standards

The contractor shall meet the following performance standards during operation of the Replacement Medicaid System:

7.5.4.1 Maintain the electronic interface (EVS, ARU, POS, RJE, PC dial-up, and CPU to CPU) for inquiry, verification, and adjudication purposes for twenty-four (24) hours a day, seven (7) days a week.

7.5.4.2 Provide operator assistance for providers in using the electronic commerce functions from 7:00 a.m. to 10:00 p.m., Eastern Time, Monday through Friday. Provide operator assistance on weekends and Department-approved holidays from 8:30 a.m. to 5:30 p.m., Eastern Time.

7.5.4.3 Provide sufficient in-bound access lines so that Medicaid providers are connected with the ARU system within two (2) telephone rings at least ninety-nine percent (99%) of the time; initial response shall be within ten (10) seconds ninety-nine percent (99%) of the time.

7.5.4.4 Ensure that the response time for non-ARU provider-submitted transactions is not greater than two (2) seconds for ninety percent (90%) of the transactions and no response time is greater than five (5) seconds.

7.5.4.5 Ensure less than one percent (1%) of incoming telephone calls receive a busy signal and all calls on hold are answered in less than fifteen (15) seconds.

7.5.4.6 Notify the State immediately when the inquiry system is down.

7.5.5 State Responsibilities

7.5.5.1 Ensure that client file updates from the WMS are timely and that the most current data is made available to support the ARU and EVS.

7.5.5.2 Review and approve all manuals and other documentation furnished to providers and State and regional offices.

7.5.5.3 Provide access to and technical assistance for the NYT.

7.5.6 Contractor Responsibilities

In operating the Electronic Commerce component of the Replacement Medicaid System, the contractor shall perform the following responsibilities:

7.5.6.1 Maintain an eligibility verification system (EVS), with access via point-of-service, remote job entry, PC dial-up, and CPU to CPU, and an audio response unit (ARU) for providers to verify and inquire about a client's eligibility status, including managed care eligibility and to meet other requirements, such as UT and Post and Clear.

7.5.6.2 The EVS and ARU shall provide on-line access to the database containing twenty-four (24) months of all necessary eligibility data; TPR and Medicare service limitations; prior approvals/authorizations; and recipient restriction, managed care, and claims history information to operate the dial-up inquiry system.

7.5.6.3 Supply the necessary customer helpline assistance, at no charge to providers, to access the ARU by using standard touch-tone phones.

7.5.6.4 Supply, to requesting providers, POS devices and necessary PC software to perform eligibility verifications through use of a terminal keypad or interface with the provider's computer to enter necessary information. Software shall be provided at no charge; hardware shall be supplied at no more than a fair market price to providers.

7.5.6.5 Provide PC software or interface specifications, at no charge, and incoming dial-up and dedicated access lines for providers to access information using personal computers, unless such software is commercially available (e.g., Internet browsers).

7.5.6.6 Provide necessary training and assistance to providers and State personnel in installing and using various inquiry functions, such as ARU, as needed, regardless of geographic location, including a help desk.

7.5.6.7 Maintain, and assume all communications and transaction costs for, the network(s) required to support POS transactions.

7.5.6.8 Produce and distribute electronically system manuals, reference codes, and other documentation to providers and State staff.

7.5.6.9 Transmit a confirmation number to providers for each eligibility authorization.

7.5.6.10 Develop and maintain a New York State Medicaid Web site for communication with providers and other authorized entities. The contractor will maintain the Web server with appropriate firewalls and other security features, including log-on requirements and limiting information to the authorized user. The Web site will have the following capabilities:

- Publish provider manuals with hypertext links from indexes to the text and hypertext links for appropriate cross-referencing.
- Publish fee schedules and service coverage information for access by providers. The information will have hypertext links for ease of navigation.
- Complete a provider application on-line and submit for processing.
- Complete and submit claims on-line, using the EDI standards adopted under the Health Insurance Portability and Accountability Act.

7.5.6.11 Provide a full-time Webmaster to maintain the Web site specified in Section 7.5.6.10.

7.5.6.12 Provide a help desk to assist providers and State staff in the use of all electronic commerce components of the Replacement Medicaid System. The help desk shall be staffed during the hours of 7:00 a.m. to 10:00 p.m., Eastern Time, Monday through Friday and from 8:30 a.m. to 5:30 p.m. on Saturday, Sunday, and Department-approved holidays. Provide a voice mail capability at all times that the help desk is not staffed. Provide an on-call staff person with paging capability for emergencies when the help desk is not staffed.

7.5.6.13 Provide the capabilities needed to support full electronic banking, including electronic funds transfer, zero-balance disbursement account, and check redemption patterns as needed to support Cash Management Improvement Act agreements with the US Secretary of the Treasury.

7.6 Claims and Encounter Processing

7.6.1 Overview

The purpose of the Claims and Encounter Processing function is to ensure that claims for eligible clients from enrolled providers for covered services are accurately processed and adjudicated in accordance with State and Federal requirements. The Claims and Encounter Processing function encompasses the receipt, tracking, and processing of claims and encounter transactions up through adjudication. Data from Reference, Provider, Client, Third-Party Resources (TPR), and Prior Authorization are utilized in processing claims. High-level processes that support the Claims and Encounter Processing function are:

- Accept claims and other transactions via hard-copy and electronic media to include tape, diskette, point-of-service (POS), and telecommunications transmission and the Internet, and encounters via electronic media.
- Return claims to providers for predefined reasons.
- Convert claims to machine-readable format and enter the claims into the system.

- Process claims, applying appropriate pricing logic and daily, weekly, and combination edits.
- Process claims submitted through electronic claims capture.
- Pend claims for review where they fail certain edits.
- Generate claim correction forms (CCFs) to providers as appropriate, and monitor their return by providers.
- Adjudicate claims.
- Send payments and remittance statements.
- Produce reports to monitor claims processing-related activities.
- Implement policy and procedures related to claims processing.

Claims are submitted to the fiscal agent in either hard-copy or electronic format. Upon receipt by the fiscal agent, claims are assigned a claim reference number for tracking the claim. Paper claims are returned to providers for missing information. Paper claims are data-entered, and electronic claims are loaded into the New York State Replacement Medicaid System for processing. Claims pass through edits and pricing logic during processing to adjudication. Claims passing through this logic will be assigned a status of deny, pend, or approved.

Since the counties are responsible for half of the State share, Medicaid benefits will vary by region of the State. Since the system will be processing claims for other programs, such as OMH or OMR/DD, the benefit package will also vary by program. These variances will result in varied edit disposition by region or program.

7.6.2 Business Objectives

The purpose of the Claims and Encounter Processing function is to ensure that fee-for-service claims and encounter data from health plans are received, tracked, and processed accurately and in a timely manner. Specific objectives of the Claims and Encounter Processing function are:

- Ensure that all transactions, paper and electronic, are electronically captured at the earliest possible time and in an accurate manner.

- Establish control over transactions during their entire processing cycle, including pended transactions.

- Verify that all providers submitting claims are properly eligible for payment on the date of service.

- Ensure that all clients for whom transactions are submitted are eligible on the date of service.

- Ensure that all fee-for-service claims are processed completely and priced in accordance with State and Federal policy and that reimbursements to providers are rendered promptly and correctly.

- Ensure that all encounter data is processed completely and in accordance with Department direction.

- Maintain accurate and complete registers and audit trails of all processing.

- Identify uniquely, and be able to locate, any transaction.

- Automatically pend all claims in error until corrections are made or the claim is denied.

- Check each claim prior to payment, against all system edits and against current and previously paid claims for which a duplicate payment could exist.

- Provide a prompt response to all inquiries regarding the status of any transaction.

- Issue remittance statements to providers detailing claims and services covered by a given payment at the same time as the payment and furnish clear and adequate reasons for edit failures.

- Identify all claims/encounter data relating to all services covered by the State plan, including family planning services and EPSDT (C/THP).

- Record Medicare deductibles and coinsurance paid by Medicare on crossover claims. Be able to process crossover claims and pay appropriately.

7.6.3 System Requirements

One of the primary motivations for the design, development, and implementation of the Replacement Medicaid System is to modernize the capabilities for processing and paying fee-for-service claims in a timely and accurate manner that is consistent with State and Federal program policy. This includes the ability to perform edits across programs, across claim types, and across provider types.

In addition, the Replacement Medicaid System must support the Managed Care program by supporting the enrollment of clients with health plans, including autoassignment; making timely and accurate premium (capitation) payments to health plans, including pro rata premium payments and premium adjustments; and capturing and processing encounter data.

7.6.3.1 Inputs

The inputs to the Claims and Encounter Processing function are:

7.6.3.1.1 All claim forms, transactions, and attachments on all media

7.6.3.1.2 Encounter transaction data

7.6.3.1.3 Returned CCFs from providers

7.6.3.1.4 Claims for Medicare coinsurance and deductible (crossover claims), in both paper and electronic formats

7.6.3.1.5 On-line entry of claim corrections to the fields in error

7.6.3.1.6 Claim adjustment document

7.6.3.1.7 Accept requests for adjustments from HMOs or MCOs

7.6.3.1.8 Provider, Client, and Reference data related to the claims

7.6.3.1.9 Non-claim-specific financial transactions, such as fraud and abuse settlements, TPR recoveries, and cash receipts

7.6.3.2 Processing Requirements

The current MMIS claims processing functions are documented at the Claims Daily, Claims Weekly, Claims Monthly, and Claims Call Module volumes. The New York State Replacement Medicaid System must meet the requirements of the MMIS and enhance that capability according to the following requirements.

7.6.3.2.1 Accept submission of claims from providers, of the appropriate claim type and format.

7.6.3.2.2 Provide standardized PC software to providers, on request, for use in entry and transmission of claims data.

7.6.3.2.3 Perform logic and consistency editing to screen the claim before acceptance by the Replacement Medicaid System.

7.6.3.2.4 Provide dial-up telecommunications facilities.

7.6.3.2.5 Support electronic claims capture data for pharmacy and all other claim types through the POS system.

7.6.3.2.6 Assign a unique claim reference number that includes date of receipt, batch number, and sequence of claim within the batch.

7.6.3.2.7 Accept, control, process, and report separately claims for Medicaid and State-only programs as defined by the Department.

7.6.3.2.8 Maintain batch controls and batch audit trails for all claims and other transactions entered into the system.

7.6.3.2.9 Maintain an on-line audit trail record with each claim record that shows each stage of processing, the date the claim was entered in each stage, and any error codes posted to the claim at each step in processing.

7.6.3.2.10 Support on-line inquiry to claims from data entry through to payment, including pertinent claim data and claim status, with access by client ID, provider ID, and/or claim reference number.

7.6.3.2.11 Accept claims via hard-copy, electronic or any media from providers, billing services, Medicare carriers, and intermediaries.

7.6.3.2.12 Provide for on-line corrections to pended claims.

7.6.3.2.13 Produce control and audit trail reports during various stages of the claims processing cycle.

7.6.3.2.14 Edit each data element of the claim record for required presence, format, consistency, reasonableness, and/or allowable values.

7.6.3.2.15 Generate CCFs to obtain corrected claims data from providers, and match CCF data to the claim to permit processing.

7.6.3.2.16 Perform automated edit processing using history claims, pended claims, in-process claims, and same-cycle claims (include cross-invoice editing).

7.6.3.2.17 Provide, for each error code, a resolution code; an override, force, or deny indicator; and the date that the error was resolved, forced, or denied.

7.6.3.2.18 Identify the allowable reimbursement for claims according to the date-specific pricing data and reimbursement methodologies contained on applicable Provider, Reference, or Department-specified data for the date of service on the claim.

7.6.3.2.19 Deduct client deductible amounts; patient liability; client copayments; and TPR amounts, as appropriate, when pricing claims.

7.6.3.2.20 Perform global changes to pended claims based on Department-defined criteria.

7.6.3.2.21 Maintain twenty-four (24) months of adjudicated (paid and denied) claims history, all claims for "lifetime procedures" and nine (9) years of inpatient/nursing home history on a current, active claims history file for use in edit processing, on-line inquiry and update, and printed claims inquiries.

7.6.3.2.22 Provide a purge function to purge inactive records to an archive file based on criteria established by the Department. Process claims over (2) two years old

against six (6) years (nine (9) years for clinic) of claims history as determined by the Department.

7.6.3.2.23 Maintain claims that have been purged from active claims history indefinitely on a permanent history archive with key elements of the history claim.

7.6.3.2.24 Archive all hard-copy claims, attachments, and other documents on micromedia in accordance with State retention requirements and dispose of in accordance with Department-approved procedures.

7.6.3.2.25 Provide a variety of claims reporting functions in Department-determined media, including:

- Claim detail reporting
- Client and provider history requests
- Summary screens for claims and related data

7.6.3.2.26 Edit each claim record as completely as possible during an edit cycle, rather than ceasing the edit process when an edit failure is encountered and report each edit failure reason in a clear and concise manner on provider remittance statements.

7.6.3.2.27 Edit and pend each line on a multi-line claim independently (to allow continued processing of other lines) as well as edit and suspense of common area errors.

7.6.3.2.28 Identify and track all edits posted to the claim.

7.6.3.2.29 Identify and hierarchically assign status and disposition of claims (pend, CCF, or deny) which fail edits, based on the edit disposition file.

7.6.3.2.30 Maintain flexibility in setting claim edits to allow dispositions and exceptions to edits based on bill/claim type, submission media, provider type, or recipient table (i.e. NYC, upstate, OMH/OMR).

7.6.3.2.31 Edit for potential and exact duplicate claims, including cross-references between group and rendering providers, multiple provider locations, and across provider and claim types and categories of service.

7.6.3.2.32 Identify and calculate payment amounts according to the fee schedules, per diems, DRG rates, and other rates and rules established by the State.

7.6.3.2.33 Identify potential and existing third-party resource (TPR), including Medicare, and deny the claim if it is for a covered service under a TPR, for applicable claim types (e.g., drug claims are generally excluded from TPR cost-avoidance).

7.6.3.2.34 Provide the capability to calculate State and local shares of payments based on different share percentages for different fields on a single claim (e.g., an inpatient claim with major public hospital add-on will not have a local share for the add-on.).

7.6.3.2.35 Provide the capability to pend claims for providers on review based on user-defined parameters.

7.6.3.2.36 Provide the capability to pay or deny a large volume of claims pended for a provider based on certain criteria, such as services or dates of service. Currently, this is accomplished through several on-line screens.

7.6.3.3 Outputs

The outputs to the Claims and Encounter Processing function are:

7.6.3.3.1 Statistics of all claim submissions

7.6.3.3.2 Reports of unsuccessful transmissions and claim errors or rejections

7.6.3.3.3 Claim inventory management analysis

7.6.3.3.4 Input control listings

7.6.3.3.5 Returned claim logs

7.6.3.3.6 Exception reports of claims in suspense in a particular processing location for more than a Department-specified number of days

7.6.3.3.7 Inquiry screens to include pertinent header and detail claim data and status

7.6.3.3.8 Claims entry statistics

7.6.3.3.9 Data entry operator statistics

7.6.3.3.10 Reports of receipts and production

7.6.3.3.11 Reports of claims inventory, processing activity, and average age of claims

7.6.3.3.12 Reports of claim correction forms sent, returned, and types of errors

7.6.3.3.13 Inventory trend reports

7.6.3.3.14 Reports of claims and payments after each payment cycle

7.6.3.3.15 Reports of finalized claims, tapes, and electronic media transmissions input into the weekly payment cycle

7.6.3.3.16 Error code analysis

7.6.3.3.17 Pend file inventory summary and detail reports

7.6.3.3.18 Edit override analysis

7.6.3.3.19 Processing cycle time analysis

7.6.3.3.20 Prepayment edit savings analysis

7.6.3.3.21 Reports of "specially handled" or manually processed claims

7.6.3.3.22 Reports of claims withheld from payment processing

7.6.3.3.23 Client EOMBs

7.6.3.3.24 Summary reports of the EOMBs generated

7.6.3.3.25 Client and provider history printouts

7.6.3.3.26 Weekly adjudicated claims files

7.6.3.3.27 Nursing facility/transportation rosters

7.6.3.3.28 Reports to meet all Federal, State, and local reporting requirements

7.6.3.3.29 Quarterly report on all new edits introduced during the quarter and all edits inactivated during the quarter

7.6.3.3.30 Reports on pay-in amounts

7.6.3.4 Interfaces

The interfaces to the Claims and Encounter Processing function are:

7.6.3.4.1 Welfare Management System

7.6.3.4.2 Eligibility Verification System

7.6.3.4.3 PC transmission

7.6.3.4.4 Direct interface between the Replacement Medicaid System and the provider

7.6.3.4.5 Health plans for rejection and acceptance reporting of encounter data

7.6.3.4.6 Medicare carriers and intermediaries

7.6.4 Performance Standards

The performance standards for the Claims and Encounter Processing function are:

7.6.4.1 Assign a unique claim reference number to every paper claim, CCF, and adjustment within one (1) business day of the date received in the mail room. Attachments should receive the same unique number as the document to which it is attached. Process/archive every claim and attachment within three (3) business days of receipt at the contractor's site.

7.6.4.2 Provide on-line notification to providers, within twenty-four (24) hours of transmission, regarding any transmission or claim data errors or acceptability for further processing.

7.6.4.3 Assign a unique claim reference number to electronic media capture claims, CCFs, and adjustments within one (1) business day of the date received in the mail room. Process/archive every claim and attachment within one (1) business day of receipt at the contractor's site.

7.6.4.4 Return claims missing required or unreadable data within five (5) business days of receipt. Any attachments must be returned with the claims.

Instructions for the providers on how to correct and resubmit the returned claims must be included when the claims are returned.

7.6.4.5 Maintain data entry keying accuracy standards of ninety-seven percent (97%) for claims and other transactions.

7.6.4.6 Load claims submitted electronically by tape, diskette, and batch transmissions, including encounter claims, within one (1) business day of receipt by the contractor.

7.6.4.7 Produce, reconcile, and submit balancing and control reports that reconcile all claims, including encounter claims, entered into the system to the batch processing cycle input and output counts. The reports shall be provided on a weekly basis. Include management-level reports to account for all claims at all times.

7.6.4.8 Retrieve hard-copy claim documentation, client and provider data sheets, and reports within three (3) business days of receiving the request.

7.6.4.9 Provide on-line response notification to providers within five (5) minutes of receipt of incoming electronic claim transactions.

7.6.4.10 Update the claims entry files daily with all claims.

7.6.4.11 Ensure POS access is available for claim editing for pharmacy claims twenty-four (24) hours a day, seven (7) days per week.

7.6.4.12 Edit and adjudicate claims and encounters five (5) times per week.

7.6.4.13 Correctly adjudicate ninety percent (90%) of all claims within thirty (30) calendar days of receipt by the contractor and ninety-nine percent (99%) of all claims within ninety (90) days of receipt by the contractor. Time during which claims are under review by the Department will not count toward the adjudication standard.

7.6.4.14 Update claims data with CCF responses within three (3) business days of receipt.

7.6.4.15 Pay, deny, or pend paper claims within thirty (30) calendar days of receipt by the contractor.

7.6.4.16 Pay, deny, or pend electronically submitted claims within twenty-one (21) calendar days of receipt by the contractor.

7.6.4.17 Reprocess erroneously denied claims within ten (10) business days of discovery of erroneous denial.

7.6.4.18 Enter, within one (1) business day of receipt, Department and local office requests for client and provider history printouts. Deliver history printouts within five (5) business days of receipt of the request.

7.6.4.19 Generate and submit claims inventory and operations reports after each claims processing cycle.

7.6.5 State Responsibilities

Operational State responsibilities for the Claims and Encounter Processing function are as follows:

7.6.5.1 Specify archival standards.

7.6.5.2 Monitor the contractor through review of claims processing cycle balancing and control reports.

7.6.5.3 Specify changes to data requirements for State-unique claim forms, standard claim forms, and required attachments.

7.6.5.4 Specify revisions to provider manuals.

7.6.5.5 Approve ECC standards, policies, guidelines, documentation, and manuals drafted by the contractor to be furnished to providers.

7.6.5.6 Provide written approval of internal and external claims processing procedures that are used to adjudicate claims and control the audit trails and location within the claims processing system.

7.6.5.7 Approve adjudication procedures and processes, including the requirements and procedures for manual pricing of claims.

7.6.5.8 Approve error override policy and procedures for use by the contractor in claims correction.

7.6.5.9 Specify edit criteria, including edit dispositions.

7.6.5.10 Approve criteria and procedures for adjudication of "special" claims (i.e., bypass edit conditions).

7.6.5.11 Perform manual pricing and other medical resolution of pended claims.

7.6.6 Contractor Responsibilities

Operational contractor responsibilities for the Claims and Encounter Processing function are as follows:

7.6.6.1 Operate the New York Claims and Encounter Processing function effectively, efficiently, and in compliance with the performance standards listed in Section 7.6.4 and with applicable State and Federal policy, law, and regulation.

7.6.6.2 Prepare and control incoming and outgoing New York State Medicaid program mail, as directed by the Department, to ensure claims and other correspondence are picked up at and delivered to any site designated by the Department, in the most effective and efficient means available.

7.6.6.3 Deliver to the Department and pick up at the Department, contractor mail, reports, and other deliveries once in the morning and once in the afternoon each business day, and at the request of the Department.

7.6.6.4 Maintain controls to ensure no mail, claims, claim attachments, adjustment requests, tapes, diskettes, or checks are misplaced after receipt by the contractor.

7.6.6.5 Sort and prescreen hard-copy claims before entering into the system, and return those not meeting required criteria to providers; track returned claims daily. Prescreen, including review of claim attachments (e.g., sterilization consent forms), for completeness and appropriateness to the claim.

7.6.6.6 Assign unique claim reference numbers and batches to claims, encounters, and accompanying attachments on all media.

7.6.6.7 Archive hard-copy claims, accompanying documentation, and ECC transmittal documents.

7.6.6.8 Perform balancing procedures to ensure control within the Replacement Medicaid System processing cycles.

7.6.6.9 Reconcile all claims and encounter claims entered into the system to batch processing cycle input and output figures.

7.6.6.10 Produce on-line and hard-copy balancing and control reports according to Department specifications.

7.6.6.11 Perform data entry of all hard-copy claims.

7.6.6.12 Load electronically submitted claims and encounter claims.

7.6.6.13 Perform required presence and validity editing on entered claims and encounter claims according to Department specifications.

7.6.6.14 Perform validity editing on entered claims and encounter claims against Provider, Client, and Reference data.

7.6.6.15 Generate and submit claims entry statistics reports in a format conducive to assessment.

7.6.6.16 Maintain an electronic claims capture (ECC) system to allow electronic submission of claims.

7.6.6.17 Provide appropriate staff to support both technical and informational aspects of ECC.

7.6.6.18 Provide necessary ECC application and PC interface software to providers, including installation and troubleshooting assistance, free of charge.

7.6.6.19 Perform necessary logic and consistency editing for submitted claim data.

7.6.6.20 Maintain standard claim control and tracking standards.

7.6.6.21 Perform claims adjudication in accordance with medical policies in effect at the time of provision of service.

7.6.6.22 Ensure that Department-approved prepayment and medical review criteria are met.

7.6.6.23 Process “special” claims, including late billing, client retroactive eligibility, out-of-state emergency, and other Department-defined situations, in accordance with Department instructions.

7.6.6.24 Maintain sufficient staff to resolve claims that pend and to manually price claims according to Department-specified criteria.

7.6.6.25 Price claims in accordance with New York State Medicaid program policy, benefits, and limitations as defined by the Department.

7.6.6.26 Process Medicare coinsurance and deductible charges from providers on hard-copy and electronic media.

7.6.6.27 Process encounter claims received from MCOs via electronic media.

7.6.6.28 Maintain a method to process for payment any specific claim(s), including claims from MCOs to be paid under stop-loss provisions, as directed by the Department, on an exception basis; maintain an audit trail.

7.6.6.29 Process CCFs received from providers.

7.6.6.30 Manually and systematically review and resolve any claims that pend for any of the edits as determined by the Department.

7.6.6.31 Monitor the use of override codes by contractor staff during the claims resolution process to identify potential abuse, based on State-defined guidelines.

7.6.6.32 Provide on-line inquiry access to active and permanent claims history files and the status of pended claims, including denied claims.

7.6.6.33 Provide the Department with archived or hard-copy original claims, adjustments, attachments, CCFs, non-claim transaction documents, ECC billings, encounter claims, checks, and remittance statements.

7.6.6.34 Provide training to State staff in the use of the processing system on an ongoing basis, as requested by the Department.

7.6.6.35 Generate required claims entry statistics, ECC claims submission, inventory, and operations reports, and deliver to the Department.

7.6.6.36 Calculate and report to the Department the encounter claim submittal error rates as compared to MCO standards for encounter claim standards.

7.6.6.37 Implement a quality assurance program to review claims processed through the system, to ensure claims resolution and claims adjudication activities are performed in accordance with approved guidelines.

7.7 Financial Management

7.7.1 Overview

Financial Management includes the activities associated with processing and distribution of provider payments and all of the related accounting and reporting for those activities. Each weekly payment cycle results in the production of approximately 15,000 to 20,000 checks which are held by the fiscal agent for two (2) weeks prior to their release to providers in both New York City and Albany every Wednesday afternoon. Since provider payments currently average more than $400 million per week, the contractor will be held to high standards of processing, reporting, and accounting for those payments.

A significant aspect of the funding of the Title XIX program in New York State is the participation of the local districts. Unlike other states, New York State counties participate in the non-federal share of Title XIX expenditures.

In addition, it is the desire of New York State to be able to process claims for other non-Title XIX programs. This includes mixed programs, such as the Office of Mental Health, in which some clients are Title XIX-eligible and some are not.

The Legislature requires New York State Medicaid to make financial contributions to the "Public Goods Pool." The payments are based on a percentage of provider payments for inpatient hospital care, outpatient services, ambulatory surgery centers, and hospital-based pharmacy services.

There are a number of Title XIX payments currently made outside the MMIS. Some of these payments shall continue off-line but be recorded in the Replacement Medicaid System and the Medicaid data warehouse. Some of these payments shall be transitioned to the Replacement Medicaid System. The details are presented in Exhibit 7.2.

Exhibit 7.2
Transition Requirements for Payments Currently Made Outside the MMIS

State Agency	Payment Description	Avg. Ann. Amount	Comments

State Agency	Payment Description	Avg. Ann. Amount	Comments
OMRDD	HCBS environmental modification or adaptive technology	$ 1,000,000	Payments made through contracts; retain off-line
	Care at Home case management	100,000	Transition payments to the Replacement Medicaid System
	Family Care Residential Habilitation	24,000,000	OMRDD prefers off-line payments for management and control
	Transportation	350,000	Providers would have difficulty with enrollment and billing; retain off-line
	Advance/settlement process; claims are processed through MMIS; manual reconciliation by OMRDD	2,400,000,000	Continue processing claims through the Replacement Medicaid System; provide improved information for reconciliation and settlement of advance payments
OMH	Residential Treatment Facility tuition payments	7,200,000	Transition payments to the Replacement Medicaid System
	Prepaid Mental Health Plan (PMHP)	300,000,000	These payments are scheduled to implemented in the MMIS; will continue in the Replacement Medicaid System
	Disproportionate-share payments	605,000,000	Payments are discretionary and need to be made in short time frames; continue off-line.
	Advance/settlement process; claims are processed through the MMIS	440,000,000	Continue processing claims through the Replacement Medicaid System; provide improved information for reconciliation and settlement of advance payments
Court-Ordered Payments	Krieger v. Peralez - Reimbursement for covered services to eligible clients by enrolled providers for up to three (3) months prior to date of eligibility	300,000	Invoices are submitted to LDSS which verifies and certifies service; payments made by DOH finance; amounts too small for implementation in MMIS; consider for the Replacement Medicaid System
	Greenstein v. Dowling - reimbursement to eligible clients whose coverage was delayed due to agency error	30,000	Invoices are submitted to LDSS who verifies and certifies service; payments made by DOH finance; amounts too small for implementation in MMIS; consider for the Replacement Medicaid System
	NYC MAP Payments - Payments made on behalf of NYC and based on Greenstein v. Dowling; claims checked to ensure that they were not paid under any other decision	90,000	Invoices are submitted to LDSS which verifies and certifies service; payments made by DOH finance; amounts too small for implementation in MMIS; consider for the Replacement Medicaid System

State Agency	Payment Description	Avg. Ann. Amount	Comments
	McMahon v. Dowling - Disabled Audit Children who were entitled to, but did not receive, extension of benefits; recipients are reimbursed for medical bills, pay-in; Part B premium	50,000	Invoices are submitted to LDSS which verifies and certifies service; payments made by DOH finance; amounts too small for implementation in MMIS; consider for the Replacement Medicaid System
	Seittelman v. Sabol - Similar to Kreiger v. Peralez but payments can be made to non-enrolled providers	None	Invoices are submitted to LDSS which verifies and certifies service; payments made by DOH finance; amounts too small for implementation in MMIS; consider for the Replacement Medicaid System
Other Payments	Fair hearing decisions	10,000	Very small dollar amounts; paid to individuals not providers; should continue off-line

Exhibit 7.2 (continued)
Transition Requirements for Payments Currently Made Outside the MMIS

State Agency	Payment Description	Avg. Ann. Amount	Comments
	NYC MAP Provider Payments - Made to NYC nursing homes because the principal provider file cannot be updated with dates of service over fifteen (15) months old	1,500,000	Payments not in MMIS due to system limitations; should be transitioned to the Replacement Medicaid System
	Oxford Home ADM-47 Payments - Reimbursement of spouses of NYS Veterans' Home residents for health insurance or Medicare premiums paid on behalf of spouses	25,000	Very small dollar amounts made to individuals who are not providers; continue off-line
	General Off-Line Payments - Reimbursement to Medicaid providers for services which cannot be made through the MMIS: • Partial DRG payments • Part A Medicare deductibles • Medicare coinsurance days • Recipient eligibility problems • Organ donors • Other miscellaneous reasons	500,000 (Partial DRGs) 500,000 (all other reasons)	These payments cannot be made through the MMIS due to system limitations; they must be transitioned to the Replacement Medicaid System
	Community Health Care Conversion Demonstration Project (CHCCDP) - Claims from various programs, such as PEP, EPIC, and ADAP not normally eligible for Title XIX, are now allowable due to approval of Section 1115 waiver	500,000,000	These payments are claimable under special circumstances and cannot and should not be made under the Replacement Medicaid System; retain as off-line payments
	Intergovernmental Transfer (IGT) Payments - Payments made to certain public hospitals and nursing homes based on their operating deficits and other criteria	830,000,000	Payments are based on complicated funding/payment/ credit procedures; continue off-line

Exhibit 7.2 (continued)
Transition Requirements for Payments Currently Made Outside the MMIS

State Agency	Payment Description	Avg. Ann. Amount	Comments
	Payments to the State's Bad Debt and Charity Care Pool Administrator	Several Hundred Million Dollars	Some calculations are performed in the MMIS processing but actual payments are highly discretionary and must be made on short notice; continue present process (system calculations; State payment)
	Payments made by LDSSs (Schedule E claims) - Payments made by LDSSs on their own behalf with Title XIX reimbursement	Net Zero	Currently handled through an efficient process; continue under that process
	Medicare Part A and Part B Insurance Premiums	400,000,000	Buy-in processing currently handled by the State; offerors should present proposals for incorporating buy-in as a Replacement Medicaid System process

7.7.2 Business Objectives

The objectives of the Financial Management function are as follows:

- Ensure that funds are appropriately disbursed and accounted for.
- Produce accurate and timely provider payments, remittance statements, and financial reports.
- Produce accurate and timely premium payments as addressed in Managed Care Support, Section 7.11.

7.7.3 System Requirements

Documentation of the current financial management processing is split between the Claims Weekly, Claims Monthly, and MARS volumes. The New York Replacement Medicaid System shall meet the capabilities identified in these volumes and shall enhance that capability as follows in order to meet the Department's objectives.

7.7.3.1 Inputs

The inputs to the Financial Management function are:

7.7.3.1.1 Adjudicated claims from the claims processing system

7.7.3.1.2 On-line entered financial transactions, both claim-specific and non-claim-specific, such as recoupments, mass adjustments, cash transactions, etc.

7.7.3.1.3 Provider, client, and reference data from the Replacement Medicaid System

7.7.3.2 Processing Requirements

The processing requirements for the Financial Management function shall include the following:

7.7.3.2.1 Maintain payment mechanisms to providers, including check generation and electronic funds transfer (EFT).

7.7.3.2.2 Generate capitation payment as required, with supporting detailed documentation.

7.7.3.2.3 Provide the capability to assign weekly payment cycle funding information by various State agency appropriation, such as those for the Department of Health, the Office of Mental Health, and the Office of Mental Retardation and Developmental Disabilities.

7.7.3.2.4 Provide the capability to process extra payment cycles in addition to the normal weekly payment cycles.

7.7.3.2.5 Generate provider Remittance Statements in electronic or hard-copy media.

7.7.3.2.6 Provide the capability to process the following transactions:

- Accelerated payments
- Collection of accounts receivable
- Manual checks
- Application of refund checks to claims on history file

- Stop payment/reissue
- Voids and void/reissues

7.7.3.2.7 Maintain lien information to be used in directing or splitting payments to the provider and lien holder at the direction of the State.

7.7.3.2.8 Provide the capability to make lump sum payments to providers that are not related to specific claims.

7.7.3.2.9 Maintain provider accounts receivable and deduct amounts from payments due to providers as directed by the Department. Generate overpayment notification letters or other informational letters relating to account activity.

7.7.3.2.10 Maintain accounts receivable for Third Party Resources and Drug Rebate as addressed in Sections 7.9 and 7.12 respectively.

7.7.3.2.11 Track all financial transactions by source, such as TPR recoveries, fraud and abuse recoveries, drug rebate, and provider payments, etc.

7.7.3.2.12 Maintain sufficient controls to track each financial transaction, balance batches, and maintain appropriate audit trails on the claim and payment history files.

7.7.3.2.13 Provide the capability to trigger an adjustment of a claim based on a rate change.

7.7.3.2.14 Maintain an on-line mass adjustment selection screen, limited to select users, to enter selection parameters such as date(s) of payment, date(s) of service, provider type(s), provider number(s), client number(s), client category, service code(s), and claim type(s); claims meeting the selection criteria shall be displayed for initiator review, and the initiator will have the capability to select or deselect chosen claims for continued adjustment processing.

7.7.3.2.15 Provide the capability to pend payment(s) (fiscal pend mechanism) based on claim type(s), provider type(s), provider number, program, and other State-defined criteria.

7.7.3.2.16 Maintain on-line access and update capability to a Public Goods Pool file which contains percentages and fixed dollar amounts used to calculate the Medicaid Program's contribution to the Public Goods Pool.

7.7.3.2.17 Generate provider 1099 reports annually, which indicate the total paid amount minus any recoupments or credits.

7.7.3.3 Outputs

The outputs to the Financial Management function are:

7.7.3.3.1 Report of claims paid under both Medicaid and Non-Medicaid-funded programs including when a client has switched program eligibilities (to monitor payment under the proper program)

7.7.3.3.2 Standard accounting balance and control reports

7.7.3.3.3 Weekly Shares Reports by local social services district

7.7.3.3.4 Summary of Shares Reports by local social services district

7.7.3.3.5 Disbursement account reconciliation reports

7.7.3.3.6 HCFA-37 worksheet

7.7.3.3.7 HCFA-64 worksheet with all expenditures categorized in accordance with Federal reporting requirements

7.7.3.3.8 Accounts receivable collection activity reports

7.7.3.3.9 Cash receipts and returned funds reports

7.7.3.3.10 Checks and check registers

7.7.3.3.11 Retroactive rate adjustments summary

7.7.3.3.12 Reports that segregate and identify claim-specific and non-claim-specific adjustments by type of transaction (payout, recoupment, or refund) and provider type

7.7.3.3.13 Reports reflecting Medicaid's payment due to the Public Goods Pool Administrator. Medicaid's payment is calculated by applying the values in the Public Goods Pool file to the Medicaid payments for certain types of services during the month

7.7.3.3.14 Reports reflecting claims paid for which checks or EFT payments have not yet been made. The reports shall be produced weekly.

7.7.3.3.15 Remittance statements, both paper and electronic

7.7.3.4 Interfaces

The Financial Management function establishes and maintains interfaces with:

7.7.3.4.1 Banks utilized for checking and EFT

7.7.3.4.2 The Department and/or other State agencies to transmit financial data

7.7.4 Performance Standards

This subsection presents the performance standards for the Financial Management business function.

7.7.4.1 Perform up to two (2) payment cycles weekly on a schedule approved by the Department.

7.7.4.2 Produce and provide through electronic transmission a check register, EFT register, and all shares reports to the Department by 7:00 a.m. on Monday of each week. Provide hard copy shares reports by 11:00 a.m. on Monday of each week. This is to be followed for all regularly scheduled payment cycles. For any extraordinary or additional payment cycles, produce and provide check and EFT registers and all shares reports to the Department within 24 hours of payment cycle completion.

7.7.4.3 Produce provider payment accounts receivable balance reports after each weekly financial cycle and submit electronically to the Department.

7.7.4.4 Produce and submit to the Department monthly, all accounts receivable reports, including provider, TPR, and Drug Rebate reports in aggregate and/or individual accounts, as directed by the Department.

7.7.4.5 Execute and perform retroactive and mass adjustment processing within ten (10) business days of receipt of the request or rate change notice.

7.7.4.6 Review and adjudicate ninety percent (90%) of all requests for adjustments within thirty (30) calendar days of receipt. The remaining ten percent (10%) must be adjudicated within forty-five (45) calendar days of receipt.

7.7.4.7 Deposit returned or problem checks into the contractor's bank account within twenty-four (24) hours of receipt.

7.7.4.8 Produce and mail (or transmit electronically to some providers) provider 1099 earnings reports in accordance with Federal and State regulations.

7.7.4.9 Produce and mail Federal and State 1099 tapes in accordance with Federal and State regulations.

7.7.4.10 Produce a monthly summary, by provider, detailing provider assessments and add-on rate calculations, based on information in the Public Goods Pool files, made during the month.

7.7.4.11 Produce, and submit to the Department, the HCFA-64 worksheet within ten (10) business days after the end of the quarter.

7.7.5 State Responsibilities

Operational State responsibilities for the Financial Management function are as follows:

7.7.5.1 Approve contractor procedures and schedules for payment distribution.

7.7.5.2 Review inventory management, other operational claims reports, and financial reports from the contractor.

7.7.5.3 Provide at least five (5) business days' notice to the contractor prior to requiring the processing of any payment cycle in addition to the normal weekly payment cycles.

7.7.5.4 Deliver to the contractor any provider returned checks within two (2) business days of receipt.

7.7.5.5 Monitor weekly payments to providers and notify the contractor of any apparent discrepancies.

7.7.5.6 Prepare and submit the necessary financial documents to the Office of the State Comptroller to allow checks from each weekly payment cycle to be

released to providers, based on shares report information provided by the contractor.

7.7.5.7 Act as a liaison between the contractor and providers on payment or financial matters.

7.7.5.8 Work with the contractor to define and update expenditure summarization categories for interface with the statewide accounting system.

7.7.5.9 Review verbal notifications and written reports of inappropriate payments to decide whether further research and analysis is required, determine if a correction plan is required, review and approve the plan for correction, and establish a correction date.

7.7.5.10 Enter on-line provider accounts receivable transactions including recoupment percentages and/or amounts. Maintain accounts receivable and notify the contractor on a weekly basis of any changes in collection rates or interest assessment, as determined by the Department.

7.7.5.11 Provide and/or enter data required for processing lump sum payments to providers.

7.7.5.12 Monitor all contractor Financial Management activities and processes to ensure compliance with program requirements.

7.7.6 Contractor Responsibilities

Operational contractor responsibilities for the Financial Management business function are as follows:

7.7.6.1 Operate the New York Financial Management functions effectively, efficiently, and in compliance with the performance standards listed in Section 7.7.4 and with applicable State and Federal policy, law, and regulation.

7.7.6.2 Provide and maintain staff knowledgeable in policy and procedures as they pertain to the financial management requirements of the Medicaid program.

7.7.6.3 Produce and maintain comprehensive, accurate, written procedures documenting all major aspects of the financial management system and procedures followed by contractor staff and management.

7.7.6.4 Provide and execute quality assurance procedures to ensure that the financial management system disburses, tracks, and accounts for Medicaid payments accurately.

7.7.6.5 Provide a high level of customer service to the program stakeholders who interface with, and rely on, information, reports, and processes of the financial management system.

7.7.6.6 Produce provider payments in hard-copy check format or through electronic funds transfer procedures and release in the manner and on the schedule determined by the Department.

7.7.6.7 Produce remittance statements (hard copy or electronic), combine remittance statements with checks and CCFs where appropriate, and transmit or deliver to the correct providers.

7.7.6.8 Maintain a secure storage area for checks prior to release to providers.

7.7.6.9 Present messages on the remittance statement in a nontechnical language that is understandable to providers, especially in regard to pended and denied claims and recoupments.

7.7.6.10 Send the check register and EFT register to the Department at the end of each claims payment cycle, as specified by the Department.

7.7.6.11 Provide for all banking services necessary to maintain the provider payment function, including zero-balance checking accounts.

7.7.6.12 Produce reports necessary for the Department to monitor the daily balances in the contractor's provider payment account(s).

7.7.6.13 Update claim history and on-line financial files with the check number, date of payment, and amount paid after the claims payment cycle.

7.7.6.14 Maintain full responsibility for all Federal form 1099 processing, including issuance to providers, submission of data to Federal and State tax authorities, and issuance of special forms such as “B” notices to providers for purposes of correcting mismatched employer identification numbers.

7.7.6.15 Perform adjustments to original and adjusted claims and maintain records of the previous processing.

7.7.6.16 Provide for the proper handling of returned checks.

7.7.6.17 Issue manual checks to providers on an as-needed basis for any special payments as determined by the Department.

7.7.6.18 Provide for the release of certain provider checks or EFT transactions prior to the normal weekly release date, upon written notice from the Department.

7.7.6.19 Provide the capability to split or reduce already-produced provider checks and/or EFT payments not yet released for reasons such as last-minute fraud and abuse holds or court orders, funding issues, etc.

7.7.6.20 Monitor the status of each accounts receivable, including provider, TPR, and Drug Rebate. Report monthly, quarterly, and on request to the Department in aggregate and/or individual accounts, as required, both on paper and on-line.

7.7.6.21 Collect principal and interest owed by providers on Medicaid accounts receivable, at the direction of the Department.

7.7.6.22 Provide on-line access to financial information, including claims and provider payment information.

7.7.6.23 Prepare and submit a report to the Department separately listing all contractor- or State-identified inappropriate and/or incorrect payments.

7.7.6.24 Maintain a bank account for special payments. Reimbursement from this account shall be under the direction of the Department. Any interest earned on this account shall accrue to the Department.

7.8 Service Utilization Management

7.8.1 Overview

The Service Utilization Management business area includes a group of functions that are designed to capture requests from providers or clients for the Department to authorize services. These services are covered by the New York State Medicaid program only if such authorizations are granted by the Department. These features are used either to control client utilization of services or to prevent fraudulent or abusive billing practices by providers.

The specific components of the Service Utilization Management function are Service Authorization (SA) and Prior Authorization (PA). SA includes

Utilization Threshold (UT), Post and Clear, and the Medicaid Override Application System (MOAS), while PA includes both prior authorizations and prior approvals. Below is an explanation of the current processes. The new system will need to provide information on both SA/PA when providers inquire information on client eligibility.

Utilization Threshold

Utilization Threshold (UT) is a mechanism by which benefit limitations are reserved by the provider. SAs are generated by the EMEVS when providers inquire as to the availability of services for which the benefits are limited. A counter for each eligible client is set to a limit annually, then the UT process decrements the number of services used and compares the number of remaining services to the established benefit limit prior to the submission of the claim. When claims are processed, the SAs are used to allow payment of the claim. If providers find that clients are near or at their annual limit with a medical necessity for additional services, they are required to send a request through the Medicaid Override Application System (MOAS). If approved, the MOAS is used to increment the limit available on the EMEVS for the client. If a SA is not used by a claim within a certain period of time, a transaction is sent back to the EMEVS to increment the client's limit. This concept helps control utilization rather than merely limit payment.

The current systems support for the UT program is provided by the EMEVS. The On-Line System Manual will provide technical documentation. The MOAS documentation is contained in the four (4) MMIS volumes related to MOAS.

Post and Clear

Post and clear activities are used for certain laboratory and pharmacy services. A post occurs when a practitioner ordering laboratory, DME, or pharmacy services enters the order through the EMEVS, which creates a SA transaction that is passed to the claims system. The laboratory, DME, or pharmacy enters a transaction on the EMEVS to receive authorization and to clear the posted order. When claims are processed, the SA allows payment of the claim. Additionally, some providers are required to swipe the client's card a certain percentage of the time in order to demonstrate that they have the card in hand. Although designed primarily as a provider control to prevent billing of services not rendered, this process has some utilization control effects. From

The systems support for Post and Clear is an integral part of the EMEVS. The On-Line Systems Manual provides technical documentation.

Prior Approvals/Prior Authorizations

Providers request prior approval for services through the Department for durable medical equipment, dental services, certain physician services, eye care, hearing aids, private-duty nursing services, out-of-state nursing facilities, prosthetic shoes, medical supplies, and certain pharmacy services. The Department approves and enters the prior approvals. Prior authorizations for transportation and personal care services are approved and entered by the local districts. New York City personal care authorizations are sent to the fiscal agent via magnetic tape. New York City also sends approximately forty thousand (40,000) paper transportation, day treatment, and other medical practitioner PAs per week. Changes are anticipated that may allow local districts to define other entry points for magnetic media prior approvals. Additionally, the contractor receives approximately six hundred (600) transportation telephone PA requests per day. Lastly, IPRO approves surgical admissions to inpatient care and ambulatory surgery, with plans of approving elective admissions as well.

As described in Section 7.1.2.4.3, prior approval of certain DME services is accomplished through the EMEVS.

7.8.2 Business Objectives

The Service Utilization Management business area serves as a utilization management measure allowing payment for only those treatments and/or services that are medically necessary, appropriate, and cost-conscious. This process also reduces overutilization and/or abuse of specified services.

7.8.3 System Requirements

The Prior Authorization on-line system must accept approval/authorization of services by service code, dollar amount, provider, client, recipient, category of service, and date ranges. To be paid, claims submitted for these services must match the provider, client, services, units of service, dollar limitations, and authorized dates on the Prior Approval file.

7.8.3.1 Inputs

The inputs to the Service Utilization Management function are:

7.8.3.1.1 PA/SA requests

7.8.3.1.2 Access to, or extracts from, other Replacement Medicaid System files to obtain reference information, including service limitations

7.8.3.1.3 Inquiries from providers via electronic transmissions (e.g., POS devices, PC dial-in access)

7.8.3.1.4 Updates from claims processing that decrement PA services

7.8.3.1.5 Updates from claims processing that increment unused SA services

7.8.3.2 Processing Requirements

In order to support the State's goals of cost-containment and utilization review, the Service Utilization Management function must have the following capabilities. Offerors may propose additional specialized or advanced Service Utilization Management software insofar as such capabilities can be demonstrated to provide positive benefits to the State. The UT and Post and Clear processes must at least be of the same nature and same service level as now exists:

7.8.3.2.1 Accept on-line entry and update of PA requests (received on all media), including the initial entry of PA requests pending determination.

7.8.3.2.2 Provide on-line capability to the Department and the counties.

7.8.3.2.3 Provide the capability to load PA requests from the counties' systems.

7.8.3.2.4 Maintain the ability to inquire on all PA requests on-line (the system stores all PA requests regardless of their current status, e.g., under evaluation, approved, denied).

7.8.3.2.5 Assign system-generated unique PA numbers to approved, pended, and denied PA requests.

7.8.3.2.6 Decrement PA units/dollars during claims processing.

7.8.3.2.7 Maintain an authorization history for all clients with a PA on file.

7.8.3.2.8 Provide the capability to access old and new PA records and EMEVS transactions.

7.8.3.2.9 Provide the capability to limit authorization of services based on eligibility criteria.

7.8.3.2.10 Link PAs to relevant claims history against the approved PA.

7.8.3.2.11 Maintain all PA/SA administrative review and appeal information on-line.

7.8.3.2.12 Produce a variety of daily, monthly, and quarterly reports for use by the contractor and State staff; reports provide information used to evaluate and improve the PA/SA process and monitor the timeliness of PA processing.

7.8.3.2.13 Provide the capability to produce PA approval, denial, and other status notifications which are sent to providers.

7.8.3.2.14 Establish services allowable under the UT program and increment services used.

7.8.3.2.15 Accept and process modifications to authorized limitation services through MOAS based on provider requests.

7.8.3.2.16 Provide the capability to automatically increment services allowable under the UT program if unused within the Department's specified time frame.

7.8.3.2.17 Post and clear laboratory, pharmacy, and DME services SAs when requested by the provider, as specified by the Department.

7.8.3.2.18 Utilize SAs during claims processing.

7.8.3.3 Outputs

The outputs from the Service Utilization Management function are:

7.8.3.3.1 On-line inquiry screens to the PA/SA data set to include all pertinent PA/SA data which are authorized and used

7.8.3.3.2 Approval, denial, and pending notices to providers and clients

7.8.3.3.3 Letters for clients who are identified as receiving services at a rate which will exceed the limit before year's end or having reached the established service limit for the UT program

7.8.3.3.4 Reports will include:

- Number of prior authorizations received, approved, denied, and pended; include the reason for deny or pend status
- Frequency of procedure codes requested and authorized
- Cost savings (amount requested versus amount approved)
- Utilization reports, including the activity of providers by provider type and provider number, such as the number of requests, type of request, the number approved, or denied
- PAs/SAs not used within one hundred twenty (120) days of approval
- Reports of the timeliness of PA processing, including days from receipt of request to the date of approval or denial, and aging of pending requests, and the number of days in specific pending locations
- PAs/SAs identified as subject to review or appeal proceedings
- Swipe statistics reports

7.8.3.4 Interfaces

The Service Utilization Management function of the Replacement Medicaid System must exchange data with the following systems and entities:

7.8.3.4.1 Utilization files and other supporting Replacement Medicaid System or extract files, including EMEVS-type files

7.8.3.4.2 Providers' automated telecommunication systems, including phone systems, billing systems, and personal computers

7.8.4 Performance Standards

The performance standards for the Service Utilization Management business function are:

7.8.4.1 Enter all requests for prior authorization into the system within the time frame specified by the Department during the Business Design Task.

7.8.4.2 Generate and mail ninety-five percent (95%) of PA notices to requesting providers and clients within seven (7) calendar days of receipt of request. Generate and mail the remaining five percent (5%) within ten (10) calendar days of receipt.

7.8.4.3 Load PAs submitted electronically within one (1) business day of receipt by the contractor.

7.8.4.4 Maintain a sufficient number of toll-free PA phone lines and qualified personnel to staff the phone lines so that no more then ten percent (10%) of incoming calls ring busy or remain on hold for more than one (1) minute.

7.8.4.5 Staff phone lines from 7:30 a.m. to 6:00 p.m., local time, Monday through Friday (excluding Department-approved contractor holidays).

7.8.4.6 Provide monthly reports regarding phone statistics within fifteen (15) calendar days following the end of each month.

7.8.5 State Responsibilities

Operational State responsibilities for the Service Utilization Management business function are as follows:

7.8.5.1 Review and approve content of all SA and PA error messages and notification letters.

7.8.5.2 Approve the format of all PA/SA request forms and service utilization-related material.

7.8.5.3 Enter PA requests into the Replacement Medicaid System's PA system on-line.

7.8.5.4 Specify SA/PA record purge criteria.

7.8.5.5 Provide the contractor with specific requirements for Service Utilization Management related reports.

7.8.5.6 Specify and approve types of services that may be requested by phone, fax, or other electronic inquiry.

7.8.5.7 Establish and provide criteria and adjudication guidelines for use by the contractor's medical consultants and reviewers when prior authorizing services including the guidelines for MOAS.

7.8.5.8 Monitor PA and MOAS decisions rendered by contractor staff to assure determinations comply with established criteria.

7.8.5.9 Contract with peer review organizations and other appropriate entities to perform pre-certification of elective hospital admissions and admissions to inpatient psychiatric hospitals for client under the age of twenty-one (21) and greater than sixty-five (65) PASARR screenings.

7.8.5.10 Act as the liaison between the contractor and the precertification review contractors.

7.8.5.11 Act as the liaison between the contractor and the local district offices.

7.8.6 Contractor Responsibilities

The operational responsibilities of the contractor for the Service Utilization Management function are:

Prior Authorization

7.8.6.1 Receive and determine approval/denial of PA requests for services.

7.8.6.2 Enter PA requests into the Replacement Medicaid's PA system, on-line.

7.8.6.3 Provide update capability to PA records by dial-up or other telecommunication alternatives.

7.8.6.4 Provide on-line inquiry to PA information.

7.8.6.5 Operate the PA system of the Replacement Medicaid System.

7.8.6.6 Produce and mail provider rosters to the local districts.

7.8.6.7 Produce all Prior Authorization Reports according to Department specifications.

7.8.6.8 Purge old PA records according to Department-specified criteria.

7.8.6.9 Maintain and staff toll-free (for New York State and the forty-eight [48] continental states) telephone lines dedicated to PA purposes for use by providers in making requests and inquiries.

7.8.6.10 Provide monthly reports of PA calls and type of call, and reports regarding line availability, incomplete calls, and disconnects.

7.8.6.11 Receive PA requests via telephone or fax, process requests in accordance with State regulations, enter caller responses on-line, and provide the authorization number or denial reason to the caller.

7.8.6.12 Respond to phone calls and correspondence from providers regarding PA, including requests for the status of a PA.

7.8.6.13 Provide weekly PA activity reports to the Department.

7.8.6.14 Provide training to the Department in the use of the PA screens and reports.

7.8.6.15 Produce, print, and distribute to providers, free of charge, PA forms and procedures manuals.

7.8.6.16 Research and prepare appropriate, timely, and accurate responses to PA inquiries received by the Department.

Service Authorization/MOAS

7.8.6.17 Receive and determine approval/cutback of requests for service limitation increases based on criteria and guidelines provided by the Department, and consult with the Department, as necessary.

7.8.6.18 Enter the service limitation override (thus setting up the service authorization) into the MOAS of the Replacement Medicaid System.

7.8.6.19 Operate the MOAS of the Replacement Medicaid System.

7.8.6.20 Provide on-line inquiry to the SA information.

7.8.6.21 Produce and mail provider and recipient notices of approved or reduced service limitation requests.

7.8.6.22 Produce all SA reports according to Department specifications.

7.8.6.23 Purge old SA/MOAS records according to Department-specified criteria.

7.8.6.24 Provide monthly reports of SA/MOAS calls and type of call, and reports regarding line availability, incomplete calls, and disconnects.

7.8.6.25 Provide adequate professional medical staff for managing the MOAS function, including medically knowledgeable analysts for processing requests.

7.8.6.26 Respond to phone calls and correspondence from providers and clients regarding SA, including requests for the status of a SA. Provide Spanish language capability.

7.8.6.27 Produce, print, and distribute to providers, free of charge, Threshold Override Application authorization forms and procedures manuals.

7.8.6.28 Provide training to the Department in the use of the SA screens and reports.

7.8.6.29 Provide weekly MOAS/SA activity reports to the Department.

7.8.6.30 Research and prepare appropriate, timely, and accurate responses to inquiries received by the Department.

7.8.6.31 Provide staff to represent the Department through written and personal testimony in SA appeal matters and court cases.

7.8.6.32 Provide research and documentation to support SA administrative hearings, appeals, and court cases.

7.8.6.33 Attend SA administrative hearings and appeal hearings, as requested by the Department.

7.9 Third-Party Resources

7.9.1 Overview

The purpose of the Third-Party Resources (TPR) functional area is to ensure that New York State Medicaid is the payor of last resort for medical services provided to the State's client population. Medicaid clients may have access to other health insurance coverage from employment, Medicare, CHAMPUS, court-ordered medical support or because of an automobile or other accident. New York State Medicaid takes advantage of these TPRs through a combination of activities, including 1) cost-avoidance, 2) postpayment billing by specialized TPR contractors and Department staff, 3) benefit recovery functions in cases where the client's medical condition is the result of an accident, and 4) recovery from deceased clients' estates.

New York State's LDSSs have collateral responsibility for identifying and investigating client TPR and undertaking collection activity as required. The LDSSs obtain TPR information from:

- Clients during the eligibility determination process
- State-conducted direct data matches between the WMS and insurance carriers and public agencies
- Investigations resulting from referrals from the Department; the LDSS investigates these referrals to determine if, in fact, TPR exists

The referrals to the LDSS from the Department are initiated by:

- Paid claims indicating that a client's services were accident-related
- Matches between the Client Eligibility Data Repository and paid claims

The LDSS investigates these referrals until determining if, in fact, TPR exists.

Information gathered by the LDSS is entered into the WMS' Third-Party file. The Third-Party file is updated weekly to the Client Eligibility Data Repository file. Information updated and maintained on the Client Eligibility Data Repository file includes the carrier, coverage, and claiming information for the client's insurance policy(ies). The Client Eligibility Data Repository file is matched against the Replacement Medicaid System paid claims on a monthly basis to determine if insurance coverage listed for the client has been billed. Although the major data exchange is from the WMS

Third-Party file to the Client Eligibility Data Repository file, data also flows from the Replacement Medicaid System to the WMS.

New York State law requires providers to identify and claim against available client TPR. Medicaid is billed only after the provider's claim is either rejected or partially paid by the client's insurance carrier. New York State provides providers with client insurance information via the EMEVS.

New York State also has contracts with three (3) vendors to handle specialized TPR collection activity. This activity includes Medicare for inpatient hospital and home health services, CHAMPUS, and medical support from absent parents.

The following are the State and contractor responsibilities and the contractor performance standards.

7.9.2 Business Objectives

The primary objectives of the TPR function are to:

- Identify third-party resources available to Medicaid eligibles.
- Avoid paying for claims with probable third-party coverage.
- Recover funds from third parties when TPR is identified after claim payment.
- Meet Federal third-party recovery reporting requirements.
- Pay the premiums for private health insurance for clients when it is deemed cost-effective to do so.

7.9.3 System Requirements

The TPR function provides capabilities to manage private health, Medicare, and other third-party resources of New York State Medicaid clients and ensures that Medicaid is the payor of last resort. This function works with a combination of cost-avoidance (claim denial) and cost recovery (postpayment billing to private insurers). To the maximum extent possible, the Replacement Medicaid System should use automated processes for cost-

avoidance, including specifying statement of benefits (SOB), for use in automatic cost-avoidance without manual review. Cost recovery shall be used as a back-up to the avoidance process.

7.9.3.1 Inputs

The following are inputs to the TPR function of the Replacement Medicaid System:

7.9.3.1.1 Client eligibility and TPR information from the WMS via the Client Eligibility Data Repository

7.9.3.1.2 Insurance carrier information, including scope of benefits and periods of coverage

7.9.3.1.3 Information from data matches from other government programs and private insurance carriers

7.9.3.1.4 Correspondence and phone calls from clients, carriers, and providers

7.9.3.2 Processing Requirements

In order for the TPR function to meet New York State's objectives, it must have the capabilities to:

7.9.3.2.1 Maintain TPR data by client, to include:

- Client demographics
- Policy number, including policy group number, or Medicare HIC number
- Name of policy-holder, relationship to eligible client, and SSN of policyholder
- Assignment/subrogation information
- Name and address of policyholder's employer

- Type of policy and coverage, including identification of services covered under the policy, effective date of coverage, termination date of coverage, coinsurance, and deductible obligations
- Insurance carrier or health plan ID
- Court-ordered medical support information
- Source of insurance coverage

7.9.3.2.2 Maintain third-party carrier information, to include:

- Carrier or health plan ID and name; accommodate the national payor ID and national health plan and employer IDs
- Correspondence address
- Contact person and phone number
- Claims submission address
- Carrier county

7.9.3.2.3 Carry multiple, specific third-party resources, including Medicare, for each client.

7.9.3.2.4 Maintain historical information on TPR for each client.

7.9.3.2.5 Maintain a cross-reference of carrier and employer data.

7.9.3.2.6 Provide on-line inquiry and update to the client TPR data and to the carrier/employer data.

7.9.3.2.7 Accept updates to TPR and carrier data from the WMS.

7.9.3.2.8 Provide access to on-line TPR data by client name, client ID, policy number, HIC number, coverage type, and SSN.

7.9.3.2.9 Edit on-line transaction data for presence, format, validity, and consistency with other data in the update transaction and in the database.

7.9.3.2.10 Maintain a process to identify previously paid claims for recovery when TPRs are identified or verified retroactively.

7.9.3.2.11 Perform data matching with other government agencies or private insurers for potential TPR, in accordance with Federal regulations, upon State request, or as determined to be cost-effective.

7.9.3.3 Outputs

The TPR function of the Replacement Medicaid System must meet the following information management needs:

7.9.3.3.1 Cost-avoidance summary savings reports, including Medicare

7.9.3.3.2 Detail listing of cost-avoided claims on request

7.9.3.3.3 Monthly data transfer to the Medicaid data warehouse

7.9.3.4 Interfaces

The TPR function must exchange data with the following systems and entities:

7.9.3.4.1 Welfare Management System

7.9.3.4.2 Other State and Federal government agencies for data matching

7.9.3.4.3 Private insurers for data matching and coordination of benefits

7.9.3.4.4 Medicare intermediaries and carriers for data matching and coordination of benefits

7.9.3.4.5 Other State contractors conducting benefit recovery activities

7.9.3.4.6 Local district offices for coordination of benefit recovery activities, data exchanges, and inquiry

7.9.4 Performance Standards

The contractor shall meet the following performance standards during operation of the Replacement Medicaid System:

7.9.4.1 Accurately exchange TPR information with the WMS on a schedule to be determined by the Department.

7.9.4.2 Generate client claims history listings within twenty-four (24) hours of request.

7.9.4.3 Provide copies of micromedia claims to the Department within one (1) business day of request.

7.9.5 State Responsibilities

DOH will perform the following responsibilities in connection with the operation of the Replacement Medicaid System:

7.9.5.1 Review and approve contractor processing for TPR data exchanges.

7.9.5.2 Develop policies and procedures for TPR data exchanges. Review and approve contractor processing of TPR data exchanges.

7.9.5.3 Refer to the LDSS for investigation of potential client TPR (accident-related and insurance resources).

7.9.5.4 Access Federal TPR requirements and ensure compliance through the contractor.

7.9.5.5 Provide written specifications, and approve procedural changes, for the TPR functional area.

7.9.6 Contractor Responsibilities

During the operation of the TPR function of the Replacement Medicaid System, the contractor shall:

7.9.6.1 Meet all insurance and TPR processing requirements defined in New York State and Federal Medicaid law, policy, and regulation.

7.9.6.2 In all activity associated with this contract, help ensure that 1) Medicaid is the payor of last resort, 2) benefits are coordinated with other payors, and 3) funds due Medicaid are recovered. At a minimum, this should include, but not be limited to, automatic re-billing to third party carriers to recover Medicaid payments when retroactive health insurance or Medicare is added to the file. This should also include a verification process to guarantee that the amount of third party payment of lack thereof on a Medicaid claim is correct.

7.9.6.3 Receive and maintain complete on-line insurance information on all clients. The following information must be captured and maintained for each insurance coverage available to the client:

- Medicare eligibility information (Part A and Part B designation), including suffix
- Medicare coverage dates
- Insurance carrier name and address
- Claim office address
- Employer name and address
- Policyholder name, address, and telephone number
- Family members covered
- Policy and group numbers
- Type of coverage
- Services covered
- Dates of coverage
- Copayment and deductible information
- Source of coverage

7.9.6.4 Provide on-line inquiry capability to client TPR and paid claim information.

7.9.6.5 Provide TPR information to EMEVS on a schedule and in a format determined by the Department. Information must include the insurance company's(ies') name, address, policy number(s), and scope of benefits.

7.9.6.6 Provide ability to accept, update, and exchange TPR data from various external files and information sources in formats required by the Department.

7.9.6.7 Develop and maintain edits to ensure that claims are identified where TPR exists.

7.9.6.8 Provide the Medicare Health Insurance Claim (HIC) number and/or the insurance company name, claim address, group number, and policy number on all provider remittance messages when claims fail the edits for evidence of appropriate billing to Medicare or insurance.

7.9.6.9 Produce State-defined client history profiles and copies of paid claims to assist in various collection activities and administrative processes.

7.9.6.10 Edit claims for trauma, accident, and casualty-related services, and produce a monthly report and questionnaires of such claims.

7.9.6.11 Produce all required State and Federal TPR reports.

7.9.6.12 Provide the capability to produce ad hoc reports on all TPR data and activity maintained on the Replacement Medicaid System.

7.9.6.13 Provide the capability to produce billing forms in formats specified by the Department.

7.9.6.14 Provide information as required to support the contractors providing specialized TPR recovery services.

7.9.6.15 Provide training to State personnel in the use of the TPR capabilities of the Replacement Medicaid System as prescribed by the Department.

7.9.6.16 On behalf of the Department, negotiate data exchange arrangements with insurance carriers and governmental agencies, as required.

7.10 The Child/Teen Health Plan (EPSDT)

7.10.1 Overview

The Child/Teen Health Plan (C/THP) is New York State's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and serves as New York State's mechanism to identify and track EPSDT services and to generate notification letters to eligible clients. C/THP also operates several other programs involving children's health, including the Teen Alcohol and Services Act (TASA) program, various model waiver programs for special needs children, medical assistance for special education students and children in foster care, and an immunization tracking program.

The C/THP program supports the State's EPSDT goals to:

- Provide medical assistance to clients that are under the age of twenty-one (21) with a continuing system of health screenings and treatment services to permit early detection of potentially chronic or debilitating health conditions.

- Encourage regular health care for these clients to reduce the occurrence of more serious and costly health problems.

C/THP-eligible children are allowed to receive services that are not available to the general Medicaid population if they are needed to treat identified conditions.

C/THP and related programs are managed by LDSS agencies with oversight by the Department of Health. Current Medicaid systems support includes:

- Participation (eligible) reports, fee-for-service reports by individual client, and reports required from managed care plans; these reports are provided in hard-copy form to the LDSS offices

- On-line access to current Management and Administrative Reporting (MAR) reports, monthly hard-copy MAR reports, claim detail reports, and Surveillance and Utilization Review (SUR) data, and ad hoc reports provided through the Office of Medicaid Management

- Fiscal agent support of provider training related to C/THP and related programs, along with provider relations support

The entry of detailed screening data into the MMIS was eliminated. While some of the children's programs do not use the EMEVS to track eligibility or participation, some of the waiver programs do use specific indicators on WMS.

7.10.2 Business Objectives

The primary business objectives of the automated C/THP function of the Replacement Medicaid System are to:

- Maintain identification of all individuals eligible for C/THP services.
- Establish automated procedures to support the initial notification of eligibles and periodic renotification of nonparticipants and participants about the availability of C/THP services.
- Provide reports to meet Federal and State reporting requirements.

7.10.3 Systems Requirements

Many states approach EPSDT program monitoring and tracking by requiring screening forms from the providers, which are entered into the Replacement Medicaid System and generate open records. These records are closed only when a claims payment is made matching the screening condition. New York State, in the earlier stages of the program, required screening forms. This approach requires careful definition of EPSDT program services to determine full compliance with Federal EPSDT participation percentages; many states, like New York State, have discontinued this approach based on the need to include all possible EPSDT services. A major disadvantage is the number of records that remain "unclosed" because of difficulties in matching claims payment with screening criteria. This requires a largely manual follow-up on the part of the LDSS offices. This has proved burdensome for smaller-volume states and would be unwieldy for New York State.

In lieu of an EPSDT tracking function, the C/THP function of the Replacement Medicaid System shall provide case management functionality, which can be used for individual and targeted case management. Automated interfaces shall be developed to automatically load case management data for global C/THP program participants.

7.10.3.1 Inputs

Inputs to the New York State C/THP function include:

7.10.3.1.1 Client demographics and program eligibility (in conjunction with the Client Eligibility Data Repository)

7.10.3.1.2 Periodicity schedules for ongoing notification

7.10.3.1.3 Paid claims and encounter data from the claims/encounter processing function

7.10.3.2 Processing Requirements

7.10.3.2.1 Provide on-line provider manuals for easy query and maintenance.

7.10.3.2.2 Provide bulletin boards or Internet data exchange to facilitate communication among providers, LDSS staff, and State staff.

7.10.3.2.3 Identify newly eligible or reinstated families, inform them about the availability of C/THP health screening and diagnostic services, and encourage them to participate.

7.10.3.2.4 Generate notices, based on the State periodicity requirements, to participating C/THP-eligible families; automatically generate initial notices to families about the availability of screening and treatment services.

7.10.3.2.5 Generate annual notices to non-participating, eligible families about C/THP services.

7.10.3.2.6 Maintain all C/THP program eligibility records, periodicity schedules, client notification and notification response dates, and screening dates.

7.10.3.2.7 Accept on-line updates of notification responses, screening information, and periodicity schedules.

7.10.3.2.8 Provide the capability to track abnormal conditions which were identified in medical screenings, on an individual, ad hoc basis.

7.10.3.2.9 Provide an on-line case management function to track treatment for specific individuals.

7.10.3.2.10 Provide on-line access to detailed service history for C/THP eligibles and participants of related programs.

7.10.3.3 Outputs

The C/THP function will produce the following outputs:

7.10.3.3.1 Reports to meet all Federal and State reporting requirements

7.10.3.3.2 Mandated Federal EPSDT report (HCFA-416)

7.10.3.3.3 On-line claims detail report information, accessible by client ID and by provider ID

7.10.3.4 Interfaces

The Replacement Medicaid System shall provide for communications and data exchange between the following systems and entities:

7.10.3.4.1 Communications and information exchange among the LDSS, the Department, and C/THP and related program providers, including electronic mail capabilities

7.10.3.4.2 Data interfaces with other State programs, including the statewide immunization tracking system

7.10.4 Performance Requirements

The contractor shall meet the following performance standards during operation of the C/THP and related programs function:

7.10.4.1 Provide access to the on-line case management system, Monday through Friday, from 7:00 a.m. to 6:00 p.m., Eastern time.

7.10.5 State Responsibilities

The Department or the LDSS agencies will perform the following responsibilities in support of the C/THP and related programs:

7.10.5.1 Provide information concerning covered services and referrals to clients and families or caregivers.

7.10.5.2 Monitor C/THP reports to ensure the effectiveness of the program.

7.10.5.3 Provide case management services for C/THP and related program participants.

7.10.6 Contractor Responsibilities

During operations of the Replacement Medicaid System, the contractor shall:

7.10.6.1 Operate and maintain the C/THP and related program components of the Replacement Medicaid System.

7.10.6.2 Maintain a file/database of services provided to program participants.

7.10.6.3 Prepare and verify all federally-mandated reports, as specified by the Department.

7.10.6.4 Maintain and provide on-line access to information on resources available to county LDSS agencies for the referral of C/THP clients.

7.11 Managed Care Support

7.11.1 Overview and Objectives

The New York State managed care program, The Partnership Program, was approved by the Department of Health and Human Services as a Section 1115 demonstration program on July 15, 1997. Prior to approval, enrollment of the AFDC and AFDC-related populations had begun on a voluntary basis in response to the Statewide Managed Care Act of 1991. The Act required LDSSs to develop Medicaid managed care programs over a five - (5-) year period, which would provide services to at least fifty percent (50%) of the Medicaid population. Two (2) mandatory Medicaid managed care programs were also implemented during this time, one in the southwest region of Brooklyn and the other in Westchester County. As of July 1, 1997, 653,308 Medicaid clients were enrolled in managed care.

The Partnership Plan will build upon the efforts of the voluntary managed care programs developed in forty-three (43) of the State's fifty-eight (58) local districts and will expand mandatory managed care into all regions of the state with sufficient managed care capacity. It is expected that the number of Medicaid clients enrolled in managed care will increase to 1.7 million (seventy-four percent [74%] of eligible clients) as The Partnership Plan is implemented. The program will initially be restricted to AFDC, AFDC-related, and Home Relief clients and will be implemented in five (5) thirteen-(13-) month phases on a county-by-county basis. MCOs are contracted on the local district level and are required to offer a comprehensive benefits package, including primary, preventive, and acute care services covered under the Medicaid program.

Mandatory enrollment of the SSI and SSI-related populations is expected to begin implementation on a county-by-county basis starting on October 1, 1998. However, under The Partnership Program, certain special needs populations may be eligible for exemption from mainstream MCOs at the discretion of the local districts. These populations include foster care children in involuntary placement, the Medicare/Medicaid dual-eligible, homeless populations, the developmentally disabled, and the severely chemically dependent. Furthermore, Special Needs Plans (SNPs) will be developed for individuals with HIV/AIDS and Seriously and Persistently Mentally Ill (SPMI) adults and Seriously Emotionally Disturbed (SED) children. The SNPs will be specifically designed to meet the particular needs of the HIV/AIDS and mentally ill populations.

7.11.2 Business Objectives

It is the vision of OMC that "New York State will have the healthiest and most satisfied health care consumers in the world. As a result of greater efficiencies achieved through managed care, all New York State residents will have universal access to a managed care system that provides demonstrated high quality in a cost-effective environment."

In order to meet this goal, the State has undergone a significant reorganization to better coordinate all managed care and Medicaid activities under the auspices of the Department of Health. All managed care functions have now been centralized at OMC, which is under the authority of the Commissioner of Health. It is OMC which retains overall responsibility for the administration of The Partnership Program, including program design, implementation, and oversight. The Office of Medicaid Management is

responsible for claims processing, fair hearings, and eligibility standards and policy.

Much of the operational activities for Managed Care business functions are performed at the local district level and will be outside of the scope of the new fiscal agent contract. The LDSS are responsible for eligibility determinations, education and enrollment, and contracting and oversight of MCOs. The State Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and Office of Alcoholism and Substance Abuse Services will continue their roles of establishing policy, developing standards, and coordinating care for their target populations.

7.11.3 System Requirements

The managed care system requirements for the Replacement Medicaid System are intended to centralize processing for functions which are currently handled by several different systems. The objective for the managed care system is to accurately process enrollments, disenrollments, provider network affiliations, capitation payments, and encounter claims in an integrated manner. The WMS will still be used to accept enrollment data from the counties and will transmit enrollment information to the Department.

OMC has begun implementation of a Managed Care Systems Enhancement Project to upgrade the individual components of the current managed care system. The functionality attained by these projects should be incorporated into the new system design. The project has six (6) subcomponents:

- Services/Medical Assistance Interface (SERMA)
- PCP file - Allows any day enrollment and ability to carry more than one (1) managed care plan
- Enrollment/Disenrollment - Allows daily enrollment and disenrollment in more than one (1) plan at a time
- Stop/Loss - Allows auto-claims submission and auto-attachments
- Claims Processing - Incorporates referrals and changes to pay managed care and out of plan fee-for-service claims based on the eligibility and Scope of Benefits file

- Reporting - Allows capture of month, day, year of birth, and geocoding

The new system must be able to accept and process encounter claims to be used in developing federally required reports. Additional analysis of managed care data, such as cost and utilization data and quality and performance indicators, will be handled through the managed care data warehouse being developed by OMC. The new system will be required to interface with the managed care data warehouse and transmit encounter data.

7.11.3.1 Inputs

The Managed Care Support function of the Replacement Medicaid System shall accept the following inputs:

7.11.3.1.1 All current data elements and new elements as needed

7.11.3.1.2 Encounter data

7.11.3.1.3 Future encounter data with fields for HIV/AIDS and Mental Health Special Need Plan initiatives

7.11.3.1.4 Exact month, day, and year values for client dates of birth

7.11.3.1.5 All values for enrollment and disenrollment and codes determined by OMC

7.11.3.1.6 Changes in client MCO enrollment from the WMS

7.11.3.1.7 All provider numbers, including numbers assigned to non-Medicaid managed care providers

7.11.3.1.8 All data elements necessary to calculate capitation rates

7.11.3.1.9 Test encounter data from new managed care plans

7.11.3.2 Processing Requirements

In order to meet the business objectives of the Managed Care Support function, the Replacement Medicaid System must have the following capabilities:

7.11.3.2.1 Process disenrollments through the WMS PCP subsystem, retroactive to the first day of the month in which the disenrollment should have been effective.

7.11.3.2.2 Process enrollments and disenrollments using State-supplied reason codes.

7.11.3.2.3 Update enrollment rosters daily and publish twice a month.

7.11.3.2.4 Process newborn enrollments to be effective on the newborn's date of birth.

7.11.3.2.5 Cleanse MCO encounter data according to specifications set out by OMC for transmittal to the data warehouse.

7.11.3.2.6 Maintain complete and up-to-date ICD-9, CPT-4/HCPCS, and NDC master files for encounter processing.

7.11.3.2.7 Process encounter claims daily.

7.11.3.2.8 Maintain edit logic to prevent duplication of capitation and fee-for-service payments for services covered under the managed care program.

7.11.3.2.9 Maintain edit logic to recognize once a managed care benefit threshold has been reached, and pay subsequent claims on a fee-for-service basis.

7.11.3.2.10 Calculate prorated and monthly capitation payments.

7.11.3.2.11 Provide the capability to make retroactive premium payments for the period between birth and enrollment of newborns.

7.11.3.2.12 Maintain payment data which shows payment amount per plan, per client, per client eligibility category, and benefit package.

7.11.3.2.13 Identify all covered client services and benefits and provide enhanced messaging through the POS system to verify and authorize benefits.

7.11.3.2.14 Link providers to participating MCOs and group practices.

7.11.3.2.15 Maintain automated capability to process off-line adjustments

7.11.3.3 Outputs

The Replacement Medicaid System must provide the following outputs in support of the Managed Care program:

7.11.3.3.1 Full and prorated capitation fees

7.11.3.3.2 Encounter data to OMC's data warehouse

7.11.3.3.3 Enrollment rosters twice a month delivered to the bulletin board specified by the Department

7.11.3.3.4 All federally required managed care reports

7.11.3.3.5 Payment report showing amounts paid to plan in total, per client, and per client category of eligibility

7.11.3.3.6 All reports that are currently produced

7.11.3.4 Interfaces

In support of the New York Managed Care program, the Replacement Medicaid System must exchange data with the following systems and entities:

7.11.3.4.1 Accept managed care eligibility and health plan enrollment data from the WMS.

7.11.3.4.2 Provide interface to enrollment broker to accept client enrollment data.

7.11.3.4.3 Accept client enrollment data directly from health plans.

7.11.4 Performance Standards

Performance standards for the Managed Care business area are intended to focus on key operational processes that will enable program managers to ensure access to services and quality of care for Medicaid clients.

7.11.4.1 Conduct daily updates of member enrollments and disenrollments.

7.11.4.2 Process encounter claims daily and provide results on the provider bulletin board or Web site.

7.11.4.3 Process test encounter claims daily and provide results on the provider bulletin board or Web site.

7.11.5 State Responsibilities

The Department will perform the following responsibilities in connection of the operation of the Managed Care Support function:

7.11.5.1 Promulgate regulations, as necessary, to establish policy for managed care programs.

7.11.5.2 Establish guidelines and standards for the local districts; monitor and provide technical assistance to local district managed care activities.

7.11.5.3 Assume responsibility for oversight of enrollment activities at the local district level, including identification of individuals excluded/exempted from managed care.

7.11.5.4 Maintain responsibility for oversight of the collection and data entry, or electronic transfer, of enrollment forms at the local district level.

7.11.5.5 Perform automatic assignments of eligible managed care clients to an MCO if the client has not chosen a MCO within sixty (60) days of eligibility

determination. Autoassignments will be transmitted to the Replacement Medicaid System.

7.11.5.6 Assume oversight responsibility for outreach and consumer education at the local district level, through existing staff or the State-contracted enrollment broker.

7.11.5.7 Enroll MCOs into The Partnership Plan and generate confirmation letters to the MCO and the Department.

7.11.5.8 Develop and monitor consumer hotlines at both the State and local district levels.

7.11.5.9 Prepare, produce, and distribute Managed Care operational protocol for managed care programs to be used by local district staff, MCOs, contractor staff, and State staff.

7.11.5.10 Review and approve the methodology for assigning MCO capitation rates to enrolled clients; validate that the correct capitation rate for each rate cell for each MCO is correctly loaded into the system.

7.11.5.11 Generate, update, and adjust capitation payments when necessary.

7.11.5.12 Develop and administer a statewide standardized survey of client satisfaction with MCO care.

7.11.5.13 Conduct analyses of managed care cost, utilization, and quality data.

7.11.6 Contractor Responsibilities

In support of the New York Managed Care program, the contractor shall:

7.11.6.1 Load and verify State-approved capitation rates into the appropriate rate cells for each MCO.

7.11.6.2 Generate, and adjust when necessary, capitation payments.

7.11.6.3 Monitor and report on reasons for disenrollment.

7.11.6.4 Generate monthly lists of plan-specific PCPs for use by clients in choosing a PCP.

7.11.6.5 Generate monthly lists of all specialists, facilities, and ancillary providers participating within each network for use by clients in choosing a PCP.

7.11.6.6 Provide monthly listing to MCOs of known TPR resources for their enrolled clients.

7.11.6.7 Accept and process encounter claims on a daily basis.

7.11.6.8 Generate reports on MCO compliance with encounter claims submission.

7.11.6.9 Generate reports from encounter data on MCO compliance with C/THP indicators.

7.11.6.10 Maintain a process to coordinate, review, and process payments to MCOs for eligible clients reaching an established stop-loss threshold.

7.11.6.11 Verify that data is being transmitted correctly from the Replacement Medicaid System to OMC's data warehouse.

7.11.6.12 Implement policy changes which affect the Replacement Medicaid System within a time frame agreed to with the Department.

7.12 Drug Rebate

7.12.1 Overview

The Drug Rebate program is intended to ensure compliance with the Health Care Financing Administration's (HCFA) drug rebate program which was established under the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). Under the Drug Rebate program, drug manufacturers must sign rebate agreements with HCFA and with state Medicaid agencies in order for their covered outpatient drugs to be reimbursed under a state's Medicaid program. Per-unit rebate amounts are determined by HCFA and distributed to states electronically or on tape. The Medicaid program invoices drug manufacturers quarterly to collect rebates on the amount of pharmaceuticals dispensed to Medicaid clients.

The New York Drug Rebate system will need to capture and maintain data associated with drug rebate agreements between HCFA and drug manufacturers and provide the capability to:

- Summarize utilization of pharmaceutical products to determine appropriate rebates for drug manufacturers.
- Create manufacturer's/labeler's invoices based on the amount of the rebate.
- Collect payments and track accounts receivable.
- Resolve disputes with drug manufacturers/labelers.
- Maintain an accounts receivable subledger that includes the original invoice amount, units claimed/disputed, units paid, paid amount, corrections, and balance due.

7.12.2 Business Objectives

The primary objective of the Drug Rebate business area is to invoice and collect financial rebates, in a timely manner, from drug manufacturers and labelers that have signed a rebate agreement with HCFA that allows them to receive payment for dispensing products to Medicaid clients.

7.12.3 System Requirements

The New York Replacement Medicaid System shall provide the following system capabilities in order to meet the Department's objectives.

7.12.3.1 Inputs

The inputs to the Drug Rebate function are:

7.12.3.1.1 Drug rebate files from HCFA

7.12.3.1.2 Claim data

7.12.3.1.3 Payments from manufacturers/labelers

7.12.3.2 Processing Requirements

The processing requirements for the Drug Rebate function shall include the following:

7.12.3.2.1 Capture and maintain data associated with drug rebate agreements between HCFA and drug manufacturers.

7.12.3.2.2 Summarize utilization of pharmaceutical products to determine appropriate rebates from drug manufacturers.

7.12.3.2.3 Provide the capability to exclude disproportionate-share providers from drug rebate information processing based on Department-defined criteria.

7.12.3.2.4 Calculate rebate amounts due from each manufacturer.

7.12.3.2.5 Maintain an accounts receivable ledger that includes the original invoice amount, paid amount (including any accrued interest), units invoiced and units paid, corrections, and balance due to NDC level.

7.12.3.2.6 Create and mail invoices based on the amount of the rebate and tracking of correspondence related to rebate activity.

7.12.3.2.7 Generate rebate invoice reports.

7.12.3.2.8 Follow HCFA requirements regarding tracking and resolution of rebates/disputes based on units.

7.12.3.3 Outputs

The outputs to the Drug Rebate function are:

7.12.3.3.1 Invoices to manufacturers/copy of invoices to the Department

7.12.3.3.2 HCFA rebate information on-line

7.12.3.3.3 Accounts receivable information on-line

7.12.3.3.4 Drug rebate reports (for the Department and manufacturers)

7.12.3.3.5 Reports and bills to manufacturers on rebate details and amounts due

7.12.3.3.6 Reports to track rebate recoveries

7.12.3.3.7 Detail drug claims listing reports

7.12.3.3.8 Invoice cover letters

7.12.3.3.9 Invoice follow-up letters

7.12.3.3.10 Collection letters

7.12.3.3.11 Drug rebate dispute spreadsheets and reports

7.12.3.3.12 Report on prescriptions questioned for a disputed NDC and prescriptions that resulted in adjustments

7.12.3.3.13 Report on drug rebate dispute claim discrepancies/adjustments on utilization by quarter

7.12.3.3.14 Updated utilization summaries on disputed products with State-specified information

7.12.3.3.15 Periodic reports on current and past accounts receivable information for each drug manufacturer

7.12.3.3.16 Reports on payment discrepancies and disputes with manufacturers

7.12.3.3.17 Report on drugs excluded from the drug rebate invoice process

7.12.3.3.18 Billing history reports by quarter by NDC

7.12.3.3.19 Billing history reports by quarter for all drugs

7.12.3.3.20 Billing history reports by quarter by labeler

7.12.3.3.21 Billing history reports by quarter by manufacturer

7.12.3.3.22 Dispute reports by manufacturer, by quarter, by NDC, that may be sent to manufacturers

7.12.3.3.23 Monthly balancing reports

7.12.3.3.24 Summary reports to assist in the preparation of the quarterly HCFA-64 reports and schedules (e.g., pending drug rebates at the beginning of the quarter, the amounts of rebates computed for each drug labeler, amounts written off, other

adjustments [including any accrued interest], amounts collected, and remaining pending drug rebates at the end of the quarter)

7.12.3.4 Interfaces

The Drug Rebate function establishes and maintains interfaces with:

7.12.3.4.1 HCFA for the quarterly tape

7.12.3.4.2 Drug manufacturers and labelers for recoupment and for dispute resolution

7.12.3.4.3 Interface with the EPIC program to coordinate drug rebate collection and billing

7.12.4 Performance Standards

This subsection presents the performance standards for the Drug Rebate business function.

7.12.4.1 Load and process the HCFA Drug Rebate tape within five (5) calendar days of receipt.

7.12.4.2 Prepare and mail invoices for all rebate amounts identified within fifteen (15) business days of receiving the HCFA drug rebate tape.

7.12.4.3 Collect ninety percent (90%) of the dollar amount of rebates invoiced by the end of the fiscal quarter following the period for which the rebate was issued.

7.12.4.4 Require drug utilization tape and letter to be returned to HCFA within thirty (30) calendar days of receipt of original tape from HCFA.

7.12.5 State Responsibilities

Operational State responsibilities for the Drug Rebate business function are as follows:

7.12.5.1 When necessary, arrange for receipt of rebate-related information from HCFA and forward to the contractor.

7.12.5.2 Review and approve the format used by the contractor for correspondence sent to drug manufacturers.

7.12.5.3 Receive and respond to all inquiries from manufacturers or their authorized representatives regarding Medicaid drug coverage policies, drug reimbursement status, and other issues.

7.12.5.4 Perform all aspects of the formalized dispute resolution process in accordance with HCFA guidelines and dictates.

7.12.5.5 Take primary responsibility for resolving cases of formal appeal of a rebate invoice by a manufacturer.

7.12.5.6 Interpret HCFA guidelines for the drug rebate process.

7.12.6 Contractor Responsibilities

Operational contractor responsibilities for the Drug Rebate business function are as follows:

7.12.6.1 Receive, load, and process all rebate information from HCFA and the Department.

7.12.6.2 Generate and mail rebate invoices to manufacturers quarterly.

7.12.6.3 Calculate rebate amount and assess interest.

7.12.6.4 Develop and receive Department approval for correspondence sent to the manufacturers.

7.12.6.5 Receive payments from drug manufacturers and apply payments to outstanding accounts receivable.

7.12.6.6 Process prior-period adjustments.

7.12.6.7 Invoice and receive payments from manufacturers electronically, when possible.

7.12.6.8 Produce and send to HCFA the required drug utilization tape and letter within thirty (30) days of receipt of the original tape from HCFA.

7.12.6.9 Generate reports to support management and monitoring of drug rebate accounts.

7.12.6.10 Provide information to the Department to use in the dispute resolution process (i.e., ZIP code, disproportionate-share providers listing, provider and client data to the prescription level).

7.12.6.11 Provide interaction with, and provide technical support to, the State staff involved in rebate issues.

7.12.6.12 Meet with the State staff on a regular basis (at least twice per month as required) regarding Drug Rebate issues and objectives. The contractor shall be responsible for coordinating the meetings with appropriate Department staff and distributing an agenda prior to each scheduled meeting and for distributing meeting minutes to all participants.

7.12.6.13 Establish an accounts receivable (dollars and units) for invoices dated back to 1991.

7.13 Surveillance and Utilization Review (SUR)

The Department has a considerable investment in the Surveillance and Utilization Review Subsystem that is in the current MMIS. The Department has further determined that the SUR components of potential transfer bases will not meet the needs of the users of the SUR component. Therefore, the Department requires the contractor to take over and operate the existing SUR Subsystem.

Detailed documentation on the existing SURS can be found in the Procurement Library. Specifically, the following documents present the overview and technical details of the New York State SURS:

- SURS Monthly, Volumes I and II
- SURS Quarterly, Volumes I, II, and III
- On-Line MAR/SUR Subsystem (OLMS), Volumes I and II
- Explanation of Medical Benefits and Claim Detail Special Reporting System (EOMB and CDSR)

The contractor shall develop an interface from the relevant Replacement Medicaid System components to support the existing SURS operations and shall meet the performance standards specified in Appendix E.

The contractor shall:

- Maintain a sixty (60) month rolling On-Line SURS current history file.
- Maintain ten (10) years of SUR Annual Claim files.

7.14 Prospective Drug Utilization Review (ProDUR)

7.14.1 Overview

The prospective component of the DUR system alerts Medicaid Pharmacy Providers to potential problems with the drug for the client via accessing the client's drug profile (created from previous ProDUR transactions) and processing them against a drug database. ProDUR can prevent the dispensing of inappropriate drugs through direct intervention by the pharmacist. POS drug data is screened against preestablished criteria, and a DUR rejection or warning ("alert") to the pharmacist is instantly issued. This will provide safety for the client and allow the Department to decrease costs by reducing and/or eliminating:

- The excessive utilization of drugs
- Adverse drug interactions and additional physician visits and/or hospital stays
- Therapeutic duplications (drugs within the same therapeutic class or two [2] different doses of the same drug)
- Incorrect drug dosages
- Drug-age conflicts
- Drug-pregnancy conflicts
- Drug-disease contraindications
- Others, as user needs define

The ProDUR system will be made available to providers through PC dial-in or CPU-to-CPU interface as is currently available in the EMEVS.

The Prospective DUR Provider Manual is in the Procurement Library.

7.14.2 Business Objectives

The primary business objective for the DUR function is to eliminate unnecessary and/or inappropriate use of drugs and reduce the potential for abuse. It helps to identify possible inappropriate drug therapy problems, thereby ensuring greater client safety and curtailing unnecessary drug and inpatient hospital costs due to adverse drug outcomes.

7.14.3 System Requirements

Offerors will be required to subcontract with a Department-approved ProDUR contractor for providing alert criteria.

The specific system requirements in the following paragraphs focus on ProDUR requirements. Offerors should analyze these requirements in conjunction with the requirements for Electronic Commerce in Section 7.5 and the requirements for Claims and Encounter Processing in Section 7.6. The new system shall meet or exceed the capabilities of the existing EMEVS so that the technical documentation in the On-Line Systems Manual, the EMEVS Subsystem Manual, and the ProDUR User Manual, which are available in the Procurement Library, is also important.

7.14.3.1 Inputs

The ProDUR component of the Replacement Medicaid System must accommodate the following inputs:

7.14.3.1.1 Criteria sets and modules for therapeutic and drug alerts from ProDUR contractor

7.14.3.1.2 Drug claims history (both paid and denied)

7.14.3.1.3 Point-of-service drug claims and encounter records

7.14.3.1.4 The Department's Formulary file

7.14.3.1.5 Other Reference files

7.14.3.2 Processing Requirements

The ProDUR component of the Replacement Medicaid System must have the following capabilities:

7.14.3.2.1 Provide updated alerts through the interactive/real-time POS system for the entire time period during which the POS system is operational.

7.14.3.2.2 Generate ProDUR interactive/real-time alerts to pharmacists, at POS terminals, in the following areas, as currently defined by HCFA requirements:

- Drug-drug interaction
- Therapeutic duplication
- Overutilization
- Drug-age
- High-dose
- Low-dose
- Drug-pregnancy

- Drug-disease
- Early refill
- Others as user needs define

7.14.3.2.3 Create client drug history profiles from three (3) months of POS transactions submitted and historical paid claims data.

7.14.3.2.4 Receive and maintain a DUR database with associated DUR processing algorithms to allow prospective DUR processing. Provide the capability of receiving updates to both the database and algorithms on a monthly basis.

7.14.3.2.5 Provide for processing up to four (4) transactions per claim.

7.14.3.2.6 Capture the claim for adjudication purposes.

7.14.3.3 Outputs

The ProDUR component of the Replacement Medicaid System must provide the following outputs:

7.14.3.3.1 Drug history profile reports

7.14.3.3.2 Therapeutic class reports

7.14.3.3.3 Diagnosis code reports

7.14.3.3.4 Retrospective reports on client drug usage patterns

7.14.3.3.5 Claims, DUR, and service authorization

7.14.3.3.6 Client reports by number and type of alert generated by date of service, Drug, and other user-defined criteria

7.14.3.3.7 Provider profiling reports based on prescribing patterns by drug, demographic and other sort capabilities as designated by the Department

7.14.3.3.8 ProDUR Alert Reports on the generic drug level

7.14.3.3.9 Reports to meet all Federal and State reporting requirements

7.14.3.4 Interfaces

The Replacement Medicaid System must support data exchanges with the following systems and entities:

7.14.3.4.1 Obtain DUR modules and drug database from the ProDUR subcontractor (currently First Data Bank).

7.14.4 Performance Standards

The Prospective DUR component shall meet the response times specified in Section 11.10.2.3.3.

7.14.5 State Responsibilities

The Department will perform the following responsibilities with respect to the ProDUR function:

7.14.5.1 Perform prospective DUR activities, including related analysis, review, corrective action, and follow-up activities. Oversee all changes to the ProDUR system.

7.14.5.2 Work in conjunction with the DUR Board to define specific requirements for DUR standards and criteria sets.

7.14.5.3 Identify practitioners to be profiled using vendor software.

7.14.5.4 Request and approve modifications of reports to meet State and Federal requirements.

7.14.5.5 Communicate necessary information and policies between the DUR Board, the SUR unit, the State Medicaid Fraud Control Unit, the State, and any other required agency or body, on a regular basis.

7.14.6 Contractor Responsibilities

During the operational period of the Replacement Medicaid System, the contractor shall:

7.14.6.1 Generate reports listing the number of alerts, by alert type and number, in descending order, that are triggered by individual providers. Include the provider's name, address, and phone number.

7.14.6.2 Provide currently defined DUR outputs, including necessary information for the State's Annual Report to HCFA.

7.14.6.3 Update the database with various input Reference files within the time frame specified by the Department. This includes updating the Department formulary file monthly, or as needed.

7.14.6.4 Accept changes to DUR criteria from the DUR Board via the Department not less than monthly.

7.14.6.5 Participate in monthly vendor-state systems and program staff conference call to assess the systems status of changes to current processing.

7.15 Retrospective Drug Utilization Review

7.15.1 Overview

The objective of the Retrospective Drug Utilization Review System is to support a user-friendly, PC-based or minicomputer-based system to ensure quality and integrity in the prescribing, dispensing, and utilization of pharmaceuticals to New York State Medicaid clients, thereby enhancing and ensuring cost-effectiveness.

The system shall use the following criteria to develop and prioritize profile alerts:

- Drug-drug interaction
- Therapeutic duplication

- Overutilization
- Drug-age
- High-dose
- Low-dose
- Drug-pregnancy
- Drug-disease
- Early refill
- Others as user needs define

RetroDUR provides a methodology to monitor patterns of prescribing, dispensing, and utilization of Medicaid-reimbursed drugs through retrospective analysis of drug history data. The New York Medicaid DUR Board approves RetroDUR criteria that are used in the retrospective review of the Medicaid drug history data.

The program will assess drug history data on drug use against predetermined standards and criteria consistent with the following compendia:

- United States Pharmacopeia - Drug Information
- American Hospital Formulary Service Drug Information
- American Medical Association Drug Evaluations
- Drugdex System (Micromedex)

The contractor will subcontract with the successful RetroDUR vendor to purchase the computer capacity, hardware, and software necessary to continue all RetroDUR operations for New York State.

The contractor evolution staff will work with the RetroDUR vendor so that the history file can be used by this Retro software.

7.15.2 Business Objectives

The primary business objective for the DUR function is to eliminate unnecessary and/or inappropriate use of drugs and help identify possible inappropriate drug therapy problems, thereby ensuring greater client safety and curtailing unnecessary drug and inpatient hospital costs due to adverse drug outcomes.

7.15.3 System Requirements

The RetroDUR component of the Replacement Medicaid System must provide at a minimum all of the capabilities currently provided by the incumbent contractor's RetroDUR subcontractor, Pharmark Corporation.

7.15.3.1 Inputs

The RetroDUR component of the Replacement Medicaid System must accommodate the following inputs:

7.15.3.1.1 Criteria sets for therapeutic and drug alerts from ProDUR contractor

7.15.3.1.2 Drug claims history (both paid and denied)

7.15.3.1.3 Point-of-service drug claims and encounter records in the NCPDP 3.2 format

7.15.3.2 Processing Requirements

The RetroDUR component of the Replacement Medicaid System must have the following capabilities:

7.15.3.2.1 Generate alert reports for the Department in the following areas:

- Therapeutic duplication
- Drug-to-drug interaction
- Drug-to-disease precaution
- Drug-to-pregnancy alert

- Drug-to-age precaution
- High-dose
- Low-dose
- Early refill warning
- Others as user needs define

7.15.3.2.2 Generate client RetroDUR profiles for the Department using specialized software to detect and prioritize cases by risk of adverse outcomes including hospitalizations. The following criteria must be utilized in the software package.

- Drug-to-drug interaction
- Therapeutic duplication
- Overutilization
- Drug to age
- High-dose
- Low-dose
- Drug to pregnancy
- Drug to disease
- Other criteria specified by HCFA
- Early refill
- Temporality, duration, and proximity data
- Others as user needs define

7.15.3.2.3 Create client drug history profiles from submitted and drug history data.

Outcomes-Based Profile Review

7.15.3.2.4 Provide the capability to profile recipients based on an algorithm that takes into account the increased likelihood of hospitalizations if the problematic drug therapy is allowed to occur.

7.15.3.2.5 Provide the capability to create a severity index by using a relative ranking among clients exhibiting drug therapy conflicts, including factors such as age, sex, co-morbidities, and multiple number of providers all within a user-predefined time frame.

7.15.3.2.6 Provide the capability to create user-defined class groups for specific drugs, diseases, and co-morbidities.

7.15.3.2.7 Provide the capability to change variables on an ad hoc, month-to-month basis.

Ad Hoc Pharmaco-Epidemiologic Reports (Pharmaco-Economic Subsystem)

7.15.3.2.8 Provide a comprehensive set of drug or disease cost analysis function that enables costs to be isolated either to very specific prescription/diagnosis/ treatment relationships or broadly defined over a diverse disease/condition/ syndrome period.

7.15.3.2.9 Provide access to a monthly claim file by patient age, sex, eligibility, demographic, prescription, diagnosis, and covariant event/economic indications.

7.15.3.2.10 Provide the capability to pair drug and disease within a study. Multiple indicators, prescriptions, diagnosis, and without conditions must be functionalities of the system.

Provider Profile Capabilities (Provider Profiling)

7.15.3.2.11 Create provider dispensing history profile from drug record data. Key elements for identifying providers are the provider ID and the provider specialty. Therefore, cases with providers that have more than one ID number must be linked. Users select these data elements to generate provider reports as needed.

7.15.3.3 Outputs

The RetroDUR component of the Replacement Medicaid System must provide the following outputs:

7.15.3.3.1 Drug history profile reports ranked by adverse risk and outcome probability

7.15.3.3.2 Therapeutic class reports

7.15.3.3.3 Diagnosis and procedure code reports

7.15.3.3.4 Risk rank reports by disease, drug, client, county, provider, and prescriber

7.15.3.3.5 Therapeutic class, NDC, client, and provider reports

7.15.3.3.6 Reports on client drug usage patterns

7.15.3.3.7 Provider dispensing profile reports

7.15.3.3.8 Client utilization reports

7.15.3.3.9 Annual HCFA report

7.15.3.3.10 Reports to meet all Federal and State reporting requirements

7.15.3.4 Interfaces

The Replacement Medicaid System must support data exchanges with the following systems and entities:

7.15.3.4.1 Obtain modules and the drug database from the RetroDUR contractor.

7.15.3.4.2 Provide claims data and drug criteria to the RetroDUR contractor.

7.15.4 Performance Standards

The RetroDUR component of the Replacement Medicaid System must meet the following performance standards:

7.15.4.1 Update the database monthly to ensure that new drugs are added appropriately.

7.15.4.2 Deliver DUR reports and outputs within the time frame specified by the State.

7.15.5 State Responsibilities

The Department will perform the following responsibilities with respect to the RetroDUR function:

7.15.5.1 Perform RetroDUR activities, including DUR systems capabilities to perform related analysis, review, corrective action, and follow-up activities.

7.15.5.2 Work in conjunction with the DUR Board to define specific requirements for DUR standards and criteria sets.

7.15.5.3 Identify practitioners to be profiled using vendor software.

7.15.5.4 Request and approve modifications of reports to meet State and Federal requirements.

7.15.5.6 Communicate necessary information and policies between the DUR Board, the SUR unit, the State Medicaid Fraud Control Unit, the Department, and any other required agency or body on a regular basis.

7.15.5.7 Submit DUR criteria modifications to the contractor.

7.15.6 Contractor Responsibilities

During the operational period of the Replacement Medicaid System, the contractor shall:

7.1.5.6.1 Update the software using the most current reference files for the entire time period during which the profiles are generated.

7.15.6.2 Generate Federally required reports using the most current software and updated algorithm.

7.15.6.3 Generate reports listing the number of alerts, by alert type and number, in descending order, that are triggered by individual providers. Include the provider's name, address, and phone number.

7.15.6.4 Generate patient profiles and provider alert letters monthly using user-defined parameters.

7.15.6.5 Accept changes to DUR criteria from the Department for the DUR Board.

7.15.6.6 Participate in periodic DUR board meetings.

7.15.6.7 Participate in monthly status telephone calls to assess the systems status of changes/modifications to the current processing.

7.15.6.8 Provide user-defined DUR outputs, including necessary information for the State's Annual Report to HCFA.

7.16 Systems Operations and Integrated Test Facility

7.16.1 Overview

To ensure that the New York State Medicaid program operates according to Federal and State regulations, it is imperative that the contractor maintain a system operational environment that ensures:

- Accurate, complete, and timely system processing
- Availability to systems applications and telecommunications during hours specified by the Department
- Fully-tested system changes prior to implementation in the production environment

This section presents operations responsibilities for system operations and maintaining an integrated test environment.

System Operations

System operations encompass the activities performed by the contractor to execute Replacement Medicaid System processing and reporting cycles; maintain internal controls; and perform routine back-up of programs, tables, and files.

Integrated Test Facility

The integrated test facility (ITF) is an environment to implement system changes during operations while ensuring quality control is maintained. The environment includes a test (mirror) version of on-line and batch programs and system files that are identical to the production environment. The ITF allows the Department to monitor the accuracy of the Replacement Medicaid System and to test changes to the system before promotion to the production system by processing test data and other transactions through the system without affecting normal operations.

7.16.2 Business Objective

The business objective is to provide systems that effectively and consistently meet processing requirements to support the operational business activities of the Medicaid program.

7.16.3 System Requirements

The business objective must be supported by the following automated features within the Replacement Medicaid System.

7.16.3.1 Inputs

The inputs to the integrated test facility function are:

7.16.3.1.1 Test claims (all claim types) and other test transactions

7.16.3.1.2 Test clients

7.16.3.1.3 Test providers

7.16.3.2 Processing Requirements

The Systems Operations/ITF function must be supported by a Replacement Medicaid System with the capabilities to:

7.16.3.2.1 Generate reports to support system operations.

7.16.3.2.2 Transmit files and data through automated processes.

7.16.3.2.3 Maintain an ITF.

7.16.3.3 Outputs

The outputs of the ITF business function are:

7.16.3.3.1 Claims processing output from the ITF claims processing runs, to include reports, files, tapes, micromedia, etc.

7.16.3.3.2 Reports of the results of ITF cycles

7.16.3.4 Interfaces

No interfaces have been identified for the ITF function.

7.16.4 Performance Standards

This subsection presents the performance standards for the Systems Operations and ITF business function.

7.16.4.1 Execute cycles in accordance with established schedules.

7.16.4.2 Maintain and back up daily all data and software.

7.16.4.3 Support immediate restoration and recovery of lost or corrupted data or software.

7.16.4.4 Establish and maintain in electronic format a weekly back-up that is adequate and secure for all computer software and operating programs; tables; files; and system, operations, and user documentation.

7.16.4.5 Establish and maintain in electronic format a daily back-up that is adequate and secure for all computer software and operating programs, tables; files; and systems, operations, and user documentation.

7.16.4.6 Provide test outputs within the time periods determined by the Department.

7.16.4.7 Provide a written report before production promotions, in a Department-approved format, on the results of integrated test cycles within seven (7) business days of running the cycles and include a comparison of the expected impact of edit and pricing changes against actual processing results.

7.16.4.8 Produce, review, and submit, by noon the next business day, control reports generated for each test update and processing cycle run.

7.16.5 State Responsibilities

Operations responsibilities for the System Operations and ITF business function are presented below.

System Operations

7.16.5.1 Monitor the contractor's daily operation of the Replacement Medicaid System and supporting functions.

7.16.5.2 Monitor the contractor's file maintenance process to ensure integrity of the files.

Integrated Test Facility

7.16.5.3 Use the ITF to monitor test and operations activities by submitting test inputs, modifying test files, and reviewing system outputs.

7.16.5.4 Review and approve test results prior to the contractor promoting changes to production.

7.16.5.5 Attend contractor walk-throughs to validate test case and test case results for accuracy and quality.

7.16.6 Contractor Responsibilities

System Operations

7.16.6.1 Maintain and operate the Replacement Medicaid System according to Department-approved requirements.

7.16.6.2 Establish and adhere to processing schedule requirements as specified by the Department.

7.16.6.3 Provide system and application availability according to specifications established by the Department.

7.16.6.4 Provide availability of on-line access to the Replacement Medicaid System to other State agencies and contractors as specified by the Department.

7.16.6.5 Perform internal control reviews on the Replacement Medicaid System operations, notify the Department of any deficiencies found, and correct the deficiencies identified through the reviews.

7.16.6.6 The contractor will embed audit routines into the production version of the Replacement Medicaid System as directed by the Office of the State Comptroller. In addition, the contractor shall provide audit software packages necessary for accessing the Replacement Medicaid System and provide access, training and manuals to Department and OSC personnel.

Integrated Test Facility

7.16.6.7 Operate and maintain a complete and current on-line test system, including a test version of batch and on-line programs and test tables and files.

7.16.6.8 Identify providers, recipients, and claims used for testing to maintain the integrity of routine claims processing operations and files.

7.16.6.9 Generate test output, including tables, files, reports, tapes, and micromedia. Output shall be separately identified and clearly labeled. Test outputs shall be separate from routine Replacement Medicaid System outputs and available to the Department during business hours without notice.

7.16.6.10 Perform claims processing in a simulated production environment.

7.16.6.11 Provide the Department with on-line access to the ITF and test tables and files to submit test data independently without notice to the contractor.

7.16.6.12 Accept test claims data submitted by the Department, without notice to the contractor, on hard-copy or electronic media.

7.16.6.13 Report on the results of test cycles, including the expected impact of edit and pricing changes and compare those results to the actual processing results.

7.16.6.14 Initiate and conduct walk-throughs of system test changes that are ready to be moved into the production environment. Walk-throughs of test cases and results shall include a discussion of programs that are impacted by the system change. The contractor shall include an on-line demonstration verifying the accuracy of system changes and handouts of test results. Walk-through materials will be available for Department review after the walk-through. Walk-throughs will be conducted for system changes involving major modifications or where a significant number of programs and/or files are modified or at the Department's discretion.

7.16.6.15 Develop and execute Department-approved test cases for system changes.

7.16.6.16 Maintain ITF functions, tables, files, and data elements necessary to meet Department requirements and simulate production.

7.16.6.17 Produce and review control reports generated for each test update and processing cycle.

7.17 Management and Administrative Reporting (MAR)

The Department intends to migrate all analytical reporting to the data warehouse when it is complete. However, the Department also must continue to meet its obligations to a large number of State and Local District users who depend on the information provided by the MAR Subsystem of the current MMIS.

To ensure that this need is met on a continuing basis, the Department requires that the contractor take over and operate the Management and Administrative Reporting Subsystem (MARS) of the current MMIS.

After all of the components of the Replacement Medicaid System, including the data warehouse, are operational and stable, the Department will work with the contractor to begin the process of migrating all such reporting to the Medicaid Data Warehouse.

The technical specifications for the current MARS can be obtained from the MARS Volumes I, II, and III in the Procurement Library, along with the On-Line MAR/SUR Subsystem (OLMS), Volumes I and II. A list of the current MARS reports and the required output media is provided in Appendix F.

Master copies of all print and data files must be maintained for six (6) years for reproduction of reports as required.

The contractor shall meet the following performance standards for MAR report production:

- Monthly and quarterly reports shall be delivered to the Department no later than the fifteenth (15th) day of the month following the end of the report period.

- Annual reports shall be delivered to the Department no later than the fifteenth (15th) of the month following the end of the applicable year (State fiscal, Federal fiscal, or calendar). The schedule for 1099 forms shall be in accordance with Internal Revenue Service guidelines.

- Financial/funding reports (MR-O-30, MR-O-31, and MR-O-39) must reconcile in local, State, and Federal shares and total expenditures.

- Operations reports (MR-O-08, MR-O-09, MR-O-40, MR-O-41, and MR-O-42) must reconcile to each other in terms of total claims adjudicated, paid, and denied.

The New York State MAR must be updated to comply with the Medicaid Statistical Information System (MSIS) as required by the balanced budget act of 1997.

THIS PAGE INTENTIONALLY LEFT BLANK

Table of Contents
Section 8

Table of Contents
Section 8 (continued)

Section 8
Medicaid Data Warehouse

8.1 Background

The Department of Health has assumed responsibility for all Medicaid management functions needed to support the New York State Medicaid program, including the Office of Medicaid Management (OMM) and the Office of Managed Care (OMC).

The Office of Medicaid Management has assumed the primary role of management of the Medicaid program for New York State. Through this role, OMM has absorbed the Quality Assurance and Audit (QA&A) unit, previously a part of the Department of Social Services, and its provider surveillance and utilization review functions, along with all other programmatic and operational responsibilities for the New York State Medicaid program. With these responsibilities, OMM becomes the de facto "host agency" for Medicaid health care data within the Department.

The most universally expressed need by State and local Medicaid stakeholders is the need for better, faster, and more analytically rich access to Medicaid data. As the owner of the New York State data-rich Medicaid systems, the Department needs to develop the capability to produce this information for policy decisions concerning eligibility, utilization, provider participation, health care quality and outcomes, and cost containment. Therefore, the Department seeks a data and system integration solution to its information and program management needs. The solution includes the development of a new Medicaid data warehouse along with data marts, decision support applications, and executive information capabilities, and coordination of the Medicaid data warehouse with existing data warehouses.

In addition to the analytical and policy analysis benefits of the data warehouse, it is the Department's intent to use the capabilities to:

- Support budget analysis and forecasting.
- Support data mining to identify health care practices and billing patterns that are not consistent with expected norms.
- Perform both general and focused reporting now performed by the Management and Administrative Reporting Subsystem (MARS).

- Supplement the analytical reporting now performed by the Surveillance and Utilization Review Subsystem (SURS).

8.2 Ongoing Initiatives

The need for decision support capabilities has been recognized for some time by agencies within the State. As a result, several offices and units have started data warehousing initiatives.

The State of New York has made substantial investments in these data warehouse initiatives. The Department intends to preserve the financial, data-gathering, and training investments made in these data warehouse initiatives. The Department expects that the data warehouse developed as a result of this procurement will leverage the knowledge and experience gained from these initiatives.

8.2.1 Office of Managed Care

OMC has decided on a data warehousing solution with decision support and executive information capabilities for its information and business requirement needs. These needs are to improve productivity of program managers and analysts through more efficient, convenient, consistent, and user-friendly access to such information as service utilization, enrollment, cost of care, access to care, and quality of care. The foundation data sets for the Managed Care data warehouse are encounter data of all services provided by managed care plan providers and monthly enrollment data. However, the data warehouse will eventually include data from other administrative data sets, including Medicaid fee-for-service claims, Vital Records, provider information, and the Department's Statewide Planning and Research Cooperative System (SPARCS) inpatient discharge data.

Statewide collection of encounter data began in July 1996 for the approximately 650,000 enrollees of the State's voluntary Medicaid managed care program. Enrollment is expected to increase to 2 million over the next two and one-half (2-1/2) years as the Department implements a mandatory managed care program.

A business plan, conceptual data model, and physical data model for the initial implementation of the Managed Care data warehouse have been completed. This effort has been accomplished through a contract with Sybase Corporation and Consultec, Inc. Data cleansing, staging, and loading procedures have been tested and put into production. Testing of the performance of the data warehouse including stress testing with data volumes approaching those expected after three (3) years of operation is expected to be completed by the end of March 1998. Planned queries are being developed in PowerBuilder to test data warehouse performance and to provide rudimentary analytic capabilities.

By March 1998OMC will have a fully tested, optimized, and operational Managed Care data warehouse. It includes the foundation components of the database, including encounter types, diagnoses, procedures, enrollment, eligibility, client demographics, special and chronic populations, client location, plans, counties, and plan/county contracts. It also includes reference code tables for procedures, diagnoses, DRGs, formulary drugs, and New York State ZIP codes.

The Managed Care data warehouse platform has been purchased and consists of a Sun Enterprise 6000 server with twenty-four (24) 250 MHz UltraSPARC processors with 8 GB of RAM. The system uses the Sun Solaris 2.5 operating system. Approximately 420 GB of storage has also been purchased.

The database management system is Sybase SQL Server/Sybase IQ. Development tools include PowerBuilder Enterprise and Power Designer. The Department is currently evaluating various Decision Support System (DSS) tools. Purchase and implementation of a DSS tool is expected early to mid 1998. It will employ an object-based, three- (3-) tiered client/server architecture; and will provide server-based query and report processing. Access to the decision support tool will be through the Department's Health Provider Network (HPN) intranet Web site. Access will be available to Department, area office, county government, and managed care organization (MCO) users.

8.2.2 Office of Medicaid Management

The Office of Medicaid Management has delayed major investment in data warehousing until the issuance of this RFP. With the transfer of the Quality Assurance and Audit unit from the then Department of Social Services to the Department of Health, OMM has inherited some data warehousing capability. In addition, the Bureau of Program and Data Analysis (BPDA) has been

making a significant effort to meet the information management and ad hoc reporting needs of the entire Office with limited tools and resources.

8.2.2.1 Quality Assurance and Audit

The Quality Assurance and Audit unit has developed a data warehouse that contains the complete Adjudicated Claim file and provides access to paid medicaid payment claims data. Access has been made available to the Attorney General's office, the Division of Budget, legislative staff, the Governor's Office, and all LDSSs.

The system architecture includes the server hardware platform and the software for the server and QA&A workstations:

- **Hardware platform** - A DEC Alpha 8400 Server with 440 GB of disk space is located at the HSASC. The DEC Alpha 8400 is supported with one (1) terabyte of EMC Symmetric storage, which holds the detail payment data.

  QA&A staff at the Riverview Center use a DEC Alpha 2100 server, which has 130 GB of disk space, to access the DEC Alpha 8400 environment. Over five hundred (500) IBM-compatible 486 and Pentium client workstations access the DEC Alpha 8400 environment via the DEC Alpha 2100 to submit queries.

- **Operating system -** The DEC Alpha 8400 runs the UNIX operating system, and the DEC Alpha 2100 runs the Windows NT operating system.

- **Telecommunications:** A T1 datalink (1.5 Mbps) provides connectivity between the DEC Alpha 2100 and the DEC Alpha 8400. The communication protocol is TCP/IP. QA&A staff at the 800 North Pearl site (the current MMIS contractor site) are able to access the DEC Alpha 2100 and the DEC Alpha 8400 via the datalink.

- **Desktop productivity package -** The Microsoft Office suite of desktop productivity applications is used by QA&A staff to build front-end applications to process data retrieved from the QA&A Oracle database. These applications are available to authorized users via an Ethernet LAN.

QA&A has loaded all data elements from the Adjudicated Claims file for 140 million paid claims to the Oracle database. As of late 1997, this includes all paid claims for fourth quarter 1996, first quarter 1997, and second quarter

1997. This data occupies 280 million rows of the Oracle database. Each quarter takes up 35 GB, with an additional 20 GB for database housekeeping and is currently expanding to include two (2) years of data.

QA&A has defined a minimum number of indices for the data; the number of indices may double the storage requirement and exceed the one (1) terabyte of storage on the DEC Alpha 8400.

QA&A investments include 1) a Business Assessment and Strategy document, 2) a collection of required data elements, 3) a logical data model, and 4) a physical database. In addition, QA&A has begun initial loading of the Adjudicated Claim file to the Oracle database as described above. Plans call for QA&A to advance the initiative by implementing the physical database model and developing decision support capabilities by the fall of 1998.

Appendix H lists the QA&A spreadsheets which contain flat-file layouts of the Claims Adjudication file. Copies of these diskettes are available in the Procurement Library.

8.2.2.2 Bureau of Program and Data Analysis

The bureaus and units of the Office of Medicaid Management have relied extensively on the expertise and capabilities of the Bureau of Program and Data Analysis to support their information and data analysis needs. This has been accomplished through the receipt of print-image tapes of MAR reports that have been subsequently manipulated and tapes of adjudicated claims which have been loaded to PC-based databases and have been manipulated to meet user needs, resulting in a significant collection of various databases and data files.

This collection of data is documented in two (2) database files containing the file layout and data element requirements for its data warehouse initiatives:

- The files STOR.DBF and STOR.TXT are the data elements of the current 1062-byte Adjudicated Claim file, less the 60-byte sort key and two- (2-) character filler.

- The files OMM2.DBF and OMM2.TXT contain the file layout that the OMM developed to populate a data mart. The record layout in this file is 576 bytes. This layout provides the most current five (5) years of adjudicated claims history data elements.

These files are available on 3-1/2" diskettes in the Procurement Library and are listed in Appendix H.

8.2.3 Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General has implemented a data mining project utilizing Medicaid data stored and accessed by the Fraud, Waste, and Abuse (FWA) software developed by the Los Alamos National Laboratory. The project is intended to support the investigative efforts of the MFCU.

This analytical effort is a user of Medicaid data. Because of the investigative support nature of this project, it is not considered to be a part of the overall Medicaid data warehouse. However, because the FWA project is a user of Medicaid data, staff of the Attorney General's Office will participate in the development of the Medicaid metadata.

8.3 General System Requirements

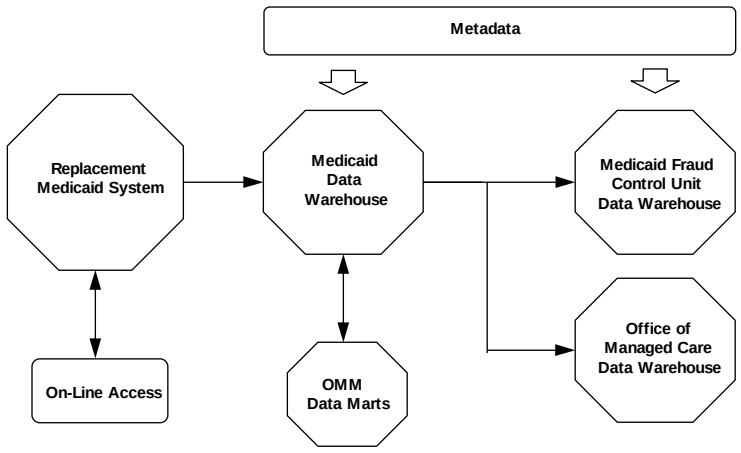
The contractor shall develop a Medicaid data warehouse containing data mining, decision support, and executive information capability that improves the analytical quality of, and access to, Medicaid data. A major objective will be to allow policy analysts to evaluate the Medicaid program and support executive decisions.

Because of the availability of the QA&A Oracle database and its platform, the Department requires the contractor to use this as the interim data warehouse and as a starting point for development of the Medicaid data warehouse.

The progress will continue on the Managed Care data warehouse under the Sybase/Consultec contract. The Department requires that the contractor coordinate efforts for development of the Medicaid data warehouse with the efforts of OMC and the Attorney General's office. The contractor will also coordinate with the Department's Information Systems and Health Statistics Group, the Human Services Application Service Center, and the State Office for Technology. It is the Department's intent that the contractor organize and coordinate the effort to develop a consistent metadata to be used across all platforms and organizational entities that use Medicaid data.

The contractor shall develop a Medicaid data warehouse that will be a part of an overall integrated information environment for the use of Medicaid data. An overview of this environment is illustrated in Exhibit 8.1. The Medicaid data warehouse shall consist of the underlying Medicaid data store and two (2) data marts: one (1) data mart to meet the specific needs of QA&A and one (1) data mart to meet the specific needs of the Bureau of Program and Data Analysis.

Exhibit 8.1
Overview of the Integrated Information Environment



The Department requires that the data warehouse be able to address three (3) broad issues:

- Organizing the data to recognize the temporal and longitudinal nature of Medicaid data; many analytical issues involve questions of duration or sequence of enrollment and utilization

- Integrating Medicaid managed care encounter data with fee-for-service data as early in the development of both the Medicaid and managed care initiatives as possible

- Facilitating the linkage of Medicaid enrollment data with other enrollment data on the same persons; for example, the data warehouse must enable the Department to follow children who move between Medicaid and other health care programs

- Cleansing of data and staging data for extracts and loading to OMC, MFCU, and other data warehouses using Medicaid data

The package of the analytical tools shall include a variety of on-line analytical processing (OLAP) tools and shall include data mining tools.

8.3.1 Users

The Medicaid data warehouse will be used by State personnel with a wide range of data and technological sophistication.

8.3.1.1 Levels of Users

To assist the contractor in understanding the customer, the following descriptors are used:

- The Level III user (the Executive user) will access the data warehouse using point-and-click techniques and pull-down menus to select aggregated or summarized indicators and measures. Level III users have the least knowledge and experience in PC use and query generation. The Level III user will seek data presented as charts, graphs, and reports. The aggregation or summarization rules and data subsets will be predefined and static, and the range of data presentation choices and drill-down capabilities will be limited by those predefined rules. The capabilities of the data warehouse for Level III users will be implemented in Stage IV, as specified in Section 6.2.10.4.

- The Level II user (the Analyst user) will generally be a staff member who works in program management, program audit, fiscal management or policy development. This person typically has a great deal of Medicaid program knowledge, but who has limited technical knowledge of databases and query languages. Level II users will be a mixture of those with extensive knowledge and experience as well as those with limited or no knowledge in the use of Windows applications, such as spreadsheets and desktop databases. Level II users will 1) create routine queries by selecting from a menu of data items, time periods, and query functions; 2) request execution of preexisting queries stored in the data warehouse library; and 3) modify and execute existing queries from the library. Level II users will be able to access the data warehouse using Level III capabilities as well. The capabilities for Level II users will be implemented in Stage IV, as specified in Section 6.2.10.4.

- The Level I user (the Technically Proficient user) will have a solid understanding of the data warehouse database, skills in using data extraction software, and extensive technical training. This user will generally have knowledge and experience in using the PC with spreadsheets and desktop databases, as well as Structured Query Language (SQL) and other standardized database query languages. The Level I user will construct and execute the more complex queries and require the greatest access to the detail data in the data warehouse database. Level I user queries will most often require off-line, overnight, or multiple-night batch processing to complete. Level I users will also use the Level II and III capabilities and will have available all the analysis and presentation tools of the data warehouse. Some capabilities for Level I users will be available in Stages II and III, as specified in Sections 6.2.10.1 and 6.2.10.4.

8.3.1.2 Number of Users

Exhibits 8.2 and 8.3 identify the **maximum** number of State users, by level, for which the Department desires the contractor to provide access within the fixed administrative fee of the contract.

The Technical Proposal shall detail the number of authorized and concurrent users for each level offered within the fixed administrative fee bid. During operations, the Department will work with the contractor to manage the capacity provided in the data warehouse for business flexibility. For example, the Department may decide to trade off some Level II users for more Level I or Level III users, or actual experience with the use of the data warehouse may demonstrate that the capacity of the data warehouse would support more Level II and/or I users. The Department expects the contractor to provide this business flexibility to maximize the value of the Medicaid data warehouse.

Exhibit 8.2
Managed Care User Community

Level	Authorized Users	Concurrent Users
Level III	120	11
Level II	78	12
Level I	6	3
Maximum	204	26

Exhibit 8.3
Medicaid User Community

Level	Authorized Users	Concurrent Users
Level III	368	120
Level II	440	410
Level I	80	65
Maximum	888	595

In addition to all other bureaus of the Office of Medicaid Management, the number of Medicaid users includes QA&A, the Fiscal Management Group, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Alcohol and Substance Abuse Services, and the on-site staff of the Office of the State Comptroller. It also includes occasional users of Medicaid data, such as the Division of Budget and legislative staff.

8.3.2 Platform

The contractor will determine the detailed Medicaid database hardware configuration. The Department requires that the data warehouse platform be separate from the Replacement Medicaid System platform. The Department also requires that the data warehouse (hardware, software, and data storage) be located at the contractor's facility which must be located within thirty (30) miles of the Capitol Building in Albany.

The contractor shall be responsible for all hardware and software necessary to configure, establish, house, and operate the Medicaid data warehouse platform. The contractor may transfer the ownership and leasing rights if leased, of the hardware and software to the State during the contract period if

it is to the advantage of the State to do so. At the end of the contract period, the State will assume ownership of any hardware and software that was purchased with State and/or Federal funds under the contract.

The Department is not predisposed to a particular data warehouse platform. However, the data warehouse hardware, software, and telecommunications components must conform to the following general requirements:

- The data warehouse shall be supported by a commercially available ANSI-, SQL-, and ODBC-compliant database management system (DBMS).

- The primary interfaces to the data warehouse DBMS must be developed by commercially available application development tools.

- The contractor must select hardware and operating system software that follows an open systems strategy.

- All connections to State systems must be via industry-standard telecommunications protocol such as TCP/IP.

- Key attributes of the architecture must include the following:

    An open, standards-based set of application program interfaces (APIs)

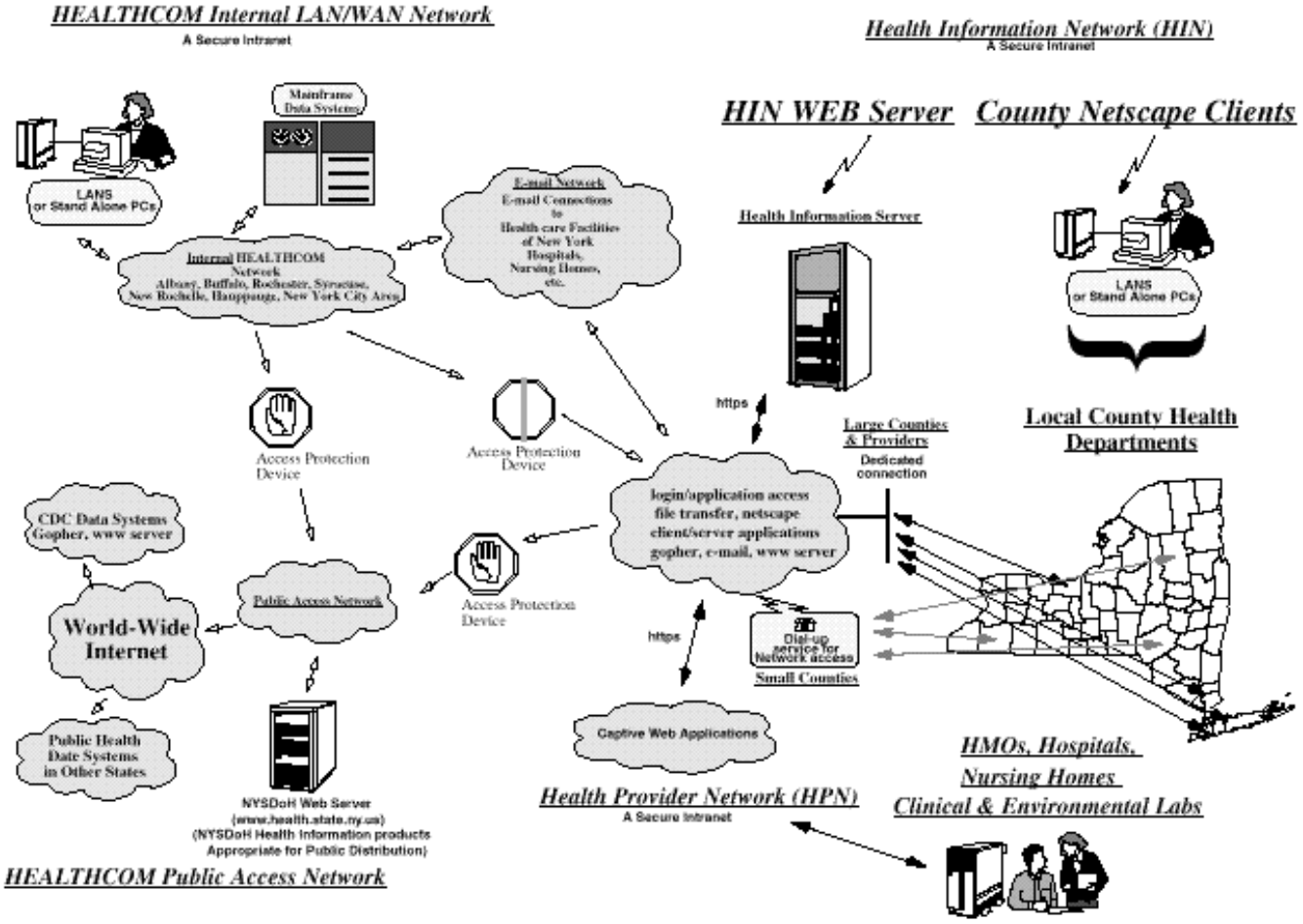
    Portability across multiple computer platforms; the platform must contain no device-dependent code; ANSI standard tools and languages should be used and proprietary extensions avoided

    Industry-standard network protocols for interconnecting multiple local area networks (LANs) to form an enterprise network and for use in the LAN computing environment

The contractor is responsible for general conformance to the New York State Strategy for Information Resources Management. A copy of this strategy document is located in the Procurement Library.

The contractor shall be responsible for providing the communication lines from the data warehouse platform to the State networks, shown in Exhibit 8.4.

Exhibit 8.4
Relationship Between the DOH Networks.



8.3.3 Local Area Network (LAN) and Connectivity

The Department has LANs in its different offices that interconnect over a statewide Wide Area Network (WAN). The Department also has two (2) intranet WANs to provide service to community health offices and health providers (HIN and HPN). Exhibit 8.4 is a schematic of the Department network and the relationships between them.

The contractor will be responsible for assessing the Department network capabilities to determine if the Department network can support the number of users in Section 8.3.1.2. To reduce the cost and risk to the contractor, the Department encourages the contractor to use the New York State connectivity infrastructure, known as NYT. NYT is discussed in Section 7.5.1, and a graphic of NYT is shown in Exhibit 4.2.

Through NYT, the contractor can work with the State to organize a high-speed datalink between the Department network, the Replacement Medicaid System, Local Departments of Health (LDOH), Local Departments of Social Services (LDSS), and the contractor's computer facility. The conceptual datalink configuration suggested by the Department is shown in Appendix G. The contractor shall be responsible for ensuring the provision and maintenance of connectivity from the data warehouse platform to the Department network throughout the life of the contract.

The evaluated cost of the Medicaid data warehouse will include the cost of any software proposed by the contractor to be resident on the Department network workstations. The contractor will be responsible for installing the software on the Department network workstations or servers.

8.3.4 Data Refresh Cycle and Data Availability

The Medicaid data warehouse shall have a weekly refresh of the detailed Medicaid data. It shall also have a monthly and quarterly refresh of the summary and aggregated data.

The contractor shall accept, validate, and load data files from the Replacement Medicaid System to ensure the timeliness and accuracy of the detailed data on a regular schedule. High-speed data transmission media, such as 4mm or 8mm DAT and/or optical disks, will be used for Replacement Medicaid System data transfer and loading. The contractor shall load data into the data warehouse, perform summarization and aggregation activities, and update the predefined queries and reports.

All data used in refresh cycles, including table files, shall be cleansed and verified before it is loaded onto the data warehouse. The data cleansing shall be performed using criteria developed during Stage II, as discussed in Section 6.2.10.2. The contractor shall validate data by producing a series of control reports from the data warehouse and comparing them to similar control reports from the data source.

Data refresh procedures shall be reversible to accommodate any reprocessing required as a result of erroneous data being received from the data sources or errors by the contractor. If the error is determined by the State to be beyond the control of the contractor, the State will negotiate with the contractor regarding the price to correct the error. The contractor shall also be responsible for those errors in loading that should be detected by the data validity and editing required before loading the Medicaid data warehouse.

The Medicaid data warehouse shall be available for on-line access twenty-four (24) hours per day, Monday through Friday. The Medicaid data warehouse must also be available Saturday and Sunday, except for scheduled maintenance and refresh times. The Medicaid data warehouse is considered not available when the LAN cannot access the data warehouse during these times.

The contractor shall notify the Department when the Medicaid data warehouse is unavailable due to system problems or network failures. In addition, the contractor shall notify Department staff when it has been determined that queries have not processed in the overnight batch processes.

The Medicaid data warehouse will provide the necessary data exchange to provide a refresh of the OMC, MFCU, or other data warehouses monthly.

8.3.5 System Back-Up and Reliability

The contractor shall incorporate the reliability features and the back-up and recovery activities for the Medicaid data warehouse into the overall error and disaster recovery requirements described in Section 3.2.5. The specific requirements for the Medicaid data warehouse are described in this section.

The Department requires mirroring of the detail data layer, located on the Department server, at the contractor's computer facility. Full and complete archives of all data and software shall be maintained and accurately backed up

on tape or other appropriate media. The contractor shall ensure that back-up copies are stored in a secure off-site location.

The contractor shall provide a plan such that normal data warehouse processing can be resumed in the event of a disaster or hardware problem at the Department site. This plan shall be a part of the plan described in Section 3.2.5.

8.3.6 System and Database Security

It is critical to develop a secure communication path between individual users and the Medicaid data warehouse servers. The contractor shall develop a secure communication path that guarantees confidentiality and access controls over the data warehouse data. The contractor shall enforce access controls by establishing a system of uniform password and user identification for Medicaid data warehouse access, regardless of user location.

The Department expects that nearly one thousand (1,000) users will need access to the data warehouse, as shown in Exhibit 8.3. To make authentication more complex, each user office has evolved its own protocols, procedures, and criteria for dealing with the exchange of confidential information with their counterparts within the State. The Department expects that, with the full implementation of NYT; however, protocols will be standardized among all State users.

Since each office knows best who should get access to specific types and levels of information, the contractor shall work with the user offices to develop system and database security capabilities that allow different program areas within the various offices to grant access to their specific data warehouse data and information. The data warehouse security system must establish an appropriate protocol between users on the data warehouse servers and users on other NYT servers, so that appropriate data and information exchanged among these users are encrypted.

The data warehouse server authentication processes shall meet a variety of access needs. Access extends from dial-in access to Internet firewall access to the different applications on the data warehouse servers. The contractor shall develop a password system that allows all access requests to be authenticated by a single user ID and password. The system must allow users to change their password. The system must also require the user to change his/her password periodically.

8.4 The Detailed Medicaid Data

8.4.1 Sources

The New York State Replacement Medicaid System will be the primary source of data for the data warehouse. For data not carried in the Replacement Medicaid System, the WMS and its subsystems or its successor will also be a source of data. Descriptions of the data maintained on the Replacement Medicaid System are presented in Section 7 of this RFP. Until Replacement Medicaid System components are fully operational, the Medicaid data warehouse will obtain data from the current Medicaid systems.

The Medicaid data warehouse will accept, clean, and sort all data elements from the Replacement Medicaid System and the WMS, including:

- Client eligibility and demographics
- Adjudicated claims and encounters
- Provider data
- Reference and pricing data
- Financial data
- Health plan data
- Managed care enrollment data
- Third-party liability data
- Prior authorization data
- Case management data

- MAR summary data
- Utilization data

The Procurement Library contains information on the current MMIS and its data files.

While the Replacement Medicaid System will be the primary source of information maintained on and used by the data warehouse under this RFP, the Department may wish to add other data. This data could include such information as census data obtained on a scheduled basis to support population analysis or a data warehouse mapping feature.

8.4.2 Requirements

The content and amount of detailed data that the data warehouse must maintain to provide analytical support to Level I, II, and III users varies within each Department office.

QA&A staff require access to a maximum of twenty-seven (27) months of paid claims data, loaded by payment cycle dates. QA&A will allow the detail data layer, shown in Exhibit 8.4, to grow from an initial load of twelve (12) months of paid claims data. The last three (3) calendar months may be dropped from the detail database and archived after a complete quarter of data is loaded. For example, consider the first quarter of a calendar year of data, January 1, 1996, through March 31, 1996. This quarter of data may not be archived from the detail database until the January 1, 1998 through March 31, 1998 quarter data is loaded.

Bureau of Program and Data Analysis (BPDA) staff require sixty (60) months of summarized paid claims and encounter data. The summarized data must reflect the 576-byte file listed in Appendix H and include client eligibility data and reference data. BPDA staff are interested in a claim date of service (DOS) as well as the claim paid date. Unlike QA&A staff who will allow the detailed data layer to grow from an initial load of twelve (12) months, BPDA Level III staff require access to summaries and aggregates of the full load of sixty (60) months of fee-for-service and encounter data.

For the detail data layer deliverable in Stage III, the Department requires that the contractor deliver an initial load of twenty-four (24) months of paid fee-for-service and encounter data. The data must be organized by payment cycle date and date of service. All support data, such as eligibility and reference data needed to support Level III analysis, must also be loaded. This delivery provides the Department with early decision support capabilities.

Within a year of implementation the Medicaid data warehouse will carry a full load of sixty (60) months of detailed claim and encounter data. This will be a rolling sixty (60) months, which will also be summarized and aggregated monthly.

8.4.3 Retention

The data warehouse shall maintain, on a rolling basis, all data identified for each Department office, as prescribed in the contractor's Business Assessment and Strategy document. The contractor will also have responsibility for archival or retrieval of information, as needed. However, the contractor must retain any information needed to meet the requirements of the RFP regarding the data warehouse back-up.

8.4.4 Flexibility in Data

The Medicaid data warehouse will be developed concurrently with some components of the Replacement Medicaid System and will be implemented prior to the development of other components. The Department expects that new data elements not captured by the current MMIS will be added to the data warehouse to support analysis.

The Department requires that offerors outline in their Technical Proposal an approach for handling data elements that are not part of the metadata repository at the time the logical metadata database schema is approved by the Department.

The data warehouse database schema must be flexible enough to accept additions of new data elements without a redesign of the logical and physical databases. In addition to modifying the database schema, the contractor shall make modifications and updates to data aggregation, data summarization, and indexing to maintain acceptable performance at the three (3) user levels.

Whenever new data elements are identified for addition to the data warehouse, the contractor shall prepare a document that presents an analysis of the data element being added to the data warehouse. The document must analyze how the database structure will need to change to accommodate the new data element. The document must also have a plan for other changes, such as data aggregations, associated with the data element change that must be accomplished.

8.5 Department of Health EIS/DSS Requirements

The Department requires decision support tools and applications. These tools must be flexible enough to accommodate additional capabilities that may be added under negotiated contract amendments or future contracts.

These decision support tools and applications are commonly referred to as executive information systems (EISs) and decision support systems (DSSs).

The database design and applications developed in Stage IV shall provide capabilities to meet the system performance requirements listed in Section 8.6. These system performance requirements are for ad hoc, parameterized, and predefined queries. In addition, the contractor shall provide capabilities for users to view summary-level reports.

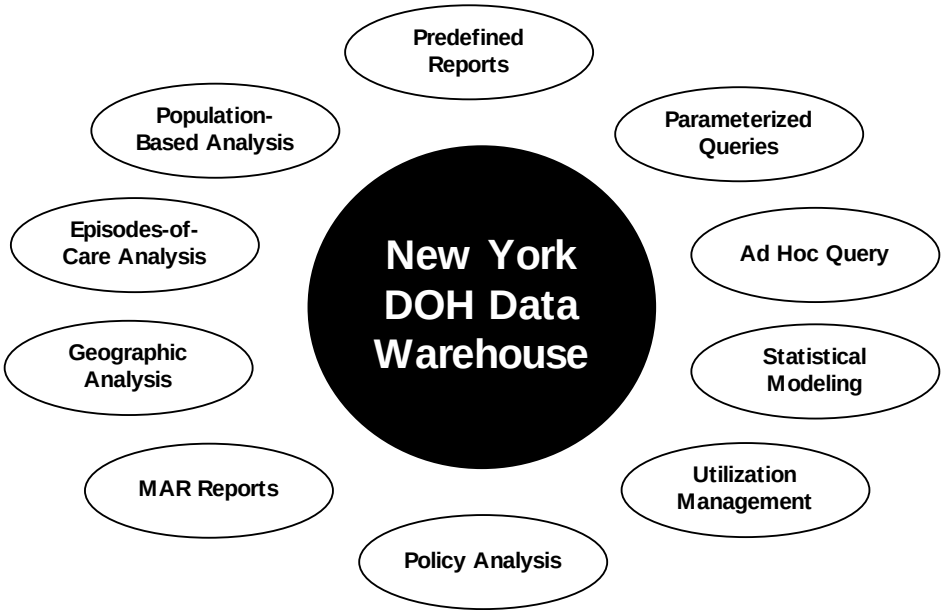
The following subsections list the requirements of the DSS.

8.5.1 Access

The data warehouse must provide decision support tools for population-based analysis; episodes-of-care analysis; utilization, quality, and access profiling; outcomes modeling; statistical calculations; pattern recognition; and comprehensive analysis of claim, provider, and recipient data.

Exhibit 8.5 summarizes the analytical functionality that the data warehouse must provide.

Exhibit 8.5
Decision Support Functionalities



The user interface and applications must provide the following functionality:

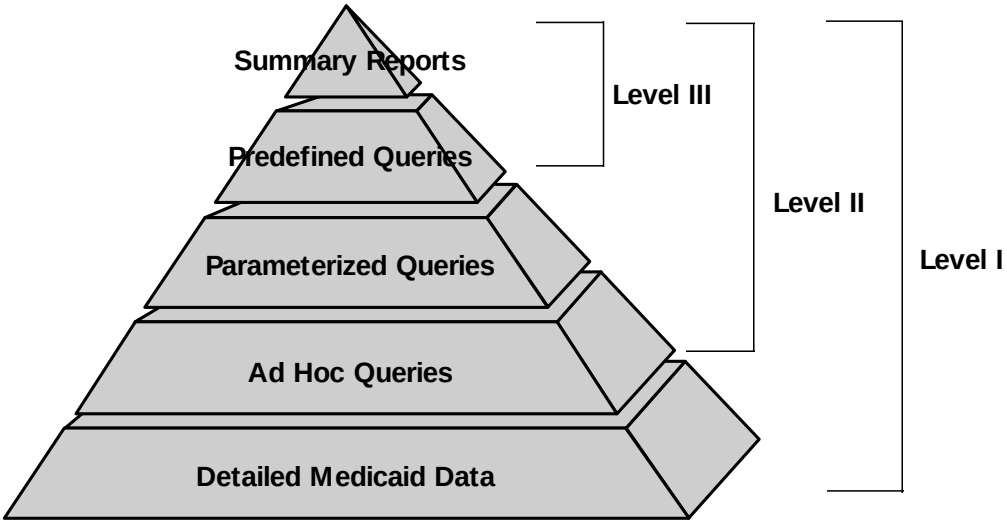
- The access tools and applications to support the query functionalities in Exhibit 8.5 while meeting the response-time requirements in Section 8.6.2; any exceptions to the response-time requirements must be specified in the offeror's Technical Proposal

- The types of access for Level I, II, and III users, as shown in Exhibit 8.6 below

- A library of predefined queries and reports; the contractor must 1) work with Department staff in JAD sessions to identify the queries and reports needed by Level II and Level III users, 2) develop the queries and reports to populate the libraries, 3) provide user support to Department staff, and 4) train all levels of users on the use of user interface tools and applications

- Query optimizations, as required, to the data warehouse so that the system performance requirements of Section 8.6 for predefined queries and reports are met; this shall include data aggregation, data summarization, and indexing

Exhibit 8.6
Types of Decision Support Access Per User Level



8.5.2 Information Presentation

The tools and applications shall provide flexibility in the presentation of output resulting from user queries, graphics, mapping, and report-formatting tools.

8.5.2.1 Graphics

The graphics capabilities shall be sufficiently flexible to provide the following:

- A range of graph types for data presentation, including bar, pie, stacked, and side-by-side bar charts
- Customization of the attributes of charts, including orientation, legends, and scaling
- Ability to import, export, and manipulate data files from spreadsheet and database management tools as well as a desktop database(s)

- Standard editing capabilities as well as capabilities for shadowing, mirroring, highlighting, and flipping axes

8.5.2.2 Mapping

The mapping capabilities shall allow all levels of users to analyze the demographics of specific geographical areas by presenting data on geographical maps. These capabilities must be resident on the local workstations or servers. The mapping capability shall:

- Provide the ability to import and export data from multiple databases and spreadsheets.
- Allow the user to assign data ranges.
- Provide prepared map sets for such data as population density by ZIP code and census tract.
- Support subdivision and mapping by counties' census tracts and ZIP codes.
- Use geocodes assigned by the Replacement Medicaid System to aggregate data.

8.5.2.3 Reporting

The reporting tools shall provide flexible data access and report formatting and editing capabilities. The reporting capability shall:

- Provide report-writing capabilities that support the use of format, text type, fonts, and screen grid designs to enhance the visual display of information.
- Provide multiple predefined report types and formats that are easily selectable by users.
- Provide the capability to design reports.
- Perform a minimum of four (4) levels of sorting in ascending and descending order, and provide subtotaling.

8.5.3 Query Capabilities

The query tool must provide on-line and batch data extraction and reporting capabilities that allow the user to access and manipulate information from the data warehouse. The query capabilities must:

- Allow the creation of queries using a graphical interface and SQL constructs.
- Allow the selection of standardized, frequently used queries from an on-line library.
- Allow users to specify query criteria, sort order, and format characteristics.
- Provide the capability to execute queries that perform unduplicated counts.

8.5.4 Computational Capabilities

The computational capabilities shall include the following:

- Support the basic and advanced statistical analysis of program data.
- Support statistical analysis routines, including regression, time-series analysis (e.g., lag difference, growth rate, percent growth, seasonal adjustments, year-to-date), descriptive statistics, log-linear models, cross-tabulations, correlations, reliability statistics, variance analysis, multivariate analysis, cluster analysis, scaling, nonparametric statistical analysis, and survival analysis.
- Support the calculation of norms and standard deviations.
- Support forecasting techniques.
- Support the built-in mathematical functions of the ANSI-compliant SQL library.

8.5.5 Information Management

The data warehouse must facilitate the publishing of analytical results and information to the user community, the creation of management administrative reports, and the creation of utilization management reports.

8.5.5.1 Publishing Analytical Results and Information

The New York State Health Information Network (HIN) project has made significant progress in developing a production-type environment for supporting data and information exchange between the State Health Department and LDOHs.

In the 1995-1996 grant year, two (2) Sun SPARC 1000 file servers were acquired and installed on a network between the HIN and the HEALTHCOM networks. Exhibit 8.4 shows the arrangement of these file servers.

These systems are designed to isolate database server functions from Web server functions so that performance of Web information access is enhanced. These systems also provide a secure environment for the dissemination of information because the Web server is outfitted with the commercial US 128-bit rc4 level encryption version of the Netscape Commerce server. Specialized access and authentication control software have also been installed on the Web server.

The Department requires the contractor to leverage the knowledge developed by the State in developing the HIN project to provide an interface from the data warehouse to the HIN for the dissemination of analysis results and information to the user community.

8.5.5.2 Management Administrative Reporting and SURS Reporting

It is the Department's intent to migrate Management and Administrative Reporting (MAR) to the Medicaid data warehouse. The Medicaid data warehouse shall have the capability to produce all required MAR reports, including replicating MAR reports produced by the current MMIS. The data warehouse will accept and store specified summary data from this process to allow additional analysis of the data. The Procurement Library contains information about the MAR reports produced by the current MMIS, and a list is presented in Appendix F.

The data warehouse shall provide data manipulation functionality for the MAR report data elements so the Department can produce reports that meet HCFA certification standards for information retrieval, as contained in Part 11 of the Medicaid State Manual; the proposed MMIS functional requirements published in the November 22, 1993 Federal Register; any replacement MMIS requirements; and any recertification requirements.

MAR reports will contain both claims and encounter data, eligibility data, and a mechanism for adding off-line fiscal payments to appropriate summary data reports. The MAR reports will include all adjustments.

The Medicaid data warehouse shall have the capability to produce MAR reports when it becomes operational. The transition of MAR reports from the Replacement Medicaid System to the data warehouse shall occur when both become fully operational.

The Medicaid data warehouse shall also provide the functionality to produce SURS Recipient Monthly Exception Processing, Claim Detail, Claim detail Special Reporting and On-line reports.

8.5.5.3 Utilization Management Reporting

The data warehouse shall be used by the Department to produce reports to assist Department staff in performing utilization management reviews to ensure the best and most appropriate care is provided to New York recipients. These will be based on both claims and encounter data (separately, together, and in comparison).

The data warehouse is expected to support such features as access to, manipulation of, and investigation of data for utilization review. Additional manual review shall be done by Department staff, outside of the data warehouse environment, regarding such things as medical records.

The data warehouse shall produce reports so that staff can perform the following:

- Review of accessibility of care to determine the ease with which recipients can obtain the health care they need when they need it

- Determination of appropriateness of care to determine the degree to which medically necessary and customary health care is provided to recipients

- Assessment of continuity of care to determine the degree to which health care needed by recipients is effectively and efficiently coordinated among practitioners, across health care organizations, and across time periods and episodes of care

- Investigation of the appropriateness of care settings to determine the degree to which health care is provided in the most clinically appropriate, cost-effective, and safe-setting manner

- Analysis and comparison of services provided in fee-for-service and managed care settings

8.5.6 Advanced Analytical Capabilities

The Bureau of Program and Data Analysis and OMC require the capabilities for analysis based on episodes of care and population-based analyses.

8.5.6.1 Episodes of Care

The contractor shall use routinely collected inpatient and ambulatory medical claims and pharmaceutical claims to identify mutually exclusive and exhaustive treatment episodes for analysis based on episodes of care.

The contractor shall use a patient-pending, episode-building, patient classification methodology, such as the Episode Treatment Groups (ETG) from Symmetry Health Data Systems, to provide ETG-based analysis. The data warehouse shall incorporate a clinically homogeneous and statistically stable grouper, such as ETG, to provide provider-profiling, demand-utilization, and disease-management reporting.

The Contractor shall provide a methodology platform that is acceptable to both clinicians and administrators. Contractors may be required to demonstrate their episodes-of-care analytical capabilities.

8.5.6.2 Population-Based Analysis

The contractor must provide small-area analysis tools that allow an understanding of the utilization and cost of health services for defined

populations. Knowledge of these events is essential to the successful health management of the Medicaid population in New York. The contractor must provide an interface that allows users to initiate and work through a series of tasks to analyze the following:

- Variations in provider practice patterns
- Variations in charged and paid amounts by geographic areas, physician specialty, and type of practice
- Variations in admission rates for specific conditions
- Comparisons of providers' performance to normative data
- Rates of hospitalization by geographic area, physician, and type of practice
- Per-capita analysis of medical resources such as physicians, beds, and nursing homes

The Department requires offerors to provide a methodology platform that is acceptable to all users. Offerors may be required to demonstrate their population-based analytical capabilities.

8.6 System Performance Requirements

The contractor shall meet the following data warehouse system performance requirements. Failure to comply with these requirements may result in assessment of damages as set forth in Section 11.10.

8.6.1 Processing Requirements

The contractor may determine that batch processing may be required in unusual situations where queries are complex, data extraction would occur overnight, and queries must be run when demand for system resources is at a minimum. Offerors shall describe in their Technical Proposal the approach they will use to determine whether queries will be processed on-line, in the background, or overnight.

8.6.2 Response Time

The data warehouse shall provide the capability to process queries either on-line, in the background, or in batch depending on the amount of data and the complexity of the query. The data warehouse shall have the capability to notify the user whether a query should run in foreground, background, or batch.

On-line query and report users shall have a reasonable response time. The Department expects offerors to commit to an on-line response time for the Medicaid data warehouse. The response time is the time interval between entry of the query execution command and the receipt of the result set on the user workstation.

The DSS must have progress meters to indicate the status of the execution of on-line queries and queries run in the background.

Batch queries may run in batch and must be available no later than 8:00 a.m. eastern time the morning following submission when submitted prior to midnight.

THIS PAGE INTENTIONALLY LEFT BLANK

Table of Contents
Section 9

Table of Contents
Section 9 (continued)

Section 9
Proposal Submission Requirements

9.1 Overview

This section provides the requirements that offerors will follow for preparing their proposals in response to this RFP. The details of overall procurement administration, including the requirements for packaging and submitting proposals, are addressed in Section 2 of this RFP. The following material provides the requirements for the contents of the Technical Proposal and Price Proposal.

9.2 Technical Proposal Requirements

The Technical Proposal shall include ten (10) separate sections, presented in the following order:

- Transmittal Letter
- Table of Contents and RFP Cross-Reference
- Executive Summary
- Response to Mandatory Requirements
- Approach to Replacement of the Medicaid Systems
- Approach to Operations of the Replacement Medicaid System
- Approach to the Medicaid Data Warehouse
- Approach to Implementation of Optional Components
- Approach to Quality Management and Customer Service
- Systems Integrator and Subcontractor Capabilities

Each section within the Technical Proposal must include, at a minimum, all items listed in Sections 9.2.1 through 9.2.10, in the order presented, as the evaluation of proposals may be done on a section-by-section basis. Where possible, the response to individual sections will provide the use of forms and tables to facilitate evaluator review.

The Department prefers proposals that are direct, clear, and concise as opposed to proposals that are elaborate or unnecessarily lengthy.

No reference to, or inclusion of, pricing information shall appear in any section of the Technical Proposal.

Each Technical Proposal (including all copies thereof) shall meet the following general format requirements:

- Use letter size (8.5 x 11-inch) paper.
- Submit in three- (3-) ring binders.
- Use tab dividers for each section of the proposal.
- Clearly page number the proposal on the bottom center of each page, with each section of the proposal separately numbered.
- Use a type size of twelve (12) points or larger.

9.2.1 Transmittal Letter

The Transmittal Letter shall be submitted on the official business letterhead of the offeror proposing to be the prime contractor (systems integrator) and shall be signed by an individual legally authorized to bind the offeror to the proposal and to a contract.

The Transmittal Letter shall include the following:

- A statement that the offeror accepts the terms and conditions as stated in the RFP and, in particular, the standard terms and conditions specified in Appendix A
- A statement that the offer is valid for a period of one hundred eighty (180) calendar days from the date of submission of the proposal

- A description of any existence of, or potential for, conflict of interest on the part of the offeror or it's subcontractors due to prior, current, or proposed contracts, or affiliations; if no such conflict of interest exists, a statement to that effect must be made

- A statement that the offeror will be responsible to the Department for performance of all work specified in the RFP, including work assigned to subcontractors

If the use of subcontractors is proposed, a letter from each proposed subcontractor, on the subcontractor's company letterhead, shall be included with the Transmittal Letter and shall be signed by an individual authorized to legally bind the proposed subcontractor, stating:

- The general scope of work to be performed by the subcontractor and the subcontractor's willingness to perform the work

- The willingness of the subcontractor to accept and abide by the terms and conditions of the RFP

Offerors may not place any conditions, reservations, limitations, or substitutions in their proposal with regard to the contract language, nor may offerors include any statements intended to alter the order of precedence as defined in Section 11.1.3 of this RFP.

9.2.2 Table of Contents and RFP Cross-Reference

The Technical Proposal shall contain a Table of Contents that includes beginning page numbers for each section and subsection of the proposal.

The Technical Proposal shall contain a cross-reference from each subsection of Sections 6, 7, and 8 of this RFP and related RFP addenda to the appropriate section and subsection of the Technical Proposal.

9.2.3 Executive Summary

The Executive Summary will condense and highlight the contents of the offeror's Technical Proposal in such a way as to provide the Department with a broad understanding of the entire Technical Proposal.

The Executive Summary will include a clear and concise summary of the proposed approach to the scope of work and the proposed staffing structure. The Executive Summary shall generally describe the capabilities and planned roles of any proposed subcontractor(s).

The Executive Summary shall present a summary description of the Replacement Medicaid System proposed, including identification of the base system(s) or systems for each functional area, and its overall approach to transition and phased replacement of the current systems (the EMEVS, the MMIS, State-operated). It shall also include a clear and concise summary of the offeror's understanding of the project. The Executive Summary shall provide an overview of the offeror's approach to a Medicaid data warehouse.

The Executive Summary shall summarize the offeror's proposed role as a partner in program operations with the Department and describe the major benefits offered by this proposal.

9.2.4 Response to Mandatory Requirements

The Technical Proposal shall include a response to the mandatory requirements of the RFP. To facilitate this response, the offeror shall use the mandatory requirements checklist in Appendix I of this RFP.

9.2.5 Approach to Replacement of the Medicaid Systems

In this section, the offeror will demonstrate that its approach to the replacement of the New York State Medicaid systems provides the most beneficial solution for the Department. Offerors may propose any of the following approaches to meet the system requirements defined in Section 7:

- The transfer and modification of a single certifiable base MMIS
- The transfer, modification, and integration of components of multiple certifiable MMIS systems
- The transfer, modification, and integration of components of one (1) or more certifiable MMIS systems in combination with commercial software
- The transfer, modification, and integration of a non-MMIS base (such a base system will be evaluated equally with competing MMIS solutions)

It is the responsibility of the offeror to demonstrate the benefits of the proposed solution to the State of New York.

The offeror should organize the description of the approach to replacement of the Medicaid systems around two major areas: 1) description of the proposed replacement system(s) capabilities and 2) approach to design, development, implementation, and transition.

9.2.5.1 Replacement Systems Capabilities

In this section, the offeror will focus on the Replacement Medicaid System components other than the Medicaid data warehouse. The data warehouse shall be addressed in the portion of the proposal defined in Section 9.2.8 of the RFP.

The offeror shall present the capabilities of the Replacement Medicaid System in the same order as presented in Section 7 of this RFP. For example, the offeror shall create a subsection to describe the capabilities of the Client Eligibility Data Repository. The description shall clearly identify the following:

- The system(s) components to be used in the replacement
- The source system of each replacement component
- The major areas of proposed modifications, enhancements, or additions to each replacement component
- Anticipated problems or issues and the proposed solutions to the implementation of each replacement component

In preparing this section of the proposal, the offeror should demonstrate how well the proposed solutions will meet the requirements defined in Section 7 of the RFP. To facilitate evaluation, the offeror shall present a crosswalk between the requirements in Section 7 and the capabilities of the transfer base for the component. The crosswalk shall be in the form of an exhibit that 1) identifies the requirement, 2) identifies whether or not the requirement can be met by the transfer base component, and 3) identifies the degree of complexity for adding the requirement.

The description of the capabilities of the transfer components should also emphasize the flexibility of the resulting Replacement Medicaid System. This flexibility should demonstrate the ability of the system to meet current and future program requirements.

9.2.5.2 Approach to Implementation

This section of the Technical Proposal shall describe the offeror's approach to some of the key issues that will impact the success of the Replacement Medicaid System construction and implementation effort. The focus of discussion in these areas should be on plans for New York State implementation, not on previous experience. The Department wants to know how its objectives will be met, what assurances of success the proposed approach will provide and what individuals will support the efforts, both on-site and at other locations during the Implementation Phase of the contract. Formatting of this section of the proposal will be left to the offeror's discretion; offerors are encouraged to present the concepts and issues in a manner that facilitates review by evaluators.

Discuss the proposed methodology for accomplishing the Implementation Phase activities. Describe the formal approach and the major features of the proposed methodology. Summarize how this approach will best meet user objectives and where the methodology has been used in the past.

Present a discussion of its approach to conducting the Joint Application Design (JAD) sessions for validation of requirements and completing business design. The discussion shall encompass:

- The logistics, physical layout, and timing of JAD sessions

- Roles and responsibilities, including the JAD facilitator, contractor staff, Department staff, and other State users

- The approach to managing and tracking requirements traceability

- The approach to identifying, documenting, resolving, and tracking changes to requirements

Identify the tools and techniques that will be used to support the design and development activities, such as CASE tools and other automated design tools. Describe how these tools will best support each of the eight tasks defined for the Implementation Phase.

Describe the products proposed for each of the tasks of the Implementation Phase. Identify what deliverables will be produced, outline their contents, explain their purpose, and relationship to other products, and demonstrate how they can be used to measure progress on the system construction and implementation effort. Describe the proposed approach for ensuring quality assurance of the products submitted.

Discuss how work plans will be developed; what logical structures will be used to prepare them and how they evolve from, augment, or derive from the methodology. Prepare a preliminary work plan, providing considerable detail for the Project Planning Task, some detail for the Joint Application Design Task, and a lower level of detail for the remaining tasks. Include a project schedule, establishing a link between the proposed methodology and the deliverables to be produced.

Describe the approach to the implementation of the Medicaid data warehouse, including approach to and proposed format for the metadata. The approach shall address coordination of development of the data warehouse with other Replacement Medicaid System components, particularly in relation to transition and data conversion.

Identify assumptions and constraints for the overall project planning and execution.

Present the proposed staffing approach to the Implementation Phase, which includes a project organization chart for the overall phase. The approach should depict staffing for each task, including numbers, labor categories, reporting relationships, and location.

The offeror shall discuss its approach to the transition of key staff from Implementation to Operations Phases. In particular, the offeror shall describe how it will use key staff in the second contract year when both implementation and operations activities occur.

Discuss the proposed approach to some of the key project management issues and demonstrate the readiness of the project team to assume its responsibilities during this phase of the contract. As a minimum, the proposal should address the issues presented in Exhibit 9.1.

Exhibit 9.1
Approach to Implementation Issues

Discuss how your approach to implementation will:
• Allow enough design and development time.
• Accommodate concurrent implementation of major initiatives.
• Accommodate policy changes that are in progress during the design of the system.
• Ensure that changes will not have to be made to CASE, DBMS, and programming languages in the middle of design or construction.
• Ensure adequate user involvement in the requirements validation and needs analysis, eliminating presumptive understanding by contractor staff.
• Ensure that the total design and scope of the system is finalized before construction begins.
• Ensure that responses will be made in a timely manner to customer concerns, comments, and recommendations regarding design deliverables.
• Provide metrics to measure completion progress, especially during construction.
• Ensure that design and development staff (and evolution staff) are trained in or experienced with the CASE tools, the programming languages, the system technologies, and the customer business processes to minimize the learning curve.
• Provide sufficient on-site “face time” between the design and development staff to understand customer/user requirements and business processes.
• Ensure adequate integrated system testing prior to the start of user acceptance testing.
• Ensure that the infrastructure (hardware, system software, etc.) is completed early enough to enable user staff to access and test the system.

Finally, demonstrate how implementation activities will be successfully coordinated for those components under development with the ongoing operations of those components already implemented. In other words, address the integration of the approach to transition (as required by Section 9.2.5.3) with the approach to implementation required by this section.

9.2.5.3 Approach to Transition

The replacement of the New York State Medicaid systems will require that offerors carefully plan the schedule, timing, and overall approach to the phased implementation. In this section of the proposal, the offeror shall clearly present its approach to implementation, transition, and conversion.

It is the Department's intent that, by November 1, 1999, the contractor will have implemented those components needed to enable the Department to terminate the contract with the incumbent EMEVS contractor and to continue operations of those components under this contract. The offeror shall describe its approach to:

- Implementation of the Client Eligibility Data Repository and conversion of client demographic and eligibility history
- Implementation of the Service Utilization Management component, including, at a minimum, the Utilization Threshold, Post and Clear, and DME authorization elements, and conversion of historical transactions
- Implementation of the Electronic Commerce component, including, at a minimum, the Eligibility Verification and Electronic Claims Capture elements, and conversion of historical transactions
- Implementation of Prospective Drug Utilization, including conversion of ProDUR history
- Ensure compliance with the EDI requirements of HIPAA that must be implemented by February 2000
- Ensure a smooth transition from the incumbent operations to the new operations so that provider access to the eligibility verification, UT, Post and Clear, DME authorization, ProDUR, and electronic claims capture continue uninterrupted during the transition
- Capture and conversion of EMEVS on-line reports.

It is the Department's intent that the Medicaid data warehouse become the primary method for disseminating information on Medicaid and related programs. In this section, the offeror should describe its approach to populating the data warehouse from the multiple source systems: the EMEVS and the MMIS, along with the WMS and other State-operated systems. The

offeror should describe how the data can be consolidated, coordinated, scrubbed, and made consistent with the metadata.

It is the Department's intent that, by November 1, 2000, the contractor will have implemented the remaining components of the Replacement Medicaid System to enable the Department to terminate the current contract with the incumbent fiscal agent and to continue operations of the entire system, including the Medicaid data warehouse, under this contract. The offeror shall describe its approach to:

- Implementation of electronic claim attachments, which HIPAA requires be implemented by February 2001

- Implementation of the replacement components to the State-operated systems, with particular focus on the Provider Enrollment and Data Maintenance and Reference Data Maintenance components, including conversion of historical data

- Implementation of the MSIS and other requirements of the Balanced Budget Act of 1997

- Conversion of data from multiple systems with potentially overlapping, inconsistent, or even conflicting data

- Takeover and implementation of the existing SURS and MARS and integration of those components into the Replacement Medicaid System

The offeror should address coordinating the implementation of all components to ensure smooth transition from the current EMEVS, MMIS, and State-operated systems on a component-by-component basis while minimizing duplication between the current and replacement systems; maximizing efficiency in processing; and minimizing the impact on the State's users, providers, and clients.

The incumbent contractors shall be responsible for ensuring that the EMEVS and MMIS are Year 2000-compliant. There is no such plan for the State-operated systems. The offeror should address the plans for ensuring Year 2000 compliance during conversion when 1) the source system is expected to be Year 2000-compliant but the data does not reflect compliance and 2) the source system is known be non-compliant.

This section of the offeror's proposal shall specify location of development and implementation activities and the timing of any change of location between development, implementation, and ongoing operation of each component of the Replacement Medicaid System.

9.2.6 Approach to Operations of the Replacement Medicaid System

In this section, offerors are to outline their strategy for operations of the Replacement Medicaid System, including the Medicaid data warehouse. The strategy shall include location of operations, organization and staffing, the approach to operation of major functional areas, and their approach to systems evolution. It shall specify the offeror's approach to assumption of operational responsibilities on a component-by-component basis.

The response format in this section will be left to the offeror's discretion.

9.2.6.1 Location of Operations

The contractor will be required to locate the business operations along with the data storage and operations for the Medicaid data warehouse for this contract at a site within thirty (30) miles of the State Capitol Building in Albany, New York. The computer facility and back-up facilities may be anywhere in the continental United States.

The offeror will discuss the proposed facilities for business functions and for data processing, including the New York City facility. The discussion should include the approach to facilitating communications between the contractor's location and the Department, planned State staff office and parking space, and the identification of each operations activity that will be performed at a location other than the proposed local facility, including the proposed site for each function.

9.2.6.2 Organization and Staffing

The offeror shall include a staffing plan for Replacement System Operations. The plan should include:

- Type and number of personnel proposed for each operational unit (including all major service components)
- Summary job descriptions for all professional, managerial, and supervisory positions
- Designation of all positions considered key personnel by the offeror or defined by the Department in this RFP as a required key position and detailed resumes for the individuals proposed for these positions

The staffing plan should address each organizational unit required or specified to meet RFP requirements (including Evolution) and contractor responsibilities. The plan shall include a summary of the responsibilities and activities of the organizational unit and the timing for filling each position or category of positions.

The staffing plan shall describe the offeror's understanding of the role of the Medicaid data warehouse user support staff. The offeror should also describe the process by which the time and effort of the user support staff will be managed. In particular, the offeror should address the methodology for handling, prioritizing, and performing user requests for ad hoc reports or requesting support staff assistance.

The plan shall describe the approach to training operations staff and the time frame when training will occur. The plan shall discuss how the contractor expects to approach the assignment of Evolution personnel. Proposed quality assurance, retraining, and performance measurement functions shall also be described (or the offeror shall refer the reader to its response to execution and update of the quality assurance plan if the discussion is contained in that response). The plan shall identify and discuss the offeror's expectations or assumptions regarding anticipated changes in staffing levels in subsequent years of operations.

9.2.6.3 Approach of Operation of Functional Areas

The offeror will describe its approach to phased assumption and ongoing operation for each of the sixteen (16) functional areas defined in Section 7 of the RFP. The discussion for each functional area will describe:

- The approach to meeting the contractor's responsibilities for the functional area
- The offeror's expectations of the Department during operations
- The offeror's plan for continuous quality assurance and approach to meeting all performance standards defined in Section 7
- The offeror's plan for reporting results of operations to the Department

9.2.6.4 Approach to Evolution

Describe the approach to Evolution, including organization of the on-site staff and use of other resources. Provide resumes of key personnel or, if a position is unfilled, the job description and candidate selection criteria.

Describe the administrative processes used to manage the evolution effort, including change control tracking and reporting to the Department. Describe the metrics used to estimate and track resources for evolution projects.

Describe the approach to the evolution projects' systems development life cycle and maintenance of documentation.

9.2.7 Approach to the Medicaid Data Warehouse

In this section, the offeror will demonstrate that its approach to the design and development of the Medicaid data warehouse specified in Section 8 provides the best solution for the Department.

The offeror will identify the nature of the data warehouse base system that it is proposing: whether it is a proprietary solution for which the Department will be making licensing fee payments or a public domain data warehouse solution that the Department will retain for a successor contractor.

The offeror shall describe how it will meet the general system requirements in terms of:

- The ability to provide access to the number of Level I, Level II, and Level III users required; specify appropriate on-line response times
- The nature of the platform for the data warehouse
- Connectivity for both State and local district users
- Data refresh cycles
- System back-up and reliability
- System and database security

While addressing the access issue, offerors shall describe their approach to giving the users the choice to run queries in the foreground, background, or overnight.

The offerors shall describe their approach to the development and presentation of the metadata for the Medicaid data warehouse. The description shall include examples of metadata entries, how the metadata will be constructed, and how it will be used to assist in the management of the development and evolution of the Medicaid data warehouse.

Offerors must describe the methodology platform for the data warehouse. The description must address the requirements for:

- Information presentation
- Query capabilities
- Computational capabilities
- Information management
- Advanced analytical capabilities

In addressing the methodology platform for advanced analytical capabilities, the offeror must demonstrate, at a minimum, the analytical capabilities for episodes-of-care and populations-based analyses.

9.2.8 Approach to Implementation of Optional Components

There are three (3) components that the Department may wish to implement as a part of the Replacement Medicaid System. The decision whether to implement these components will be based on future events which will not be entirely within the control of the Department or the contractor. To ensure maximum flexibility, the Department is requiring the offeror to be able to implement these components at some time in the future, if the Department elects to exercise its option to implement any or all of these components. The Department reserves the right to independently solicit proposals and contract for these components.

Because these requirements are options which the Department may or may not implement, they will be priced separately and independently and will not be included in the final scoring for selection of the Replacement Medicaid System contractor. The pricing will be addressed in the offeror's Price Proposal, as defined in Section 9.3. In the Technical Proposal, the offeror will describe its approach to the implementation of these two (2) components, including integrating them with the appropriate functional area.

The Technical Proposal response will be scored as a mandatory item (i.e., on a pass/fail basis). Offerors are required to provide a response, but the content of that response will not be scored. However, the Department is seeking innovative solutions for these components. The Department's decision as to whether to exercise the options will to a large extent be based upon the offerors' Technical Response.

9.2.8.1 Front-End Electronic Fraud, Waste, and Abuse Prevention Module

MMISs are designed to process fee-for-service claims efficiently and to ensure that these claims are paid in accordance with the laws, regulations, and policies of the State of New York and the Federal government. To ensure appropriate payment, these systems edit the claim for a number of consistencies within the claim and with information on file:

- Client eligibility on the date of service

- Timeliness of submission
- Spenddown accuracy
- Provider enrollment
- Service coverage
- Prior approval/authorization
- Third-party liability, including Medicare
- Additional information, if required
- Duplicate claims
- Service limitations

These edits were not designed to detect fraud or abuse but can limit some areas of potential program abuse. The Medicaid Fraud Control Unit (MFCU) has requested the development of a claims processing module that can be used to prevent the expenditure of State and Federal funds on fraudulent, abusive, or wasteful claims and to reduce the need for postpayment recovery of expenditures.

This module shall allow the detection of potential fraud and to pend claims while the Department and MFCU investigate the propriety of the claims. The claims shall be pended when they fall within a suspicious pattern or represent an anomaly from normal patterns.

To assist the claims processing element of this module to determine whether claims are suspicious or anomalous, the system will collect collateral data on providers and use that collateral data and claims history to construct profiles of providers that can be used to target fraudulent, wasteful, or abusive behavior. This profiling shall be based on mathematical and statistical analysis of historical and current data.

The updated profiles shall be used as the basis for audits of the claims prior to payment. These audits shall include:

- **"Hot list" comparison** - Identification of whether the billing or performing provider is the subject of an ongoing investigation

- **Current fraudulent scheme profiles** - Screening claims based on the comparison of procedure, diagnosis, and formulary codes to known fraud and abuse schemes; known fraud/abuse profiles will be continually updated based on results of investigations

- **Recent history** - Analysis of current claims to the most recent six- (6-) months of history using algorithms which detect potential fraud and abused through peer group analysis

- **Collateral data** - Comparison of claims in process with data from outside the Replacement Medicaid System but which is collected by the system; examples of collateral data include:

  Medicare data
  Provider data
  Client data
  MFCU files
  Private insurance data

Offerors shall present their approach to this module and shall provide further innovative concepts. Offerors may describe their approach in terms of use of the Medicaid data warehouse, the New York State SUR, and other components of the Replacement Medicaid System to meet the needs of this module.

9.2.8.2 Medical Utilization Review (MUR)

Under an initiative to encourage better medical care of Medicaid clients, the Department is considering the capability to display to physicians (or other selected providers), via personal computers, the client's recent history. All fee-for-service claims would comprise the relevant history, including physician visits, other procedures, drugs, inpatient stays, lab tests, etc.

Similar in concept to the automated Prospective Drug Utilization Review (ProDUR), participating providers can access the client's history through personal computer dial-in or CPU-to-CPU connection.

Offerors may recommend how the patient's history can be most meaningful to practitioners. Diagnoses within the claims history can be used to identify chronic conditions (such as asthma or diabetes) that can impact current treatment. Physicians in an office setting may need the client history information displayed differently than physicians in an emergency room setting.

Offerors shall describe both software and hardware capabilities (including features of NYT) to prevent unauthorized access to the client information and preserve client confidentiality.

9.2.8.3 Client Repository Enhancement

The Department currently relies on the services of HASAC to support several processes within the Welfare Management System which are necessary as recipient identifiers to support claims processing and reporting but not for Medicaid eligibility determination. At this time local district workers are responsible for input of this information into WMS. The Office of Medicaid Management is dependent upon HSASC for support, maintenance and enhancement to the systems which support these functions. Examples of these processes include, but are not limited to:

- Restriction/Exception Subsystem
- Principal Provider Subsystem
- Pay-In Subsystem
- Third Party Subsystem
- Prior Approval Systems
- PCP Subsystem, including Enrollment and Scope of Benefits

Offerors are requested to propose a system which will allow the information currently contained in these systems to be entered directly to the Client Repository by local district workers. In addition to the information/processes identified above, the Client Repository Enhancement should allow for direct update of additional information, not currently available from local district

workers. Examples of this functionality include:

- Special program indicators
- Claiming identifiers to allow proper Federal, State and Local allocation
- Lock-in indicators for specific program participation
- Functional status of an individual
- Medicare/Buy-in status

All direct entry to the Client Repository should be possible both by local district workers and designated State staff. Necessary systems security, consistent with HCFA confidentiality and data transfer must be proposed. The system proposal will need to consider screen entry, edit structures, inquiry capability, reporting, as well as daily data transfer. All existing data at the time of conversion, for existing processes, will need to be converted.

Offerors shall present their proposed approach to this enhancement, including both hardware and software solutions as well as a projected time frame for completion.

9.2.9 Approach to Quality Management and Customer Service

The Department expects to work in partnership with the contractor to operate the Replacement Medicaid System and to meet the needs of the Department's Medicaid customers: clients, providers, local districts, DOH staff, and other New York State agencies. This section will describe the offeror's approach to that partnership.

9.2.9.1 Approach to Quality Management

The Department intends to enter into a contract with an offeror with a continuous focus on the importance of delivery of quality systems and services. In this section, the offeror shall describe its quality assurance commitment and provide a detailed outline of its quality management plan as

defined in Sections 3.4 (for Operations) and 6.2.1.9 (for Implementation). The offeror shall:

- Describe the internal controls for review of key deliverables and documents before they are submitted to the Department.
- Discuss the approach to program management that will ensure on-time and accurate completion of regular and ad hoc tasks.
- Discuss the approach to communications with the Department so that key parties will have a clear understanding of the status of implementation and operations as well as any issues that arise.
- Describe the quality assurance procedures to confirm that documents and transactions are being processed correctly.
- Discuss the approach to correcting quality problems that are identified and methods to prevent problems from reoccurring.

The offeror shall also provide information on its approach to contract management, including:

- Proposed project management tools, including whether they are automated or manual
- Proposed approach to project status reporting, as defined in Section 3.4, including examples of previous types of reports

9.2.9.2 Approach to Customer Service

Obtaining a high level of customer service from the offeror is a major goal of this procurement. Continuous improvement in customer service is part of the mission of both the Office of Medicaid Management and its contractor under this RFP, and a commitment to customer service should pervade every aspect of service delivery by the offeror. As discussed in Section 3.4 of this RFP, the Department desires to contract with a qualified offeror whose staff have a strong commitment to the tenets of customer service.

In this section, the offeror shall discuss its approach to customer service and provide a detailed outline of its Customer Service Plan (as defined in Section 3.4.5). The offeror shall discuss its approach to customer service

from the perspective of the Replacement Medicaid System stakeholders: the provider community, the local districts, New York State, and the client community. The offeror shall:

- Present its definition of the customer as it pertains to this contract and to customer service.
- Describe its approach to training its staff in the basics of delivering customer service.
- Describe its methods or procedures for ensuring that staff are delivering quality customer service.
- Discuss its strategy for continuously improving the quality of customer service.
- Discuss its approach for identifying reductions in customer service and resolving problems.
- Provide a discussion of how it will involve subcontractor staff (if applicable) in customer service efforts and ensure the quality of their services to the Department.
- Describe its plan for conducting customer satisfaction assessments and identification of the firm that will be conducting the surveys.
- Discuss proposed interfaces with Department staff (e.g., contract meetings, policy development, etc.).

9.2.10 Systems Integrator and Subcontractor Capabilities

In this section, the offeror will provide information on the organization acting as the prime contractor and any organizations acting as subcontractors. The roles and responsibilities of each subcontractor must be clearly identified.

9.2.10.1 Offeror Identification

The forms for completing this section are found in Appendix D. The offeror will identify the organization through the following:

- Provide a brief description, including name and address, of the systems integrator or prime contractor organization (Use Form A).

- Complete the Contractor/Subcontractor Background Questionnaire for the Offeror and any subcontractors (Use Form B).

- List the name, title, and responsibilities of all officers, identifying those who are authorized to negotiate a contract with the Department and who will have ultimate responsibility and accountability for this contract (use Form C).

- Give the full name and address of any organization with which the Offeror will subcontract for any services under this RFP and mechanisms for assuring effective and efficient operations. List responsible officers of each subcontractor, including those individuals authorized to negotiate for subcontractors. List any financial interest the offeror has in proposed subcontractors. Evidence of a potential subcontractor's willingness to participate or enter into subcontract arrangements should be included (use Form D).

9.2.10.2 System Integrator and Subcontractor Previous Experience

The Previous Experience section shall present the offeror's experience in data processing and systems integration, eligibility verification systems, Medicaid fiscal agent, MMIS and other medical claims processing, and provider relations experience. This section is to include information for the offeror and all significant subcontractors. The information must cover the past five (5) years.

The details of corporate experience shall be presented under the following headings:

- Experience with large-scale data processing system operations and facility management (other than medical claims and MMIS)

- Experience in large-scale data processing system development, installation, enhancement, and modification (other than medical claims and MMIS)

- Experience with medical claims processing operations and facility management or development, installation, enhancement, and modification (other than MMIS)

- Experience with MMIS (indicate clearly which projects demonstrate experience with design, development system integration, conversion, installation, staff training, certification, operation, maintenance, modification, enhancement, and turnover)

- Experience as a Medicaid fiscal agent, including states, dates of duration of contract, and volume of transactions

- Experience as a Medicare fiscal intermediary or Medicare carrier, or as a subcontractor to an intermediary or carrier

- Experience with the Medicaid program (i.e., projects other than MMIS development, installation, and operation; for example, technical assistance in developing reimbursement policy, designing a managed care delivery system, performing benefit and insurance recoveries, auditing providers)

- Experience with Medicaid or other medical provider relations

- Experience managing subcontractors

- Experience in the design, development, installation, and operation of technically advanced processes, including point-of-service claims submission and adjudication, plastic magnetic stripe identification cards, automated eligibility verification, local area networks (LANs), LAN-based ad hoc reporting systems, decision support systems, ProDUR, expert systems, and other automated business solutions

- Experience in the establishment and maintenance of Internet Web sites

For each referenced project, the offeror shall provide the following:

- Title of project

- Type of experience (data processing, eligibility verification, MMIS, Medicaid fiscal agent, medical claims processing or other large scale application system)

- Customer name

- Contract start and end dates

- Subcontractors' names (if any)
- Expected and actual end date of systems design, development, and implementation (if appropriate)
- Expected and actual beginning date of successful claims processing, if appropriate
- HCFA certification date (MMIS only)
- Staff months used for system design, development, and implementation
- Annual claims volume (claim line counts) or transaction volume, as appropriate identifying claims, encounters, and other transactions
- Number of Medicaid recipients and certified Medicaid providers (if any) or other metrics of database size
- Dollar value of contract (implementation cost and estimated annual operating costs, if applicable)
- Brief description of work
- Provider relations activities (staff, telephone lines, written correspondence, training)
- List of all lawsuits within the last five (5) years related to any large systems implementation, any claims processing, or other operations, including names of all parties, nature of the lawsuit, status or final disposition, and potential impact on the New York State contract
- Customer references, including name, address, and current telephone number

If significant subcontractors are proposed, the same information shall be provided for each subcontractor.

9.3 Price Proposal Requirements

The Price Proposal shall be separately bound and sealed and shall contain the pricing schedules described in the following sections. The pricing schedules

are included in Appendix L. The offeror must also provide audited financial statements for the past three (3) years for both the primary offeror and all proposed subcontractors and demonstrate the ability to secure the Letter of Credit requirements contained in Section 11.7.5.

9.3.1 Pricing Schedule A

Pricing Schedule A summarizes the component prices for all contractor activities during the base contract period, including the design and implementation of the Replacement Medicaid System, four (4) years of fiscal agent operations, and the implementation and operation of a data warehouse. It does not include the option years for fiscal agent operations. The Total Evaluated Price on this schedule should equal the sum of all other pricing schedule totals. A signature on this pricing schedule is required.

9.3.2 Pricing Schedule B

Pricing Schedule B includes all planning design, construction, testing, and implementation costs for the Replacement Medicaid System expressed as a fixed price for each of the components, excluding the Medicaid data warehouse. The sum of the individual prices quoted shall be the total price to bring all components of the Replacement Medicaid System to full operational status, including Federal certification.

9.3.3 Pricing Schedule C

Pricing Schedule C includes the implementation of the Medicaid data warehouse expressed as a fixed price. The price quoted shall be the total price to bring the New York State Medicaid data warehouse and the two (2) OMM baseline data marts to full operation status as approved by the Department for operations and by HCFA for enhanced funding. Pricing Schedule C also includes the annual cost of operating the Medicaid data warehouse.

9.3.4 Pricing Schedule D

The offeror shall specify a fixed annual price to operate the Replacement Medicaid System. This price will represent all contractor costs of a fixed

nature (costs not affected by changes in transaction volume). It shall include all infrastructure costs, including facility lease, hardware, system software licenses, fixed levels of personnel, and any other such costs. The offeror is required to show the components of the fixed annual price.

The offeror shall specify an amount included in the Total Annual Price for each contract year that is applicable to the operations of the New York City office, as required in Section 3.1.1. The Department may elect to permit the contractor to discontinue operations in New York City. This will be the amount deducted from the Fixed Administrative Fee if the Department exercises that option.

9.3.5 Pricing Schedule E

The offeror shall provide fixed rate per transaction for each of the transaction types to represent anticipate costs that may vary by transaction volume. The offeror will describe how the fixed rates were derived.

The offeror will extend each of the fixed rates by the following volumes to provide a total annual price:

- Claims transactions 200,000,000
- Managed care encounter transactions 50,000,000
- Eligibility verification transactions 140,000,000

These annual volumes will be used for price evaluation purposes only. Neither the transaction volumes nor the ratio between the volumes of each type imply any expectation on the part of the Department for future volumes or ratios and should not be relied upon by the offeror as a representation or expectation of actual volumes. The derived annual price for each contract year will be carried to the appropriate column in Pricing Schedule A.

9.3.6 Pricing Schedule F

The offeror shall specify the daily rate for each of the labor categories specified and the number of staff required. The total number of Evolution staff shall not be less than seventy-five (75) and shall include a minimum of four (4) Documentation Specialists.

The total staffing shall also include the ten (10) Data Warehouse User Support Staff for the first year of operations and six (6) support staff for each subsequent year of operations.

Pricing Schedule F also contains a provision for a pool of evolution days to be used at the Department's discretion. These evolution days shall be priced at the Programmer-Analyst (5+ years) level but can be used at the appropriate rates for any levels of additional evolution staff needed by the Department. Any unused days at the end of a contract year shall be carried to the subsequent contract year. Unused days at the end of the contract will be rebated to the Department.

The rates proposed for each contract year shall remain fixed for the term of the contract. These rates shall also be used to develop price quotations for temporary use of additional resources or for permanent increases in the size of the evaluation staff complement.

9.3.7 Pricing Schedule G

The offeror shall present an estimated price for the implementation of each of the optional features described in Section 9.2.8.

The offeror shall also present a fixed rate for key data entry services as described in Section 6.3.1 of this RFP.

Table of Contents
Section 10

Section 10
Evaluation Approach

10.1 Introduction

This section describes the methodology that will be used to evaluate proposals received in response to this RFP. Proposals will initially be reviewed for compliance with mandatory requirements. Proposals deemed to be in compliance will then be evaluated from both a technical and cost perspective by designated Department personnel.

Each proposal will be assessed for compliance with mandatory requirements and quality using predefined criteria and the proposal submission instructions detailed in the RFP. Consistent with the "best buy" approach under which this procurement is being conducted, technical merit will be given more emphasis than price. The ratio between technical and price is seventy percent (70%) technical and thirty percent (30%) price.

After review of each proposal for compliance with the mandatory submission requirements, each Technical Proposal will be evaluated in five (5) general categories, linked to the proposal submission requirements defined in Section 9 of this RFP:

- Approach to Replacement of the Medicaid Systems
- Approach to Operations of the Replacement Medicaid System
- Approach to a Medicaid Data Warehouse
- Approach to Quality Management and Customer Service
- Systems Integrator and Subcontractor Capabilities

The Department will assign each of the general categories a portion of the overall points available for the Technical Proposal. Within each general category, detailed evaluation criteria will be point-scored on a scale of zero (0) to ten (10) by each evaluation team member. The scores of all evaluators will be added, averaged, and multiplied by the preassigned criterion weight to determine the proposal score for each criterion.

Price Proposals will be reviewed to ensure compliance with proposal submission criteria, and then prices will be evaluated on a ratio basis. The lowest price will receive the maximum evaluation points available. Other proposals will receive a proportional number of evaluation points based on the ratio of the proposal's Total Evaluated Price to the lowest Total Evaluated Price.

The highest-ranking proposal will be recommended for award of the contract. Final ranking will be based on the total Technical and Price Proposal score of each proposal submitted.

10.2 Review of Mandatory Requirements

Each Technical Proposal will be reviewed to ensure compliance with the mandatory submission criteria contained in Appendix I. The proposals will be evaluated on a pass/fail basis for each criterion. Any proposal that fails a criterion will be subject to rejection. The Department may require clarification from offerors for purposes of assuring a full understanding of responsiveness to the proposal requirements.

When Price Proposals are opened, each proposal will be reviewed for compliance with the mandatory submission criteria contained in Appendix I of this RFP. Any proposal that fails one (1) or more of the criteria may cause the Department to reject the proposal. The Department may require clarification from offerors for purposes of assuring a full understanding of responsiveness to the proposal requirements. In addition, Offerors must pass a preliminary evaluation of financial strength to be determined "qualified" for further consideration. Offeror's financial strength and stability, along with that of any proposed subcontractors, will be examined to ensure sufficient assets are avialable to perform the magnitude of services required, including expenses such as takeover, seasonal or unpredictable volume fluctuations, and potential performance penalties.

The Department reserves the right to delete a mandatory requirement if it has a minor impact on the evaluation or the contract. In this event, the requirement shall be eliminated for all proposals.

10.3 Evaluation of Technical Proposals

The evaluation of Technical Proposals will be conducted in three (3) steps:

- Scoring of Technical Proposals
- Evaluator Discussions
- Final Scoring and Ranking

A general overview of the process is provided in the following paragraphs. The technical evaluators will not have knowledge of, or access to, the Price Proposal during the technical evaluation process.

10.3.1 Scoring of Technical Proposals

Each Technical Proposal passing the mandatory submission criteria will be evaluated for the quality, completeness, value, and desirability of the offeror's response to the submission requirements detailed in Section 9 of this RFP. Evaluators will use detailed evaluation criteria within each evaluation category to score the proposals. The possible Technical Proposal points available to each category are:

Approach to Replacement of the Medicaid Systems	3,500
Approach to Operations of the Replacement Medicaid System	2,200
Approach to a Medicaid Data Warehouse	1,500
Approach to Quality Management and Customer Service	400
Systems Integrator and Subcontractor Capabilities	400
Total Technical Points	**8,000**

10.3.2 Evaluator Discussions

After all evaluators have completed their independent evaluations of each assigned proposal or proposal section, they will meet to discuss the proposals and their preliminary scores. The purpose of the discussion is not to obtain a consensus, but rather to identify significant variances in evaluator scores and to discuss those variances to ensure that all evaluators have a full understanding of each proposal. The discussion also provides the evaluators the opportunity to assess whether they have applied the scoring scale in a consistent manner across all proposals.

10.3.3 Oral Presentations and Product Demonstrations

The Department reserves the right to require offerors to make an oral presentation and/or product demonstration, as described in Section 2.2.8. It will be the Department's option to determine the schedule and format for all oral presentations and demonstrations.

No specific points will be assigned to oral presentations or product demonstrations. The evaluators will be afforded an opportunity to refine their scoring on any portion of the Technical Proposal based on the results of the oral presentations or product demonstrations.

10.3.4 Final Scoring and Ranking

Following the evaluator discussions and oral presentations, each evaluator will finalize his/her scores for each proposal and submit the final scoring sheet to the evaluation coordinator. The coordinator will calculate an average score for each criterion for each proposal, multiply the average score by the preassigned weight, and total the weighted score for each category for each proposal.

The Technical Proposals will first be ranked by the total weighted score. Then the scores will be normalized by awarding the highest-ranking proposal with the maximum Technical Proposal score. The remaining proposals will receive a proportional score, using the following formula:

$$y = (n/z) * 7{,}000$$, where:

n = Total weighted points for offeror n

z = Total weighted points for the highest-ranked offeror

y = Technical Proposal points for offeror n

10.4 Price Evaluation

Price Proposals that pass the mandatory submission criteria, as discussed in Section 10.2, will be reviewed for the mathematical accuracy of the submitted pricing sheets. Any discrepancies will be referred to the evaluation coordinator for correction and resubmission by the offeror. The Department reserves the right to reject any proposal with discrepancies in the Price Proposal.

The Price Proposals will then be ranked by Total Evaluation Price as indicated on Pricing Schedule A. The offeror with the lowest Total Evaluated Price will receive the maximum Price Proposal score, and other offerors will receive a proportional score using the following formula:

y = (z/n) * 3,000, where:

z = Lowest Total Evaluated Price

n = Total Evaluated Price for offeror n

y = Price Proposal score for offeror n

10.5 Contractor Selection

The final step in the evaluation process is the final contractor selection. This involves two steps: Evaluation Committee recommendation and Selection Committee approval.

10.5.1 Evaluation Committee Recommendation

The Evaluation Committee will combine the Technical and Price Proposal points for each offeror and determine the total point score for each. The offerors will then be ranked on the basis of total point score.

The highest-ranked offeror based on the results of this scoring will become the Evaluation Committee's recommendation of the apparent selected contractor.

10.5.2 Contractor Selection

The Evaluation Committee will submit to the Selection Committee its recommendation of the apparent selected contractor along with the final ranking of all offerors. The Selection Committee, composed of senior-level managers, will make the final contractor selection, consolidating the Evaluation Committee recommendation as well as other information to determine the selection that is in the best overall interest of the State. Any such additional information will be evaluated on an equal basis for all offerors.

The final selection is subject to review and approval by the Commissioner of the New York State Department of Health.

Table of Contents
Section 11

Table of Contents
Section 11 (continued)

Table of Contents
Section 11 (continued)

Table of Contents
Section 11 (continued)

Section 11
Contract Terms and Conditions

This section, along with Appendix A (Standard Clauses for All New York State Contracts), contains the text for the Contract terms and conditions that will be incorporated into the Contract with the selected offeror. The terms and conditions contained in this section and in Appendix A shall constitute the basis for the Contract resulting from this RFP. This RFP, as well as the selected Proposal, shall become part of any contract between the parties. The Department is solely responsible for rendering decisions in matters of interpretation of all terms and conditions.

The Medicaid data warehouse is considered to be an integral part of the Replacement Medicaid System. As such, the contract terms and conditions that follow apply to development and operations of the Medicaid data warehouse as a part of the Replacement Medicaid System.

11.1 Contract Basis

11.1.1 Parties to the Contract

The parties to this Contract shall be the selected offeror, hereinafter referred to as "the Contractor," and the New York State Department of Health, hereinafter referred to as "the Department."

11.1.2 Execution of Contract

The Contract shall become effective after review and approval by the Commissioner of Health, by representatives of all other applicable State approving agencies, and after signature by authorized representatives for each party hereto. The Contract shall be subject to approval by the Health Care Financing Administration (HCFA). By their signature, the representatives confirm that they have the proper and legal authority to sign and bind their organization and that each party has the legal right and power to perform all acts required by this Contract.

Specifically, in accordance with Clause 3 of Appendix A, the Contract shall not be effective or binding on the State until it has been approved by the State Comptroller and filed in his office.

11.1.3 Documents Constituting the Contract

The Contract between the parties, in addition to the signed clauses and any subsequent amendments, shall include the provisions of this RFP and any addenda thereto, as well as the Proposal and any agreed-upon clarification thereto, all of which are incorporated in the Contract by reference.

In the event of any conflict, ambiguity, or inconsistency among these documents, the following order of precedence shall be applied to resolve the conflict:

- First, the Contract (which incorporates Appendix A), including any Amendments thereto
- Second, the RFP (which incorporates this Section), including any addenda thereto
- Third, the Contractor's Proposal submitted in response to the RFP and any addenda requested and accepted by the Department

A higher order document shall supersede a lower order document to the extent necessary to resolve any inconsistencies between them, but silence on any matter in a higher order document shall not negate or modify the provisions of a lower order document as to that matter.

11.1.4 Compliance With Applicable Laws

The Contractor shall at all times during the term of this Contract strictly adhere to all applicable Federal and State laws and implementing regulations as they currently exist and as may hereafter be amended. This includes protection of the confidentiality of all applicant/recipient records, papers, documents, tapes and any other materials that have been or may hereafter be established which relate to this Contract. The Contractor acknowledges that these laws include, but are not limited to, the following:

- Title VI of the Civil Rights Act of 1964, 42 U.S.C. Sections 2000d-1 et seq. and its implementing regulation, 45 CFR Part 80 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, and its implementing regulation, 45 CFR Part 84

- Age Discrimination Act of 1975, 42 U.S.C. Sections 6101 et seq. and its implementing regulation, 45 CFR Part 91
- Title VII of the Civil Rights Act of 1964
- Age Discrimination in Employment Act of 1967
- Equal Pay Act of 1963
- Education Amendments of 1972
- Immigration Reform and Control Act of 1986, P.L. 99-603
- Americans with Disabilities Act, P.L. 101-336, July 1990
- All regulations applicable to these laws prohibiting discrimination because of race, color, national origin, handicap, age, sex, and religion.

This assurance is given in consideration of and for the purpose of obtaining any and all Federal and/or State funding.

11.1.5 Contract Administration

The Director of the Bureau of Medicaid Systems is designated as the Contract Administrator. The Contract Administrator or designee shall be responsible for all matters related to this Contract.

Whenever, by any provision of the Contract, any right, power, or duty is imposed or conferred on the State or the State agency, said right, power, or duty so imposed shall be possessed and exercised by the Contract Administrator. The Contract Administrator is authorized to delegate certain rights, powers, or duties. Notice of such delegation of authority will be conveyed to the Contractor in writing.

The Contract Administrator will issue, from time to time, such written specifications and instructions as may be necessary to clarify to the Contractor its scope of work and performance obligations. The Contract Administrator

may periodically conduct evaluations, or request independent evaluations be conducted, of the Contractor's performance and deliverables. The Contractor shall promptly undertake such improvements and corrections as may be reasonably necessary to correct the problems or deficiencies identified in the periodic evaluations.

The Contract Administrator will designate a Project Manager who will be the Contractor's primary contact for working with other Department staff. The Project Manager will initially receive all Contractor progress reports and deliverables, oversee scheduling of meetings with Department staff, and maintain first-line administrative responsibility for the Contract.

The Project Manager or designee shall determine successful completion of all Implementation Phase milestones. The Project Manager will also track overall progress, formally review and approve all deliverables, authorize Contractor reimbursement, and confirm final readiness for start of operations and acceptance of the system.

The Project Manager or designee will chair weekly status meetings during the Implementation Phase and attend all formal project walk-throughs.

The Project Manager shall have direct oversight of the entire Replacement Medicaid System project and may request periodic presentations by the Contractor that demonstrate progress achieved during the project.

In no instance shall Contractor staff refer any matter to the Contract Administrator or any other official in New York State unless initial contact, both verbal and in writing, regarding the matter has been first presented to the Project Manager.

11.1.6 Fiscal Agent Contract

The New York State Social Services Law, Article 5, Title 11, Section 367-b, Paragraph 8 permits the State of New York to enter into contracts with fiscal intermediaries or fiscal agents for the ". . . design, development, implementation, operation, processing, auditing and making of payments . . . for medical assistance claims . . ." This Contract constitutes a fiscal agent agreement pursuant to the Social Services Law.

The New York State Finance Law, Article 11-A, Section 179-p, Paragraph 4 exempts payments due to fiscal agent contractors from interest under the State's prompt payment requirements.

11.2 Contract Term

This Contract shall become effective on the date that is approved and signed by an authorized representative of the Contractor, by the Commissioner of Health or her designee, and by all approving agencies. The initial Contract period shall begin on that effective date and shall extend for six (6) years. At the Department's option, and with the approval of the State Comptroller, the Contract may be extended for up to two (2) one- (1-) year periods. At the Department's option the Contract may also be extended in one- (1-) month increments for up to six (6) months.

The initial Contract period shall cover all transition activities, development activities for the Replacement Medicaid System, fiscal agent start-up, Replacement Medicaid System operations, and Turnover Activities (if requested by the Department). These activities shall all be completed within the six- (6-) year initial contract term.

If the Department elects to exercise any of the one- (1-) year option periods, notice shall be sent to the Contractor at least one hundred eighty (180) calendar days prior to the end of the current contract period. If the Contractor has not received notice of the Department's intent to exercise such option, it shall then complete all remaining Turnover Task responsibilities specified in Section 6.4.4.

If the Department elects to exercise one or more of the one- (1-) month options, notice shall be sent to the Contractor at least sixty (60) calendar days before the end of the current contract period.

All contract extensions shall be subject to approval by the State Comptroller and by HCFA.

11.3 Contract Amendments and Disputes

11.3.1 Amendments

The Contract may be modified or amended at any time by the mutual consent of the Contractor and Department. All such Amendments shall be in writing and shall become effective only when approved by all applicable State authorities and HCFA, as necessary.

An approved contract amendment is required whenever a change affects the payment provisions, the scope of work, or the term of the Contract.

If any change in the scope of work affects costs or the time required to perform other work, an equitable adjustment may be made in the payment provisions or delivery schedule, or both. Failure of the Contractor to agree to an equitable adjustment shall be considered a dispute and resolved under the provisions described in Section 11.3.2.

In general, changes requiring system modifications shall be performed as part of the Evolution Process and shall not require a contract amendment nor additional funding. Provisions for the Evolution Process are addressed in Section 6.3.2.

If the Contractor is required to perform additional work based on new requirements, including changes in State or Federal regulations, the Contractor may submit an expansion of work request. Enhanced Federal funding support may be required to implement these changes. A formal proposal from the Contractor shall be submitted in response to a request to implement major system changes. That proposal will identify any additional staffing requirements and will present a work plan for the effort and an estimated budget. The Contractor's proposal/response shall be submitted in writing by the date requested by the Department. The Department will either approve or reject the estimate or request more information.

A formal Price Proposal submitted by the Contractor shall be prepared in the same format as the Pricing Schedules provided in Appendix L of this RFP. For example, if the Contractor is proposing a change in the Annual Administrative Fee as a result of the contract amendment, the proposal format shall be the same as Pricing Schedule D. Such proposal shall illustrate the proposed incremental price using the same rates, the same corporate allocation, and the same markup as was used in the Contractor's Proposal submitted in response to this RFP. The incremental prices shall be

accompanied by sufficient documentation demonstrating, to the Department's satisfaction, that the changes in the Contractor's cost due to the change in the scope of work justifies the incremental price proposal.

Amendments to this Contract are subject to the approval of the Office of the State Comptroller as specified in Clause 3 of Appendix A.

11.3.2 Disputes

Contract disputes will be handled in accordance with the following procedures.

11.3.2.1 Negotiation

Any dispute or controversy between the Department and the Contractor arising under or relating to this Contract which either party hereto feels is significant shall be reduced to writing by that party and delivered to the other party. The parties hereto shall then negotiate in good faith and use every reasonable effort to resolve such dispute and shall not resort to any formal proceedings to resolve such dispute until they have reasonably determined that a negotiated resolution is not possible.

11.3.2.2 Dispute Resolution

Any dispute or controversy between the Department and the Contractor which cannot be disposed of through negotiation shall be decided by a designee of the Commissioner of the New York State Department of Health. Both the Department and the Contractor shall present written statements of issues and facts in dispute. The designee of the Commissioner shall make a determination and issue a written decision within fifteen (15) calendar days.

Upon issuance of such decision, the parties shall proceed diligently with the performance of this Contract and shall comply with the provisions of such decision.

11.3.2.3 Appeal to the Commissioner

The decision of the designee of the Commissioner shall be final and conclusive unless the Contractor submits a written appeal to the Commissioner of the New York State Department of Health. Such appeal must be submitted within fifteen (15) calendar days of the date of the decision by the designee of the Commissioner

In the event of an appeal, the Commissioner shall promptly review the dispute resolution decision and shall confirm, annul, or modify it. The Contractor shall be afforded the opportunity to be heard de novo and offer evidence in support of its appeal.

The decision of the Commissioner shall be final and conclusive.

11.3.2.4 Proceed With Duties

During the time that the parties hereto are attempting to resolve any dispute in accordance with the provisions of the Contract, each of them shall diligently perform its duties hereunder.

11.4 Interpretations, Subcontracting, and Assignments

11.4.1 Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and subject to approval of HCFA. Forbearance or indulgence in any form or manner by either party, in any regard whatsoever, shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the provision may apply. Notwithstanding any such forbearance or indulgence, until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any legal or equitable remedy available to it.

11.4.2 Assignments

The Contractor shall not assign, or in any way transfer any interest in, this Contract without prior written approval of the Department. See Clause 2 of Appendix A.

11.4.3 Subcontracting

The services to be provided by the Contractor shall not be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without the prior written consent of the Department. However, it is the intent of the Department to encourage the Contractor to enter into subcontract relationships to obtain the expertise required to fully meet the needs of the State of New York; therefore, the Department will not unreasonably withhold approval of such subcontracts. Suppliers of equipment, expendable supplies, or other purchase orders shall not be considered subcontractors for the purposes of this Contract.

All subcontracts must be approved in writing prior to the effective date of any subcontract. All subcontracts included in the Proposal shall be considered approved by the signing of the Contract. The determination of whether such consent will be provided shall be within the sole discretion of the Department. The Contractor shall be wholly responsible for performance of all work performed under the Contract whether or not subcontractors are used. This responsibility shall include subcontractor commitments in meetings or documents where decisions are made.

All subcontracts shall be in writing and must contain certain provision which are functionally identical to, and consistent with, the provisions of this Contract. Such provisions shall include Appendix A (Standard Clauses for All New York State Contracts), Rights to System, Termination of Contract, Disputes, Audit Requirements, and Confidentiality.

Any subcontract to which the Department has consented shall in no way alter the terms and conditions therein. No subcontract or delegation shall relieve or discharge the Contractor from any obligation or liability under the Contract. The subcontractors are subject to the same conditions as the Contractor and subsequent contract amendments. Performance of any work by "contract employees" hired by the Contractor shall be considered the sole responsibility of the Contractor and not be construed as a subcontracting relationship.

11.4.4 Award of Related Contracts

The Department may undertake or award supplemental contracts for work related to the New York State Replacement Medicaid System or any portion thereof. The Contractor shall be bound to cooperate fully with such other Contractors and the Department in all such cases. All subcontractors shall be required to abide by this provision as a condition of the Contract between the subcontractor and the Contractor.

11.4.5 Existing Guidelines

Any reference to State or Federal statutes or the rules or regulations promulgated thereunder shall be deemed to be referring to such statutes, rules, or regulations as they exist on the effective date of the Contract, the date of their adoption, or the specified effective date in the approved State rule or regulation, whichever comes later.

11.5 Rights to System

11.5.1 Ownership of Medicaid Systems

The Department shall own, and the Health Care Financing Administration (HCFA) shall have a nonexclusive, royalty-free, and irrevocable license to reproduce or otherwise use and authorize others to use, all software, procedures, files, and other documentation comprising the New York State Replacement Medicaid System at any time during the period of the Contract and thereafter. The Contractor agrees to deliver such material to the Department within twenty (20) business days from receipt of the request by the Department. Such request may be made by the Department at any time prior to the expiration of the Contract.

The license shall include any software and hardware required to fully operate the Replacement Medicaid System that is not commercially available to the State of New York and shall specifically include:

- All New York State Replacement Medicaid System software and supporting programs in the most current version; the New York State Replacement Medicaid System shall be inclusive of all components

defined in Sections 7 and 8 of this RFP, including the Medicaid data warehouse as modified by the Joint Application Design sessions, documented in the approved Business Design Document, or as subsequently modified through Evolution projects under this Contract or its amendments

- All job control language (JCL), UNIX scripts, transaction management or database synchronization software, and other system instructions for operating the New York Replacement Medicaid System, in the most current version

- All data files, in the most current version

- User and operating manuals and other documentation

- System and program documentation describing the most current version of the New York State Replacement Medicaid System, including the most current versions of source and object code

- Training programs for Department and other designated State staff, their agents, or designated representatives, in the operation and maintenance of the system

- Any and all performance-enhancing operational plans and products, exclusive of equipment

- All specialized or specially modified operating system software and specially developed programs, including utilities, software, and documentation used in the operation of the Replacement Medicaid System

All computer source and executable programs and all documentation of the installed system enhancements and improvements shall become the exclusive property of the Department and may not be copied or removed by the Contractor or any employee of the Contractor without the express written permission of the Department.

Proprietary software proposed for use as an enhancement or within a functional area of the New York State Replacement Medicaid System may require the Contractor to give to the State an irrevocable right to use the software as part of the New York State Replacement Medicaid System unto perpetuity. Exemptions would be granted if the proprietary product is proposed with this right in place and is defined with sufficient specificity in

the proposal that the Department can determine whether to fully accept it as the desired solution. The Contractor shall provide sufficient information regarding the objectives and specifications of any proprietary software to allow its functions to be duplicated by other commercial or public domain products.

Any other specialized software that is not covered under a public domain license that will be integrated into the New York State Replacement Medicaid System shall be identified as to its commercial source. Licenses to such commercial software shall be established such that the license may revert to the State or successor contractor at the end of the Contract. If this assignment is not permitted by the licenser, the Contractor shall obtain a licensed copy of the commercial software in the State's and/or a successor contractor's name as a part of the Turnover Requirements as defined in Section 6.3.4.

Title to the complete system shall be transferred to the State, including portions (e.g., documentation) as they are created during the implementation of the system or prior to the start of Replacement Operations and subsequently at the time of implementation of any changes to the Replacement Medicaid System.

The Contractor shall convey to the Department, every six months or upon request and without limitation, copies of all system documentation, operating instructions and procedures, and all data processing source and executable programs that are part of the Replacement Medicaid System, whether they are developed by the employees of the Contractor or any subcontractor as part of this Contract or transferred from another MMIS or contract. If requested by the Department, the Contractor shall make this conveyance to a successor contractor.

Any software developed under this Contract, whether it is a part of the operational Replacement Medicaid System or not, shall be owned by the State of New York and shall be subject to all of the provisions of this section of the Contract.

The provisions of this clause shall be incorporated in any subcontract which relates to the development, operation, or maintenance of any component part of the Replacement Medicaid System.

11.5.2 Ownership of Information and Data

The State of New York and HCFA shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, installed or improved, or furnished by the Contractor under this Contract.

All files containing any New York State Medicaid information are the sole and exclusive property of the State. The Contractor shall not use data on the New York State Medicaid program for any purposes not directly related to this Contract without prior written permission from the Department.

11.5.3 Right to Publish

Throughout the term of the Contract, the Contractor shall secure the written approval of the Department prior to the release of any information that pertains to work or activities covered by this Contract.

11.5.4 Confidentiality of Information

The Contractor will protect the confidentiality of all records and other materials containing personally identifying information that are maintained in accordance with this Contract. No information in possession of the Contractor about any individual constituent shall be disclosed in any form without the prior written consent of the Department. The Contractor will have written policies governing access to, and duplication and dissemination of, all such information.

The Contractor will advise its employees, agents, and subcontractors, if any, that they are subject to these confidentiality requirements. The Contractor will provide its employees, agents, and subcontractors, if any, with a copy or written explanation of these confidentiality requirements. Contractor staff may be required to sign a Department-approved confidentiality statement before access to confidential data is permitted.

For purposes of this Contract, Medicaid data received by the Contractor, particularly data concerning Medicaid providers and clients, will be handled under the Contractor's confidentiality policy or under the State and Federal confidentiality policies, whichever is more restrictive. All information requests from agencies and individuals will be referred to the Department for handling. The Department has absolute authority to determine if and when any other party has properly obtained the right to have access to this confidential information.

11.5.5 Inspection of Work Performed

The Department or any authorized representative of the State of New York, the U.S. Department of Health and Human Services, the U.S. Comptroller General, the U.S. General Accounting Office, or their authorized representatives shall, at all reasonable times, have the right, without prior notice, to enter the Contractor's premises or such other places where duties under this Contract are being performed to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The Contractor and all subcontractors must provide reasonable access to all facilities and assistance to the State and Federal representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work.

11.6 Termination of Contract

This Contract shall be subject to the following termination provisions. The Contract may be terminated by mutual written consent of the parties. The Contract may also be terminated by the Department:

- For default
- For convenience
- For unavailability of funds
- For Contractor financial instability

All notices of termination, as defined in the sections below, shall be in writing and shall be forwarded by either certified or registered mail, return receipt requested, commercial overnight mail service or hand delivery.

11.6.1 Termination for Default

The Department may terminate this Contract in whole, or in part, whenever the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities or failed to negotiate a proposed contract change in a responsive manner, and that the Contractor is unable or unwilling to cure such failure within a reasonable period of time, as specified in writing by the Contract Administrator, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities or to negotiate a proposed contract change in a responsible manner, the Contract Administrator shall notify the Contractor of the failure and, unless the failure cannot be remedied, establish a reasonable time period in which to cure such failure if remedy is possible. The Department may reduce or stop payments at its sole discretion pending completion of the cure. If the Contractor is unable to cure the failure within the specified time period, the Contract Administrator will notify the Contractor that the Contract, in whole or in part, has been terminated for default on the date specified in the notice.

If, after notice of termination for default, it is determined by the Department, or by a court, that the Contractor was not in default, or that the Contractor's failure to perform or make progress in performance or to conclude negotiations was due to causes beyond the control and without error or negligence of the Contractor or any of its subcontractors, the Notice of Termination shall be deemed to have been issued as a termination for the convenience of the State, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in whole or in part, as provided by this clause, the Department may procure, upon such terms and in such manner as may be deemed appropriate, supplies or services similar to those terminated, and the Contractor shall be liable to the Department for any excess costs for such similar supplies or services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred by the Department in procuring such similar supplies or services. Charges for such costs may be assessed against the Contractor's letter of credit for any outstanding payments for services.

The rights and remedies of the Department provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

11.6.2 Termination for Convenience

The Department may terminate performance of work under this Contract, in whole or in part, whenever for any reason the Contract Administrator shall determine that such termination is in the best interest of the State upon ninety (90) calendar days' prior written notice to the Contractor.

In the event that the Department elects to terminate the Contract pursuant to this provision, the Contract Administrator shall notify the Contractor of the basis and extent of termination. Termination shall be effective as of the close of business on the date specified in the notice, and the Contractor shall comply with all specified provisions of the Notice of Termination, including completion of specified Turnover activities as specified in Section 7.3.

11.6.3 Termination for Unavailability of Funds

It is understood and agreed by the parties hereto that all obligations of the Department, including the continuance of payments hereunder, are contingent upon the availability and continued appropriation of State and Federal funds, and in no event shall the Department be liable for any payments hereunder in excess of such available appropriated funds. In the event that the amount of any available or appropriated funds provided by the State or Federal sources for the purchase of services hereunder shall be reduced, terminated, or not be continued at an aggregate level sufficient to allow for the purchase of the specified services to be provided hereunder, for any reason whatsoever, the Contract Administrator shall notify the Contractor of such reduction of available funds, and the Department shall be entitled to reduce this contractual commitment hereunder or to terminate the Contract as it deemed necessary, without penalty, under the same provisions as Termination for Convenience.

11.6.4 Termination for Financial Instability

In the event that the Contractor ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the Department may, at its option, immediately terminate this Contract. In the event that the Department elects to terminate the Contract under this provision, it shall do so by the Contract Administrator sending notice of termination to the Contractor specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor shall immediately so advise the Contract Administrator. The Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of this Contract.

11.6.5 Procedures on Termination

Upon delivery to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the Contractor shall:

- Stop work on the date and to the extent specified in the Notice of Termination.
- Place no further orders or subcontracts for materials, services, or facilities.
- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination.
- Assign to the Department in the manner and to the extent directed by the Contract Administrator all of the rights, title, and interest of the Contractor under the orders or subcontracts so terminated, in which case the Department shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts using funds due the Contractor.
- With the advance approval of the Contract Administrator, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable, in whole or in part, in accordance with the provisions of this Contract.

- Within ten (10) business days from the effective date of termination, transfer title to the State of New York (to the extent that title has not already been transferred) and deliver in the manner, at the times and to the extent directed by the Contract Administrator, all files, processing systems, data manuals, or other documentation in any form, that relate to the work terminated by the Notice of Termination.

- Complete the performance of such part of the work as shall not have been terminated by the Notice of Termination.

- Take such action as may be necessary, or as the Contract Administrator may direct, for the protection and preservation of the property related to the Contract which is in the possession of the Contractor and in which the State of New York has or may acquire an interest.

The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

11.6.6 Termination Claims

After receipt of a Notice of Termination, the Contractor shall submit to the Contract Administrator any partial or full termination claim for payments in the form and with the certification prescribed by the Contract Administrator. Such claim shall be submitted promptly, but in no event later than six (6) months from the effective date of termination, unless one (1) or more extensions in writing are granted by the Contract Administrator within such six- (6-) month period or authorized extension thereof. Upon Contractor submission of its termination claim within the time allowed, the Contract Administrator may, subject to any review required by the Department procedures in effect as of the date of execution of the Contract, determine, on the basis of information available, the amount, if any, due to the Contractor by reason of the termination and shall thereupon cause to be paid to the Contractor the amount so determined. In no case shall the Contractor's termination claims include any claim for unrealized anticipatory profits.

Subject to the provisions of the previous paragraph and subject to any review required by the Department procedures, the Contractor and the Department may agree upon the amounts to be paid to the Contractor by reason of the total or partial termination of work pursuant to this article. The Contract shall be amended accordingly.

In the event of the failure of the Contractor and Department to agree, in whole or in part, as to the amounts with respect to costs to be paid to the Contractor in connection with the total or partial termination of work pursuant to this article, the Contract Administrator shall determine on the basis of information available the amount, if any, due to the Contractor by reason of termination and the State shall pay to the Contractor the amount so determined. The Contractor shall have the right of appeal, as stated under the Disputes provisions contained in Section 11.3.2, from any such determination made by the Department.

11.7 Guarantees, Warranties, and Certifications

11.7.1 Warranty

Notwithstanding prior acceptance of deliverables or software, the Contractor shall expressly warrant all modified or developed programs and documentation as properly functioning when installed and compliant with the terms of the Contract thereafter. The Contractor must correct all errors and design deficiencies in the system enhancements and improvements installed at the start of operations and in subsequent system modifications. Incorrect or defective programs and documentation shall be replaced within one (1) week of notification from the Contract Administrator of such deficiencies or within such period as may be necessary to make correction(s) using all due diligence and dispatch as agreed upon between the Department and the Contractor. If the Contractor fails to repair an identified error, deficiency, or defect within such period, the Department may, at its sole discretion, act to repair, and the Contractor expressly agrees to reimburse the Department for all costs incurred thereby. This warranty shall be in effect throughout the term of the Contract and for three (3) months thereafter. Deficiencies properly noted before expiration of the warranty shall be covered regardless of such expiration. System modifications and other changes made during the Contract period shall also be covered by this warranty.

11.7.2 Conformance With State and Federal Regulations

The Contractor shall comply with all State and Federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Contract, including those not specifically mentioned in this section. Authority to design and develop modifications to the operational Replacement Medicaid System or to make software or operational changes to implement new State or Federal requirements will be given to the Contractor by the Contract Administrator.

In the event that the Contractor requests, in writing, that the Department issue program policy determinations or operation guidelines required for proper performance of this Contract, the Department shall acknowledge receipt of the request, in writing, and respond to the request within a mutually agreed-upon time frame.

11.7.3 Notices

Any notice required or permitted to be given to a party shall be provided in writing and delivered by hand or by mail with receipt given as requested.

If to the Department:

Ms. Joan E. Johnson, Director
Bureau of Medicaid Systems
Office of Medicaid Management
New York State Department of Health
One Commerce Plaza, Room 727
Albany, New York 12210

If to the Contractor (to be completed by the Contractor):

Contractor Name_____
Contractor Address____
_____
_____

Either party may change its addressee or address for the receipt of notices by written notice. For notices given by certified mail, return receipt requested shall be sufficient. Notices delivered by ordinary mail or by hand shall not be sufficient unless acknowledged in writing by the addressee.

11.7.4 Conflict of Interest

During the term of this Contract, the Contractor shall not engage in any business or personal activities or practices or maintain any relationships that conflict in any way with the Contractor fully performing its obligations under this Contract.

Additionally, the Contractor acknowledges that, in governmental contracting, even the appearance of a conflict of interest is harmful to the interests of the State. Thus, the Contractor agrees to refrain from any practices, activities, or relationships that could reasonably be considered to be in conflict with the Contractor's fully performing its obligations to the Department under the terms of this Contract, without the prior written approval of the Department.

In the event the Contractor is uncertain whether the appearance of a conflict of interest may reasonably exist, the Contractor shall submit to the Department a full disclosure statement setting forth the relevant details for the Department's consideration and direction. Failure to promptly submit a disclosure statement or to follow the Department's direction in regard to the apparent conflict shall be grounds for termination of the Contract.

11.7.5 Letter of Credit

The Contractor shall procure and thereafter maintain during the term of this Contract, and for a period of ninety (90) calendar days thereafter, a ten million dollar ($10,000,000) letter of credit to secure the Department against default under this Contract by the Contractor. The Contractor shall provide to the Department the letter of credit within ten (10) business days of the effective date of the Contract. Should this Contract be extended in accordance with the provisions of Section 11.2, the Contractor shall provide evidence to the Department that the terms of the letter of credit has been correspondingly extended no later than ten (10) business days after execution of the contract amendment.

11.7.6 Indemnification

The Contractor agrees to indemnify, defend, and save harmless the State and its officials, agents, and employees from any and all claims, losses, or suits accruing or resulting from any acts or omissions of the Contractor or its subcontractor, material persons, laborers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of the Contract or any breach of this Contract by the Contractor.

The Contractor further agrees to indemnify, defend, and save harmless the State and its officials, agents, and employees from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by the Contractor employees, agents, or subcontractors in the performance of this Contract.

11.7.7 Patent or Copyright Infringement

The Contractor agrees to indemnify, defend, and hold harmless the State from any and all claims, actions, damages, liabilities, costs, and expenses, including reasonable attorney's fees and expenses, arising out of any claims of infringement by the Contractor of any United States Patent or trade secret; or any copyright, trademark, service mark, trade name, or similar proprietary rights conferred by common law or by any law of the United States or any state said to have occurred because of systems provided or work performed by the Contractor. The Contractor shall do what is necessary to render the subject matter noninfringing in order that the Department may continue its use without interruption. The obligations created under this section shall continue during the term of this Contract.

11.7.8 Year 2000 Warranty

11.7.8.1 Definitions

For purposes of this warranty, the following definitions shall apply:

a. **"Product"** shall include, without limitation: any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g. consulting, systems integration, code or data

conversion or data entry, the term "Product" shall include resulting deliverables.

b. **"Contractor's Product"** shall include all Product delivered under this Contract by the Contractor other than Third Party Product.

c. **"Third Party Product"** shall include product manufactured or developed by a corporate entity independent from the Contractor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. "Third Party Product" does not include product where the Contractor is : a) a corporate subsidiary or affiliate of the third party manufacturer/developer; and/or b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

11.7.8.2 **Warranty Disclosure**

At the time of bid, Product order or Product quote, the Contractor is required to disclose the following information in writing to the Department:

a) **For the Contractor Product and for Products (including but not limited to, Contractor and/or Third Party Products and/or Department Installed Product) which have been specified to perform as a system:** Compliance or non-compliance of the Products individually or as a system with the Warranty Statement set forth below; and

b) **For Third Party Product Not Specified as Part of a System:** Third Party Manufacturer's statement of compliance or non-compliance of any Third Party Product being delivered with Third Party Manufacturer/Developer's Year 2000 warranty. If such Third Party Product is represented by Third Party Manufacturer/Developer as compliant with Third Party Manufacturer/Developer's warranty, the Contractor shall pass through said Third Party Warranty from the Third Party Manufacturer to the Department but shall not be liable for the testing or verification of Third Party's compliance statement.

An absence or failure to furnish the required written warranty disclosure shall be deemed a statement of compliance of the Product(s) or systems(s) in question with the year 2000 warranty statement set forth below.

11.7.8.3 Year 2000 warranty 'compliance' shall be defined in accordance with the following warranty statement:

The Contractor warrants that Product(s) furnished pursuant to this Contract shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap-year calculations. Where a purchase requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

In the event of any breach of this warranty, the Contractor shall restore the Product to the same level of performance as warranted herein, or repair or replace the Product with conforming Product so as to minimize interruption to the Department's ongoing business processes, time being of the essence, at the Contractor's sole cost and expense. This warranty does not extend to correction of Department errors in data entry or data conversion.

This warranty shall survive beyond termination or expiration of the Contract.

Nothing in this warranty shall be construed to limit any rights or remedies otherwise available under this Contract (see Section 11.7.1 for other warranty provisions).

11.8 Contractor Personnel

11.8.1 Contractor Commitments

Personnel commitments made in the Proposal shall not be changed without prior written approval of the Contract Administrator, unless due to the resignation, death, termination, military recall, or extended illness for any named individuals. Staffing will include the named individuals at the levels of effort proposed. All key personnel not named in the proposal shall be identified, and resumes and references shall be submitted for Department review and approval no later than thirty (30) calendar days prior to the required start date for the position. The Contractor will not be paid for unfilled key personnel positions. In the event the Department does not approve the Contractor's designee, the Contractor shall submit a replacement for Department approval within two (2) weeks.

The Department shall approve, in advance, in writing, any permanent or temporary (greater than twenty [20] consecutive business days) changes to or deletions from the Contractor's named project team management, supervisory

staff, and key professional staff. Key personnel are defined in Section 3.3 of the RFP.

At any time that the Contractor provides notice of the permanent removal or resignation of any of the management, supervisory, or other key professional personnel and prior to permanent assignment of replacement staff to the Contract, the Contractor shall provide the resume and references for a minimum of two (2) individuals qualified for and proposed to replace any vacancies in a key professional, supervisory, or management position. Upon request, the proposed individuals will be made available within fifteen (15) calendar days of such notice for an interview with the Department staff at no cost to the Department. The Department will have the right to recommend acceptance, request additional candidates, or reject any proposed replacement candidates within fifteen (15) calendar days of receipt of resumes or interviews with the proposed individuals, whichever comes later.

11.8.2 Removal of Contractor Employee

The Department, with reasonable notice and written justification, may require the Contractor or any subcontractor to remove from the Contract any employee justified by the Department as being incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable, or whose continued employment on the Contract is considered contrary to the public interest or not in the best interests of the State. In the event a primary (key) employee of the Contractor is removed from the project pursuant to the request of the Contract Administrator, the Contractor will have thirty (30) calendar days in which to fill the vacancy with another employee of acceptable technical experience and skills subject to prior written approval of the Contract Administrator.

11.9 Payments

Payment for Contractor services provided under this Contract will be in accordance with the schedules and methods defined in this section. Implementation Phase payments will be made upon completion of milestones as defined in Section 6.2 of this RFP. Operations Phase payments will be reimbursed through monthly invoices.

11.9.1 Implementation Phase Payments

11.9.1.1 Replacement Medicaid System Implementation

The Contractor will be paid a fixed price for the implementation of each of the Replacement Medicaid System components as follows:

- Client Eligibility Data Repository
- Provider Enrollment and Data Maintenance
- Reference Data Maintenance
- Electronic Commerce
- Claims and Encounter Processing
- Financial Management
- Service Utilization Management
- Third-Party Resources
- The Child/Teen Health Plan (EPSDT)
- Managed Care Support
- Drug Rebate
- Surveillance and Utilization Review (SUR)
- Prospective Drug Utilization Review (ProDUR)
- Retrospective Drug Utilization Review (RetroDUR)
- Systems Operations and Integrated Test Facility
- Management and Administrative Reporting (MAR)

The Contractor shall be paid the fixed price for each of these components upon the Department's acceptance and approval of the completion of milestones as defined in Sections 6.2.2 through 6.2.9 of this RFP. The

distribution of payment for each Replacement Medicaid System component is as follows:

- Project Planning Task — Five percent (5%)
- Joint Application Design Task — Ten percent (10%)
- Technical Design Task — Ten percent (10%)
- Conversion and Interface Design Task — Five percent (5%)
- System Construction Task — Fifteen percent (15%)
- System and Acceptance Testing Task — Fifteen percent (15%)
- Implementation Task — Thirty percent (30%)
- Certification Task — Ten percent (10%)

The payments for the Project Planning Task, the Joint Application Design Task, and the Certification Task will not be paid separately for each component. As defined in Section 6, the Department intends that the Contractor conduct those tasks for the Replacement Medicaid System as a whole. Thus, the amounts for all components for those tasks will be paid on satisfactory completion of the milestones for those tasks as defined in Section 6.3.

Reimbursement for the Certification Task shall be paid upon notification by HCFA that the Replacement Medicaid System is certified.

11.9.1.2 Medicaid Data Warehouse Implementation

The Contractor shall be reimbursed a fixed fee for the implementation of the Medicaid data warehouse and a fixed fee for the implementation of two (2) data marts for the Office of Medicaid Management.

The Contractor shall be paid the fixed price for the Medicaid data warehouse upon the Department's acceptance and approval of the completion of milestones as defined in Section 6.2.10 of this RFP. The distribution of payment for the implementation of the Medicaid data warehouse is as follows:

- Business Assessment and Strategy — Ten percent (10%)
- Metadata Management Strategy — Twenty-five percent (25%)
- Detailed Medicaid Data Layer — Twenty-five percent (25%)
- Executive and Decision Support Systems — Twenty percent (20%)
- Implementation — Twenty percent (20%)

The Contractor shall be paid the fixed price for the two (2) data marts upon Department approval of implementation and operation of both data marts.

11.9.2 Replacement Operations Payments

The Contractor shall be reimbursed for operations of the Replacement Medicaid System in two (2) parts. The term "fee" as used in this RFP is equivalent to, and interchangeable with, "price." The fees described herein are established through the Pricing Schedules.

11.9.2.1 Annual Administrative Fee

The Contractor shall be paid the fixed administrative fee, as presented in Pricing Schedule D of the Contractor's proposal, for each year of operations. The fee will be paid in equal monthly installments. The fixed administrative fee will represent the fixed costs of the Contractor for the following operations periods

- **Contract Year 1 (Contract Start Date Through October 31, 1999)**

  The first contract year is expected to be devoted to design, development, and implementation; therefore, there will be no operations payments during that year.

- **Contract Year 2 (November 1, 1999 Through October 31, 2000)**

  The administrative fee includes the fixed amount for operation of the Replacement Medicaid System components included in the EMEVS redesign (Client Eligibility Data Repository, Eligibility Verification and other elements of Electronic Commerce, the Utilization Thresholds and

Post and Clear elements of Service Utilization Management, drug electronic claims capture and Prospective DUR).

No monthly installments for Contract Year 2 will be paid for any of the components scheduled for that year ("EMEVS Redesign" and Medicaid data warehouse) which are not operational. The monthly installments will begin when scheduled components are approved by the Department for operations. If some scheduled components are not implemented, the monthly installments shall be prorated.

- **Contract Years 3 Through 6 (November 1, 2000 Through October 31, 2003)**

  The administrative fee includes the annual fixed amounts for operations of **all** components of the Replacement Medicaid System.

  Monthly installments for the annual administrative fee shall not be paid for any components not implemented. In such case, the monthly installments shall be prorated.

11.9.2.2 Transaction Fee

In addition to the fixed annual administrative fee, the Contractor shall be paid a fixed rate for each type of transaction as defined in Section 11.9.3. The three (3) transaction types for which a fee will be paid are:

- Fee-for-service claims transactions
- Managed care encounter data transactions
- Eligibility verification transactions

These transaction rates shall represent only those amounts incurred by the Contractor that vary due to variations in transaction volumes.
The Contractor must work with the Department during the JAD sessions to carefully specify how the transactions will be counted and reported. This specification shall be approved by the Department and shall not vary during the life of the Contract without the approval of the Department.

Included in the transaction definitions will be a process to avoid duplicate counting of transactions. For example, point-of-service adjudication of

claims (such as drug claims under NCPDP 3.2) have both an eligibility verification component and a fee-for-service claim component. However, this transaction may be counted only once for reimbursement purposes.

The transaction fees will be paid according to the following schedule:

- **Contract Year 1 (Contract Start Date Through October 31, 1999)**

  The first contract year is expected to be devoted to design, development, and implementation; therefore, there will be no operations payments during that year.

- **Contract Year 2 (November 1, 1999 Through October 31, 2000)**

  The Contractor shall be paid the eligibility verification transaction fee for each eligibility verification transaction processed during the year. This fee will only be paid if the Department has approved operations of the Replacement Medicaid System constituting "EMEVS Redesign" and the Contractor receives and processes such transactions.

- **Contract Years 3 Through 6 (November 1, 2000 Through October 31, 2003)**

  The Contractor shall be paid for each eligible transaction as defined in Section 11.9.3. This fee will only be paid if the Department has approved operations of all components of the Replacement Medicaid System and the Contractor receives and processes such transactions.

For any operations contract year, the number of transactions eligible for payment shall be determined by a weekly administrative claiming report submitted by the Contractor with its monthly invoice. This administrative claiming report will be subject to audit by the Department, by the Office of the State Comptroller, and by appropriate officials of the Federal government. In addition, the Contractor shall arrange for an annual independent audit of the eligible transactions in accordance with Section 11.11.6.

11.9.2.3 Cost Reimbursement

The Department shall reimburse the Contractor for the cost of postage. Postage costs shall be reported separately.

11.9.2.4 Adjustment of Operations Payments

There will be no adjustments of the operations payments on an annual or any other basis except as provided herein.

It shall be the Contractor's responsibility to inform the Department that an adjustment in the fixed fee is, in the Contractor's opinion, required. It shall also be the responsibility of the Contractor to demonstrate through detailed costing and accounting reports, in a level of detail acceptable to the Department, that such an adjustment is justified. Such reports shall be subject to audit by the Department, by the Office of the State Comptroller, and by appropriate officials of the Federal government.

The Department shall not consider any request for adjustment unless the annual volume of all transactions exceeds the threshold of seven hundred fifty million (750,000,000) or unless the Contractor can demonstrate that the Department has required a change of such magnitude that an adjustment is necessary.

If the annual volume of all transactions is less than the threshold of two hundred million (200,000,000), the Department shall cease to pay the Transaction Fee and continue to pay the Contractor only the Annual Administrative Fee. This payment will continue until the end of the contract unless 1) the volume of all transactions exceeds two hundred million (200,000,000) or 2) the Contractor can demonstrate to the Department's satisfaction the level to which the Transaction Fee and/or the Annual Administrative Fee should be reduced.

The Department will not consider such adjustments lightly. These adjustments will require a contract amendment and must be thoroughly justified.

11.9.2.5 Evolution Staffing Pricing

The Contractor shall be paid the rates defined in Pricing Schedule F for the Evolution staff as required by Section 6.3.2.1 of this RFP.

If any positions are unfilled, the Department shall reduce the payment to the Contractor by the daily amount specified in Pricing Schedule F for that position times the number of days the position remains unfilled.

It is important to the Department that the Contractor maintain a stable and skilled cadre of Evolution staff in order to meet the future needs of the Replacement Medicaid System users. Therefore, the Department will impose liquidated damages on the Contractor, as defined in Section 11.10, if the turnover rate of Evolution staff exceeds the annual percentage defined in the following table. The Department shall also impose liquidated damages if the staffing level for any type of position (as defined in Pricing Schedule F) is less than the percentage defined in the following table of the staffing level approved by the Department for a period of more than thirty (30) calendar days.

	Thresholds	
Evolution Staff Position	**Turnover Rate**	**Staffing Level**
Senior Systems Analyst	25%	90%
Systems Analyst	25%	90%
Programmer Analyst III	25%	90%
Programmer Analyst II	35%	75%
Programmer Analyst I	35%	75%
Documentation Specialist	35%	75%
Data Warehouse Support Staff	35%	75%

The Department may elect to increase or decrease the size of the Evolution staff over that defined in Section 6.3.2.1. The Contractor's reimbursement shall be adjusted by the daily amount specified in Pricing Schedule F (Appendix L) for each position. The Department may also elect to request additional evolution resources from the Contractor on a temporary basis. For these resources, the Contractor shall be reimbursed at the daily rate specified in Pricing Schedule F for each individual provided times the number of days for which the individual is used on New York State evolution projects. If the Department requires additional Evolution staff to be on-site in New York State for a period of thirty (30) calendar days or less, the Department shall reimburse the Contractor a premium of ten percent (10%) to cover travel and other business expenses.

11.9.3 Definition of a Transaction

The reimbursement of the Contractor for the fixed rate per transaction will be based on fee-for-service claims transactions, managed care encounter transactions, and eligibility verification transactions.

For the purpose of transaction volume accounting and reconciliation of changes in Contractor reimbursement, the following definitions, subject to the

qualifiers also noted, shall apply to administrative processing counts tracked and reported by the Contractor. The Contractor shall certify and demonstrate that the definition and accounting of transactions processed for the purposes of possible adjustments is in conformance with the following definitions.

11.9.3.1 Claims Transactions

Fee-for-service claims transactions are defined as follows:

- Inpatient hospital and long-term care claims (UB-92) - A claim is a paper document or an EMC record requesting payment for services rendered during a statement period for which there are one (1) or more revenue or procedure codes.

- Institutional Medicare crossover claims (inpatient and nursing facility) - A claim is a paper document or an EMC record requesting payment for services rendered during a statement period.

- Drug claims - A claim is each detail line item of a paper document or an EMC or a POS record requesting payment of a specific service/drug code rendered to a recipient by the billing provider.

- All other claim types - A claim is a line item on a paper document or an EMC record requesting payment for services rendered during a statement period for which there is one (1) HCPCS, revenue code, or other service code.

Denied claims are countable as a transaction. If the Department determines that claims are being inappropriately adjudicated, such inappropriate adjudications shall be eliminated as countable transactions.

Adjustments to fee-for-service claims submitted by providers are countable as a transaction, except as specified in Section 11.9.3.4.

All claims that require reprocessing, including mass adjustments, are not countable as transactions.

Electronic media claims (EMC) are defined for reimbursement purposes to be identical to paper claims regardless of EMC record definition or media.

11.9.3.2 Encounter Data Transactions

Managed care encounter data relating to medical services provided shall be tracked as if it were a claim transaction for accounting purposes and counted when submitted to the Replacement Medicaid System for reporting purposes by the managed care entity. Accounting of encounter data shall be in accordance with the existing accounting definitions above for fee-for-service claims.

Encounters submitted on electronic media are defined for reimbursement purposes to be identical to those submitted on paper.

11.9.3.3 Eligibility Verification Transactions

Each transaction submitted by a provider to verify eligibility will be counted as a transaction for reimbursement purposes, except where the eligibility verification is embedded in a claim or other transaction.

11.9.3.4 General Transaction Requirements

No transaction shall be counted that does not meet the specific criteria stated above. Specifically excluded are claim header/trailer records, financial transactions, adjustments, cost settlements, file or system inquiries, prior authorization requests, on-line updates, file updates, claim correction transactions, Medicare Buy-In premiums, TPL premiums, and capitation payments for health care plans, gatekeeper fees, or separate capitation rates paid to primary care providers or managed care organizations.

Also excluded from the transaction counts shall be all mass adjustments, POS rejections or reversals, and reprocessing due to retroactive rate changes or errors caused by incorrect Contractor staff actions or inaccurate system data or processing. Transaction counts shall not include claims returned to providers as a result of manual prescreening of receipts, or after entry into the system when edit codes considered by the Department as a prescreening criteria are posted and other claims are deleted by the system and later resubmitted.

The Contractor shall provide weekly Contract administration summary reports which identify, by provider type and by transaction type, the number of claim transactions, eligibility verification transactions, and encounter data transactions received; the transactions processed; and the inventory on hand.

The inventory reporting shall include all transactions in process, including pended transactions, by location. All counts and totals shall be unduplicated and shall reconcile to other claims processing and payment reports.

Regardless of whether claims/encounters are defined as a document or a line-item under the criteria stated above, counts of inventory processing detail shall be maintained and reported by document, claim line, and electronic record.

11.9.4 Contractor Incentive Payments

It is the Department's intent to share savings with the Contractor where Contractor-initiated activities result in either administrative or benefit savings to the State. The Contractor shall be reimbursed an agreed-upon percentage of measured, realized cost savings associated with cost-containment projects approved by the Department as an incentive payment for developing, implementing, and operating such projects.

Prior to initiating a project, the Contractor shall submit a project plan to the Department for approval. The plan shall present the details of the project, the estimated costs of implementation, and the estimated savings to the State and how those savings shall be measured. The plan shall also identify any Evolution changes required to the Replacement Medicaid System as a part of the plan and how the Contractor expects to effect such changes.

The Department shall review the plan and approve or reject it. Department approval of the plan may be dependent on approval by the Office of the State Comptroller. If approved, the Department shall define the method of measurement of savings and the percentage of savings to be shared with the Contractor. On approval, the Contractor may proceed with implementing the plan. If the Contractor proceeds prior to obtaining Department approval, the Contractor is at full risk for any costs incurred.

The Contractor must prepare and maintain at all times detailed documentation regarding the data, calculations, and methodologies used to arrive at the reported cost savings. The Department reserves the right to conduct detailed reviews and audits of all reported cost savings at any time and to require adjustment of payments, if necessary.

11.10 Performance Standards and Damage Provisions

The Contractor shall, at all times, comply with all system and operational performance requirements and expectations specified in this RFP, the performance levels contained in the most recent Federal Systems Performance Review (SPR), Part 11 of the State Medicaid Manual, and all related Action Transmittals (AT) and Information Memoranda (IM), as well as any modifications or changes thereto, and any changes to CFR Parts 42, 45, and 95 as they refer to the MMIS and its operations and the use of fiscal agent services. The Department, at its sole option, may continue to apply these requirements if Federal requirements are removed.

Notwithstanding anything to the contrary, the Contractor shall warrant that the new Replacement Medicaid System shall meet all requirements of this RFP, shall be fully operational by October 31, 2000, and will meet all HCFA requirements for the Department to claim the maximum allowable Federal financial participation through the end of the Contract term. The Contractor further warrants that it shall meet all performance requirements listed in this RFP during the term of this Contract.

The Contractor shall, at all times, operate the Replacement Medicaid System and perform its activities in conformity with the policies and procedures of the New York State Medicaid program.

All requirements described in the RFP are subject to monitoring by the Department. The Department reserves the right to monitor performance at any time and may exercise such option, at its discretion, without notice. In the event of a failure to meet the performance requirements, the Contractor agrees that the Department may assess and withhold from payments due its actual damages for the losses set forth below and as assessed at the Department's discretion.

The Department confirms that the amounts stated for each occurrence of each performance failure define the maximum damages due from the Contractor and that the amount claimed shall be adjusted downward to eliminate any proportion of the damage caused by the Department's failure to meet its contractual responsibility.

11.10.1 Consequential Damages - Failure to Meet Contract Requirements

It is expressly agreed by the Department and the Contractor that, in the event of a failure to meet the performance requirements listed below, damage shall be sustained by the State, and the Contractor shall pay to the State its actual

damages according to the following subsections. Written notice of said failure to perform shall be provided to the Contractor, by the Contract Administrator, within thirty (30) calendar days of the Department's discovery of such failure.

11.10.1.1 Loss or Reduction in Federal Financial Participation (FFP) for the New York State Replacement Medicaid System

11.10.1.1.1 Requirement

Section 1903(a) of Title XIX provides ninety percent (90%) FFP for development and seventy-five percent (75%) for operation of mechanized claims payment and information retrieval systems approved by HCFA.

The Contractor is responsible for all FFP penalties imposed on the State by HCFA due to any action or inaction on the part of the Contractor that delays or results in denial of approval by HCFA of the Replacement Medicaid System.

Damages shall be assessed when incurred by the State if the Replacement Medicaid System installed by the Contractor is not certified by HCFA retroactive to the beginning date of full operations. In addition, should decertification of the Replacement Medicaid System, or any component part of it, occur prior to termination of the Contract or any subsequent extension thereof, the Contractor shall be liable for resulting damages to the State.

The Contractor is responsible for maintaining the Replacement Medicaid System as well as the Contract operations to the standards required to pass any periodic System Performance Reviews (SPRs) conducted by HCFA. The Contractor shall provide support to the Department during the SPR process, including selection of samples, production of hard-copy documents, and gathering of other required data. The Contractor's staff shall assist Department staff in responding to HCFA inquiries. This level of support shall also be provided to all other State audit agencies or their designees.

11.10.1.1.2 Damages

The Contractor shall be liable for the difference between the maximum allowable enhanced Federal Financial Participation (FFP) and the amount actually received by the State, including any losses due to delays in meeting the Department-approved schedule, in meeting Federal certification

requirements, or failure to meet minimum SPR standards if attributable to the Contractor.

Damage assessments shall not be made until HCFA has notified the State of its decision in writing.

11.10.1.2 Claims and Adjustment Processing Accuracy

11.10.1.2.1 Requirement

All payments, adjustments, and other financial transactions made through the Replacement Medicaid System for capitation payments, medical services, or insurance premiums (e.g., Buy-In or indemnity) shall be made on behalf of eligible clients, to enrolled providers or insurers, for approved services, and in accordance with the payment methodology and other policies of the New York State Medicaid program. The Contractor shall notify the Department immediately upon discovery of any mispayments or duplicate payments, irrespective of cause.

11.10.1.2.2 Damages

The Contractor shall be liable for the actual amount of all Contractor-caused mispayments, duplicate payments, or payments that should have been denied. Contractor-caused mispayments may result from either the Contractor's failure to utilize available information or by a failure to process the claim or transaction correctly.

The Contractor shall provide a monthly report listing all Contractor- or State-identified inappropriate payments. This report will describe the cause of the inappropriate payment, whether the inappropriate payment represents a mispayment, and an estimate of the dollar amount of any mispayment. The Contract Administrator shall review the report, decide whether further research and analysis is required before correction of the problem, approve the plan for correction, and establish a correction date.

The Contractor shall be liable for the actual amount of the Contractor-caused mispayments that are not recovered. The actual amount of the outstanding mispayment will be deducted from Contractor payments. Recovery from providers to whom erroneous payments were made will be performed in accordance with a Department-approved recovery program. The Contractor shall be fiscally responsible for any mispayments or duplicate payments that

cannot be recovered by the State within sixty (60) calendar days. This responsibility shall apply to all mispayments caused by Contractor negligence, system failure, or other causes.

11.10.1.3 Operational Start Date - Performance Requirements

11.10.1.3.1 Requirements

It is the Department's intent to have each component of the Replacement Medicaid System fully operational on the date specified in the Project Plan as approved by the Department. Fully operational is defined as processing transactions correctly; maintaining system tables; producing required reports; and performing other Contractor responsibilities specified in this RFP.

The Department shall deem that the Contractor has not complied with the Operational Start Date performance requirements if any of the following conditions are not met:

- Any of the components defined as "EMEVS Redesign" as shown in Exhibit 1.1 are not approved by the Department for operations by November 1, 1999
- The Medicaid data warehouse is not approved by the Department for operations by February 28, 2000
- Any of the remaining Replacement Medicaid System components are not approved by the Department for operations by November 1, 2000

11.10.1.3.2 Damages

If, for any reason, the Contractor does not fully meet the operational start date for any of the Replacement Medicaid System components, and a contract amendment delaying this date or start-up of a portion of the processing requirements listed has not been approved, then the Contractor shall be liable for costs incurred by the Department to continue current operations. The Contractor shall forfeit any claims to reimbursement of monthly expenses for operational payments for that month and each month thereafter until the Contract Administrator approves operational readiness.

11.10.2 Liquidated Damages - Failure to Meet Performance Requirements

It is agreed by the Department and the Contractor that, in the event of a failure to meet the performance requirements listed in the following sections, damage is deemed to be sustained by the State. It is further agreed that it is and will be impractical and extremely difficult to ascertain and determine the actual damages that the State will sustain in the event of, and by reason of, such failure. It is therefore agreed that the Contractor will pay the State for such failures at the sole discretion of the Department according to the following subsections.

Damage assessments are linked to performance of operational responsibilities. Where an assessment is defined as an "up to (amount)," the dollar value per occurrence may be set at the discretion of the Department, up to the amount specified.

For those requirements subject to a cure period, written notification of each failure to meet a performance requirement will be given to the Contractor by the Contract Administrator. The Contractor shall have five (5) business days, from the date of receipt of the written notification of a failure, to perform to specifications to effect the cure of the failure. However, additional days can be approved by the Department, if deemed necessary, at its discretion. Liquidated damages may be imposed retroactively to the date of failure to perform and continue for the period of time until the cure is effected. The imposition of liquidated damages is not in lieu of any other remedy available to the Department.

Liquidated damages will not be assessed against the Contractor in those instances where consequential damages have been assessed.

11.10.2.1 Systems Documentation

The Contractor is responsible for providing complete, accurate, and timely documentation of the operational Replacement Medicaid System, or any components thereof, to the Department. Two (2) paper copies and an electronic version (e.g., CD-ROM or other media as approved by the Department) must be provided in accordance with the specification approved by the Department.

11.10.2.1.1 Requirement

The Contractor shall provide the systems documentation in final form for any component of the Replacement Medicaid System within thirty (30) calendar days of the date the Department approves the start of operations for that component.

11.10.2.1.2 Requirement

The Contractor shall provide the systems documentation in its final form for all operational components within fifteen (15) calendar days of a request by the Department, provided that those components have been operational for more than thirty (30) calendar days.

11.10.2.1.3 Requirement

The Contractor shall provide updates to the systems documentation in final form for any evolution changes to the Replacement Medicaid System within ten (10) business days of the Department approval of migration of the evolution changes to production operations.

11.10.2.1.4 Requirement

The Contractor shall provide a complete set of system documentation in final form every six (6) months. This requirement shall be in effect thirty (30) business days after all components of the Replacement Medicaid System have been approved by the Department for operations for thirty (30) calendar days or more.

11.10.2.1.5 Damages

One hundred dollars ($100.00) for each calendar day, or any part thereof, from the date the documentation was due until the date it is provided and found acceptable as to format and completeness of contents by the Department. If any of the systems documentation requirements results in a due date that falls on a Saturday, Sunday, or Department-approved holiday, the due date shall be deemed to be the next business day.

11.10.2.2 Deliverables

Copies of each deliverable, as approved in the Contractor's work plan, must be delivered to the Department in final form, in the number specified, and on the date specified in Department-approved plans. The Department requires up to ten (10) paper copies and an electronic copy of all deliverables. The electronic copy must be on 3.5" diskettes in the Department-approved word processing software format or on CD-ROM in the Department-approved format.

11.10.2.2.1 Requirement

Deliverables shall be delivered in final form and in accordance with Department-approved schedules.

11.10.2.2.2 Requirement

Deliverables shall meet the content requirements specified by the Department and must be approved by the Department. If the Department determines that a deliverable cannot be approved, the Contractor shall have a cure period beginning with notice from the Department that the deliverable is not approved. The cure period will be specified in the notice of deliverable rejection.

11.10.2.2.3 Damages

One hundred dollars ($100.00) for each business day that a deliverable is late, includes less than the required number of copies, or is delivered on the incorrect media. An additional one hundred dollars ($100.00) for each business day following the cure period that a deliverable continues to be unacceptable to the Department.

11.10.2.3 Network Availability and Response Time

The Contractor shall be responsible for the provision and maintenance of hardware, computer network, personal computer-based workstations (where applicable), printers, supporting modems, and software needed for the Replacement Medicaid System. The Contractor shall arrange for and coordinate the maintenance of the telecommunications lines between the Contractor and providers, the local districts, the Department, and other State users.

In support of this requirement, the Department is encouraging the Contractor to use the New York State telecommunications infrastructure (NYT). Where the Contractor uses NYT and can demonstrate to the Department's satisfaction that any failure to meet the requirements for network availability and response

time is due to a failure by NYT and is beyond the Contractor's control, the Contractor shall be relieved of liquidated damages for such failure.

The Contractor shall install software to monitor network availability and response time and shall produce a weekly report that lists the average response times (response, launch and load, printing, file opening/saving/retrieval) per workstation in the network and that summarizes the number of workstations with response times greater than the standards.

11.10.2.3.1 Requirement

The providers shall have access to the Electronic Commerce component twenty-four (24) hours per day, seven (7) days per week to be able to conduct the following transactions:

- Eligibility verification
- Utilization Threshold
- Post and Clear
- DME approvals
- Prospective DUR and electronic claims capture
- Other transactions, to be defined by the Department during JAD

All components of the Electronic Commerce component must be available on this schedule, including POS devices, personal computer dial-up, CPU to CPU, and audio response.

11.10.2.3.2 Requirement

On-line access for all other Replacement Medicaid System components, shall be available from 6:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday, except for the Medicaid data warehouse which shall be available 24 hours per day. Access is considered to be not available when an operator does not get a response within ten (10) minutes after depressing the "enter" or other function key on a workstation or other workstation device.

11.10.2.3.3 Requirement

The Replacement Medicaid System shall meet the following response time standards:

- Medicaid data warehouse on-line query and report users shall have a response time that is less than the maximum agreed to by the Department and the contractor. The response time is the time interval between entry of the query execution command and the receipt of the resulting set on the user workstation.

- The response time for provider-submitted transactions, such as eligibility verification, service utilization management, Prospective DUR, and claims capture, shall not be greater than two (2) seconds for ninety percent (90%) of the transactions and no response time shall be greater than five (5) seconds.

- Remaining Replacement Medicaid System components shall have an average display response time that is not greater than four (4) seconds ninety percent (90%) of the time. Display response time is defined as the elapsed time between the depressing of the "enter" or other function key by an operator and the completed display of the final results of the transaction on the screen.

- The Contractor shall ensure an average network response time of four (4) seconds or less per workstation transaction. Response time means the elapsed time between a) a user on the network depressing a key (or giving a command via the mouse through a graphical user interface) which causes information or instructions to be transmitted to the hardware and b) the first character, graphic, chart, and/or table being fully displayed on the monitor of the user's workstation.

- The Replacement Medicaid System shall have an average launch and load time of less than thirty (30) seconds per workstation. Launch and load time means the elapsed time between a) a user selecting the systems application on the workstation display and b) the system being fully loaded in the workstation's memory and all of the functions and features of the system being readily accessible and usable by the user through the workstation.

- The average printing time shall be fifteen (15) seconds or less per workstation. Printing time is the elapsed time between a) a user selecting the system's print command from the menu and b) the first page of the user-selected print job being produced by a printer on the network. Print time assumes that no other user's print job is in the printer's queue.

- The Replacement Medicaid System shall have an average file saving, opening, and retrieving time of ten (10) seconds per workstation or less.

11.10.2.3.4 Damages

One thousand dollars ($1,000.00) per elapsed minute that the network is not available to providers as required in Section 11.10.2.3.1

One thousand dollars ($1,000.00) per business minute that the network is not available as required in Section 11.10.2.3.2

One hundred dollars ($100.00) per workstation per week for each week that the average response time fails to meet the response time requirements specified in Section 11.10.2.3.3

11.10.2.4 Personnel

The Contractor must provide the key personnel required in Section 3.3 and the Evolution staffing required in Section 6.3.2.1.

11.10.2.4.1 Requirement

The Contractor shall commit those key personnel proposed for the Replacement Medicaid System implementation and operations as specified in this RFP and in the Contractor's proposal. Changes in personnel shall be in full compliance with Section 11.8.

11.10.2.4.2 Requirement

The Contractor shall maintain the Evolution staffing levels required by Section 6.3.2.1, including the data warehouse support staff. The Department shall deem that the Contractor has not complied with this requirement if any of the following conditions occur:

- The turnover of Evolution staff or the data warehouse support staff exceeds the percentage in any contract year specified in Section 11.9.2.5
- The staffing levels for any type of position is less than the percentage of the level for that position specified in Section 11.9.2.5 for a period of more than thirty (30) days.

11.10.2.4.3 Damages

Failure to abide by these requirements shall result in assessment of damages, as determined by the Contract Administrator, up to a maximum of twenty-five thousand dollars ($25,000.00) per occurrence, taking into consideration the role of a key person, the impact on implementation or operations, and any mitigating circumstances presented by the Contractor.

11.10.2.5 Performance Requirements for Operational Responsibilities

This standard provides the Department with an administrative procedure to address general contract compliance issues that are not specifically defined as performance requirements in Section 11.10 of the RFP but are performance standards defined in Sections 7 and 8 of this RFP.

The Department may identify contract compliance issues resulting from the Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, the Contract Administrator or designee shall notify the Contractor in writing of the nature of the performance issue. The Department shall also designate a period of time in which the Contractor must provide a written response to the notification. Based on the response, the Department will define a reasonable period of time in which the Contractor shall remedy the noncompliance.

11.10.2.5.1 Requirement

The Contractor shall continuously meet all performance standards defined in Sections 7 and 8 of this RFP.

11.10.2.5.2 Damages

If the Contractor has not achieved compliance within the period of time allotted by the Department, the Department shall assess damages in the amount of two hundred dollars ($200.00) per business day from the date specified in the Department's notice until compliance is achieved.

11.10.3 Deduction of Damages From Payments

Amounts due the Department from assessment of damages may be deducted from any money payable to the Contractor pursuant to this Contract. The Contract Administrator shall notify the Contractor, in writing, of any claim for damages pursuant to this provision at least fifteen (15) calendar days prior to the date the Department deducts such sums from money payable to the Contractor.

Such amounts as they relate to Federal certification requirements may be deducted during the entire period that MMIS or the Replacement Medicaid System certification is lacking. Should Federal certification subsequently be granted retroactively, the Department will reimburse the Contractor for amounts withheld back to the date of certification.

The Department may, at its sole discretion, return all or a portion of collected damages as an incentive payment to the Contractor for prompt and lasting correction of performance deficiencies.

11.11 Other Contract Terms and Conditions

11.11.1 Choice of Law and Venue

The laws of the State of New York shall govern this Contract. Any lawsuit arising out of this Contract, whether brought by the Contractor or the State agency, shall be brought in New York State courts.

11.11.2 Force Majeure

The Contractor shall not be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations, directly or indirectly, by an act of war, hostile foreign action, nuclear explosion, riot, strike, widespread electrical power blackout or brownout, civil insurrection, earthquake, hurricane, tornado, or other catastrophic event beyond the reasonable control of the Contractor or its subcontractor(s).

11.11.3 Licenses/Approvals/Insurance

The Contractor certifies that, at the time of entering into this Contract, it has currently in effect all necessary licenses, certifications, approvals, insurance, etc., required to properly provide the services and/or supplies covered by this Contract. Additionally, all employees of the Contractor performing services under this Contract will hold the required license or certification, if any, to perform their responsibilities. Any revocation, withdrawal, or nonrenewal of necessary license, certification, approval, insurance, etc., required for the Contractor to properly perform this Contract, shall be grounds for termination of this Contract by the Department.

11.11.4 Litigation

The Contractor shall promptly notify the Department in the event that the Contractor learns of any actual litigation in which it is a party defendant in a case which involves or impacts services provided under this Contract. The Contractor, within fifteen (15) calendar days after being served with a summons, complaint, or other pleading which has been filed in any Federal or State court or administrative agency, shall deliver copies of such document(s) to the Contract Administrator. The term "litigation" includes an assignment for the benefit of creditors, and filings in bankruptcy, reorganization and/or foreclosure.

11.11.5 Contractor Not State Agent

The Contractor and its subcontractors, if any, and the agents, officers, and employees of the Contractor or any subcontractor, in the performance of this Contract shall act as independent contractors and not as officers or employees

of the State. It is further understood that this Contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and the State agency.

11.11.6 Audit Requirements

The Contractor, in accordance with 95 CFR Part 74, shall maintain accounting books, accounting records, documents, and other evidence pertaining to the administrative costs and expenses of this Contract to the extent and in such detail as shall properly reflect all revenues; all net costs, direct and apportioned; and other costs and expenses, of whatever nature, that relate to performance of contractual duties under the provisions of this Contract. The Contractor's accounting procedures and practices shall confirm to generally accepted accounting principles, and the costs properly applicable to this Contract shall be readily ascertainable therefrom.

If, during the term of the Contract, work is performed on a cost-reimbursement basis, the allowability of direct and indirect costs shall be governed by 95 CFR Section 74.175.

The Contractor shall agree to the following terms for access to records relating to the Contract:

- All original claims adjudicated under the Contract shall be retained until quality, readable micromedia is produced; micromedia copies of all claims shall be retained for at least three (3) years from the date of expiration or termination of the Contract.

- Unless the Department specifies, in writing, a shorter period of time, the Contractor agrees to preserve and make available all of its other pertinent books, documents, papers, and records involving transactions related to this Contract for a period of three (3) years from the date of expiration or termination of the Contract.

- Records involving matters in litigation shall be kept for one (1) year following the termination of litigation, including all appeals if the litigation has not terminated within the three (3) years.

- Authorized Federal and State representatives, including, but not limited to, personnel of the Department, other State entities with statutory authority, independent auditors acting on behalf of the State and/or Federal agencies

providing funds, and the Comptroller General of the United States shall have access to and the right to examine the items listed above during the Contract and during the post-Contract period or until resolution. During each Contract period, access to these items shall be provided in Albany. During the Contract and post-Contract period, delivery of, and access to, the listed items shall be at no cost to the Department.

The retention periods in the previous paragraphs are minimum time periods. All record retention must meet the requirements of Appendix A, Clause 10 - Records.

11.11.7 Employment Practices

During the term of this Contract, the Contractor shall not discriminate against employees or applicants for employment because of race, marital status, ancestry, arrest record or conviction, physical condition, developmental disability, sexual orientation, color, religion, creed, age, sex, handicap, or national origin. In furtherance of that nondiscrimination, the Contractor shall:

- Take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, marital status, ancestry, arrest record or conviction, physical condition, developmental disability, color, religion, creed, age, sex, handicap, or national origin. Such action shall be taken in conjunction with any of the Contractor's acts in the capacity of an employer, including, but not limited to, employment of individuals; upgrading; demotions; transfers; recruitment; recruitment advertising; layoffs; terminations; changes in rates of pay or other forms of compensation; selection for training, including apprenticeship; and participation in recreational and educational activities.

- Post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

- State, in all solicitations or advertisements for employees, that all qualified applicants will receive consideration for employment without regard to race, marital status, ancestry, arrest record or conviction, physical condition, developmental disability, sexual orientation, color, religion, creed, age, sex, handicap, or national origin.

- Comply with all of the provisions of Executive Order No. 11246, entitled "Equal Employment Opportunity" as supplemented in U.S. Department of Labor regulations (41 CFR Part 60) and with any rules, regulations, and guidelines as the State of New York or the United States shall issue to implement these regulations.

- Keep all such information, records, and reports as may be required by Executive Order No. 1146 and by rules and regulations or orders of the United States, and furnish or submit the same at such times as may be required. The Contractor shall also permit the Department, the United States, or any of their designated representatives to have access to any of the Contractor's books, records, and accounts for the purpose of investigation to ascertain compliance with the aforesaid rules, regulations, and orders, and the covenants and conditions herein contained.

- The Contractor shall cause the foregoing provisions to be inserted in all subcontracts for any work covered by this Contract so that the provisions will be binding on each subcontractor; provided, however, that the foregoing provisions shall not apply to subcontracts for standard commercial supplies or raw materials. The Contractor shall take such action with respect to any subcontract as the Department, or, where applicable, the United States, may direct as a means of enforcing such provisions, including sanctions for noncompliance.

11.11.8 State-Owned and Contractor-Owned Property

The Contractor shall be responsible for the proper custody and care of any State-owned property furnished by the Department for use in connection with the performance of the Contract and will reimburse the Department for any loss or damage. Likewise, the Department shall be responsible for the proper custody and care of any Contractor-owned property furnished by the Contractor to the State agency for use in connection with the performance of the Contract and will reimburse the Contractor for any loss or damage. Such property will be inventoried annually, designating specific location.

11.11.9 Insurance and Indemnity

Before delivery of service, the Contractor shall obtain, from an insurance company duly authorized to do business in New York, insurance as follows and furnish to the State agency certificates evidencing that such insurance is

in effect and providing that the carrier shall give the Contractor and State agency at least ten (10) business days' written notice of any material change in, or cancellation of, such insurance.

11.11.9.1 Workers' Compensation

The Contractor shall obtain and maintain, during the life of this Contract, workers' compensation for all of its employees at any job site of the project in New York; in the event any work is subcontracted, the Contractor shall require the subcontractor similarly to provide workers' compensation coverage for all the latter's employees employed at any side of the project in New York.

11.11.9.2 Public Liability and Property Damage

The Contractor shall obtain and maintain, during the life of this Contract, public liability and property damage insurance in the amounts of two hundred fifty thousand dollars ($250,000)/one million dollars ($1,000,000). The Contractor shall provide the Department with a certificate of insurance in the amount of one million dollars ($1,000,000) for excess catastrophic damage.

11.11.10 Severability

To the extent that this Contract may be executed and performance of the obligations of the parties may be accomplished within the intent of the Contract, the terms of this Contract are severable, and should any term or provision hereof be declared invalid or become inoperative for any reason, such invalidity or failure shall not affect the validity of any other term or provision hereof. The waiver of any breach of a term hereof shall not be construed as a waiver of any other term, or the same term upon subsequent breach.

11.11.11 Titles and Headings

In the event of any conflict or ambiguity between a title heading and the provision under such heading, the provision shall take precedence.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX A
STANDARD CLAUSES FOR ALL
NEW YORK STATE CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $10,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office.

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. In accordance with Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, age, disability or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law.

7. NON-COLLUSIVE BIDDING REQUIREMENT. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor warrants, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further warrants that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this

contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER. All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number, i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(b) PRIVACY NOTIFICATION. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law.

(2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in New York State's Central Accounting System by the Director of State Accounts, Office of the State Comptroller, AESOB, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State; or (iii) banking services, insurance policies or the sale of securities. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Governor's Office of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article XI-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily

authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of State Finance Law . 165. (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in . 165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
One Commerce Plaza
Albany, New York 12245
Phone: (518) 474-7756 Fax: (518) 486-7577

A directory of minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Minority and Women's Business Development Div.
One Commerce Plaza
Albany, New York 12245
Phone: (518) 473-0582 Fax: (518) 473-0665

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and
(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS Bidders are hereby notified that if their principal place of business is located in a state that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 amendments (Chapter 684, Laws of 1994) require that they be denied contracts which they would otherwise obtain. NOTE: S. Carolina, Alaska, W. Virginia, Montana, Wyoming, Louisiana and Hawaii are the states currently subject to this provision. (Contact the NYS Division for Small Business at (518) 474-7756 for a current list of States subject to this provision.)

Revised April 11, 1997

Appendix B
Glossary of Terms

ADA	American Dental Association; dental procedure codes portion of HCPCS and standard dental claim form have been approved by this organization
AFDC	Aid to Families with Dependent Children; categorical eligibility category prior to implementation of TANF
ARU	Audio response unit; voice response component of the EMEVS
ATC	Alcohol treatment center; inpatient facility operated by OASAS
AWP	Average wholesale price used for drug pricing
Auto Assignment	The process by which the WMS automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame
BENDEX	Beneficiary Data Exchange; a file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration
Buy-In	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible Medical Assistance recipients, enrolling them in the Medicare Part A and/or Part B program
CASE	Computer-aided software engineering; software development tool
CCF	Claim Correction Form; generated by the MMIS and sent to the provider that submitted the claim for correction of selected information and resubmitted by the provider with additional or corrected information
CCN	Cash control number; a financial control number assigned to uniquely identify transactions

CFR	Code of Federal Regulations; the Federal regulations that define Medicaid rules and regulations
Claim	A provider's request for reimbursement of Medicaid-covered services; claims are submitted to the Department using approved claim forms or approved electronic submittal media
C/THP	Child/Teen Health Plan; New York State's EPDST program
CLIA	The Clinical Laboratory Improvement Amendments (CLIA); the system is a federally mandated set of certification criteria and data collection monitoring system designed to ensure the proper certification of clinical laboratories
Contract Amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract; it shall include bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option
Contractor	Refers to the successful offeror for the services presented in this RFP
Covered Service	Mandatory medical services required by HCFA and optional medical services approved by the State for which enrolled providers will be reimbursed for services provided to eligible Medicaid recipients
CPAS	Claims Processing Assessment System; a manual or automated claims analysis tool used by the Department for contractor quality control reviews
CSC	Computer Sciences Corporation; current fiscal agent contractor to the State of New York
DEA Number	A number assigned to prescribing providers (e.g., physicians) as a part of controlled substances management

Designee	A duly authorized representative of a person holding a superior position
Deluxe, DEPS	Deluxe Electronic Payment Systems; the current New York EMEVS contractor
DHHS	U.S. Department of Health and Human Services; responsible for the administration of Medicaid at the Federal level through the Health Care Financing Administration (HCFA)
DIS	Detailed Implementation Schedule; document submitted to the HCFA regional office at the start of the Replacement Medicaid System Implementation Phase to document the project plan, and updated periodically to keep HCFA informed of progress
DME	Durable medical equipment, such as wheelchairs, hospital beds, and other nondisposable medically necessary equipment
DOH	New York State Department of Health, the Department responsible for the administration of the Medicaid program at the State level
DRG	Diagnosis-related grouping; used as a basis for reimbursement
Drug Rebate	Program authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) in which legend drug manufacturers or labelers enter into an agreement with the Secretary, DHHS, to provide financial rebates to states based on the dollar amount of their drugs reimbursed by the Medicaid program
DSH	Disproportionate share hospital; reimbursement to selected hospitals to compensate for health care services that have been provided to members of New York's indigent population
DSS	New York State Department of Social Services, the Department previously responsible for the oversight of Local Departments of Social Services (LDSS) in the determination of eligibility of Medicaid clients; DSS has been superseded by the Department of Family Assistance (DFA), which has been reorganized into several components; see Section 1 for more detail

DSS	Decision Support System; component of a data warehouse that provides analytical-level queries and reporting
DUR	Drug utilization review; a federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services and activities necessary to meet all Federal DUR requirements and all DUR equipment in this RFP
EAC	Estimated acquisition cost for drugs; the Federal pricing requirements for drugs
ECC	Electronic claims capture; refers to the direct transmission of electronic claims over phones lines to the EMEVS; ECC provides the ability to utilize point-of-sale devices and PCs used for eligibility verification, claims capture, application of ProDUR, prepayment editing, and response to and acceptance of claims submitted on-line
ECS	Electronic claims submittal; claims submitted in electronic format rather than paper
EDP	Electronic data processing
EDI	Electronic data interchange
EFT	Electronic funds transfer; paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account
Electronic Commerce	Term applied to group a variety of electronic business components of the Medicaid program; included in electronic commerce are 1) electronic banking, including electronic funds transfer (EFT), electronic benefits transfer (EBT), and cash management systems; 2) electronic transaction processing, including claims, encounter data, and EMEVS transactions; and 3) Internet on-line services and information publishing

EMEVS	Electronic Medicaid Eligibility Verification System; a major component of New York Medicaid systems which performs certain automated functions, including eligibility verification, service authorizations, prospective DUR, and managed care enrollment
EMC	Electronic media claims; claims submitted in electronic format rather than paper
EOB	Explanation of benefits; an explanation of denial or reduced payment included on the provider's remittance advice
EOMB	Explanation of medical benefits; a form provided by MMIS and then sent to clients; the EOMB details the payment/denial of claims submitted by providers for services provided to the recipient
EOP	Explanation of payment; provides a description of reimbursement activity on the provider's remittance advice
EPIC	Elderly Pharmaceutical Insurance Coverage; a New York State-funded program to cover prescriptions for the elderly population with limited income earnings
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment, also known as Child/Teen Health Plan (C/THP) in New York; a program for Medicaid-eligible recipients under the age of twenty-one (21); EPSDT offers free preventive health care services such as screenings, well-child visits, and immunizations; if medical problems are discovered, the recipient is referred for further treatment
EVS	Eligibility Verification System; a system used by providers to verify recipient eligibility using a point-of-service device, on-line PC access, or an automated voice response system
FEIN	Federal employer identification number; a number assigned to businesses by the Federal government

Fiscal Agent	A contractor who operates a claims processing system and pays providers on behalf of the State
FFP	Federal financial participation; the percentage of State expenditures to be reimbursed to the State by the Federal government for medical services and administrative costs of the Medicaid program
FIPS	Federal Information Processing Standards
Fiscal Year - State	April 1 - March 31
Fiscal Year - Federal	October 1 - September 30
FQHC	Federally Qualified Health Center
Geocoding	Code structure used by geographic information systems to accumulate data by geographic locations
GUI	Graphical user interface
GIS	Geographic information system; commercial software which uses geocoding to display data in map format
HCBS	Home- and community-based services waiver programs; a Federal category of Medicaid services, established by Section 2176 of the Social Security Act, that includes adult day care, respite care, homemaker services, training in activities of daily living skills, and services not normally covered by Medicaid; these services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution
HCFA	Health Care Financing Administration; the Federal agency that oversees the Medicaid and Medicare programs
HCFA-1500	HCFA-approved standardized claim form used to bill professional services
HCPCS	HCFA Common Procedure Coding System; a uniform health care procedural coding system approved for use by HCFA and all subsequent editions and revisions thereof

HIC	Health insurance claim number; the number used to identify Medicare beneficiaries
HIPAA	The Health Insurance and Portability Act of 1996
HMO	Health maintenance organization
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification; ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers
ICF/MR	Intermediate Care Facility for the Mentally Retarded; ICFs/MR provide residential care treatment for Medicaid-eligible, mentally retarded individuals
IMD	Institutions for Mental Disease
IOC	Inspection of care; provides a review of residents in psychiatric hospitals and ICFs/MR; review process serves as a mechanism to ensure the health and welfare of institutionalized residents
IREF	Interim Recipient Eligibility File; a system operated on the HSASC data center to gather client-related data together to transmit to the MMIS and EMEVS
IPRO	Island Peer Review Organization
ITF	Integrated test facility; a copy of the production version of MMIS used for testing maintenance and modification changes prior to implementation of changes in the "production" system
JAD	Joint application design; a formal process for conducting the requirements definition and business design phases of the system development life cycle
JCL	Job control language
LAN	Local area network
LDSS	Local Departments of Social Services; local district entities responsible for Medicaid eligibility determination and for performing a number of Medicaid functions

LDOH	Local Departments of Health; local district entities responsible for implementing health programs at the local level
LIF	Low Income Families program; New York State's TANF program
LOC	Level of care
Local District	New York State local entities; there are fifty-seven (57) Upstate local districts, corresponding to the Upstate counties; there is one (1) local district comprising New York City and environs; the local districts are responsible for one-half of the State share of Title XIX expenditures
Lock-In	Restriction of a recipient to particular providers, as determined necessary by the State
LTC	Long-term care; facilities that provide long-term residential care to recipients
MAC	The maximum allowable charge for drugs specified by the Federal government
MARS	Management and Administrative Reporting Subsystem; a federally-mandated comprehensive reporting module of MMIS, including data and reports as specified by Federal requirements
MCO	Managed care organization
MEDS	Medicaid Encounter Data System
MEQC	Medicaid eligibility quality control
MMIS	Medicaid Management Information System; a term used to refer to a claims processing and information retrieval system that has been certified under Section 1902(b) of the Social Security Act as meeting the requirements of the Secretary of HHS for enhanced funding; in this RFP, MMIS also refers to the current certified New York Medicaid Management Information System
MOAS	Medicaid Override Application System

NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code; a generally accepted system for the identification of prescription and non-prescription drugs available in the United States, including all subsequent editions, revisions, additions, and periodic updates
NPI	National provider identification number
NYT	A statewide New York telecommunications network backbone
OASAS	Office of Alcoholism and Substance Abuse Services
OMC	Office of Managed Care; the Office within the Department of Health responsible for the administration of the managed care program in the State of New York
OMM	Office of Medicaid Management; the Office within the Department of Health responsible for the administration of the Medicaid program in the State of New York
OMH	Office of Mental Health
OMR/DD	Office Mental Retardation and Developmental Disabilities
OSC	Office of the State Comptroller
PA	Prior authorization/prior approval; refers to designated Medicaid services that require providers to request approval of certain types or amounts of services from the State prior to the provision of services; PAs are reviewed by the State for medical necessity, reasonableness, and other criteria
PASRR	Pre-Admission Screening and Resident Review; refers to a set of long-term care resident screening and evaluation services, payable by the Medicaid program, that was authorized by the Omnibus Budget and Reconciliation Act of 1987
Pharmark	The current Retrospective Drug Utilization Review contractor for the State of New York
POS	Point-of-service or place of service

Post and Clear	A New York Medicaid process by which ordering/prescribing providers can authorize laboratory, drugs, or other services at the time of an eligibility verification query to the EMEVS; a service authorization is generated to the MMIS which permits the laboratory, pharmacy, or other claim to be paid
PPO	Preferred provider organization
PRO	Peer review organization
ProDUR	Prospective drug utilization review; the federally-mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all Federal prospective DUR requirements and all DUR requirements in this RFP
QDWI	Qualified disabled working individual; a Federal category of Medicaid eligibility for disabled individuals who have income less than two hundred percent (200%) of the Federal poverty level; Medicaid benefits cover payment of the Medicare Part A premium
QMB	Qualified Medicare beneficiary; a Federal category of Medicaid eligibility for aged, blind, or disabled individuals who are entitled to Medicare Part A and who have income less than one hundred percent (100%) of the Federal poverty level and assets less than twice the SSI asset limit; Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles
RA	Remittance advice; a summary of payments produced by MMIS along with provider reimbursement; RAs are sent to providers along with checks or EFT
RetroDUR	Retrospective Drug Utilization Review; a series of postpayment analytical reports which evaluate the use of drugs
RBRVS	Resource-based relative value scale; a reimbursement methodology used to calculate payment for physician, dental, and other practitioners
Replacement Medicaid	The term used in this RFP to describe the new system that the

System	contractor is to develop for the State of New York; the system must be certifiable as meeting the requirements of Section 1903(r) of the Social Security Act
RFP	Request for Proposals
SA	Service authorization
SDLC	Systems development life cycle
SDX	State Data Exchange System; the Social Security Administration's method of transferring SSA entitlement information to the State
SED	New York State Education Department
SERMA	Services/Medical Assistance interface; part of the Managed Care Readiness project
SLIMB	Specified low income Medicare beneficiary; a Federal category of Medicaid eligibility for aged, blind, or disabled individuals with income between one hundred percent (100%) and one hundred twenty percent (120%) of the Federal poverty level and assets less than twice the SSI asset level; Medicaid benefits include payment of the Medicare Part B premium
SPR	System performance review
SSA	Social Security Administration of the Federal government
SSI	Supplementary Security Income; the Federal supplemental security program that provides cash assistance to low-income aged, blind, and disabled persons
State	The State of New York and any of its departments or agencies and public agencies
Subcontractor	Any person or firm undertaking part of the work under the terms of a contract, by virtue of an agreement with the prime contractor, who, prior to such undertaking, receives in writing, the consent and approval of the State

SUR	Surveillance and Utilization Review; refers to SUR system functions and activities mandated by HCFA necessary to maintain complete and continuous compliance with HCFA regulatory requirements for SUR; SPR requirements for SUR include statistical analysis; exception processing; provider and recipient profiling; retrospective detection of claims processing edit/audit failures/errors; retrospective detection of payments and/or utilization inconsistent with State or Federal program policies and/or medical necessity standards; retrospective detection of fraud and abuse by providers or recipients; sophisticated data and claim sampling, analysis, and reporting; general access and processing features; and general reporting and output
Systems Analyst	For purposes of this RFP, systems analyst shall be responsible for performing the following types of activities: • Detailed system/program design • System/Program development • Maintenance and modification analysis/resolution • User needs analysis • User training support • Developing Medicaid program knowledge
TANF	Temporary Assistance for Needy Families, replacement program for Aid to Families with Dependent Children
TPR	Third-party resource
UB-92	Standard claim form used to bill hospital inpatient and outpatient services; paper equivalent of the Version 4 electronic format used in New York State
UCC	Usual and customary charge
UPC	Universal product code, transferred through the First Data Bank tape update; these codes are applied to products such as drugs and other pharmaceutical products
UPIN	Universal provider identification number

UT	Utilization Threshold, an automated component of the EMEVS by which providers notify the State that services subject to benefit limitations will be provided at the time the eligibility verification is made; a service authorization is generated to the MMIS which allows the claim to be paid
WAN	Wide area network
WIC	Women, Infants, and Children; a Federal program that is administered by the Department of Health; WIC provides nutritional supplements, to low income pregnant or breast-feeding women as well as infants and children under five (5) years of age
WMS	Welfare Management System; the eligibility determination system for the State of New York; the system is operated and maintained by the Human Services Application Systems Center

Appendix C
Procurement Library Contents

C.1 - Medicaid Management Information System/Fiscal Agent Contract

1. Agreement between the State of New York Department of Health and Computer Sciences Corporation, Medicaid Management Information System, dated April 10, 1991, including Ammendments 1 through 9.

2. Request for Proposal (RFP) for a fiscal agent to operate the New York State Medicaid Management Information System, dated July 16, 1990

3. Official Department responses to questions

4. Proposal submitted by Computer Sciences Corporation (CSC)

5. Clarifying questions and answers relating to the contractor's proposal

6. Oral presentation of Computer Sciences Corporation

7. CSC Turnover Plan

8. CSC Monthly Operating Reports, 1/97 through 11/97

9. Summary of Payments to CSC and Claims Processing

10. Disaster Recovery Plan

11. Provider Manuals

12. Claim forms samples

13. Envelopes used

14. Monthly Financial Statements, 1/97 through 11/97

Systems Documentation - MMIS

15. Audit Trace Function

16. Claims Daily Volumes I and II

17. Claims Weekly Volumes I, II and III

18. Claims Monthly

19. Claims Call Modules

20. DOH Criteria Based Pend Resolution User Manual

21. Online MMIS

22. Masterfiles Volumes I, II and III

23. MARS Volumes I, II, and III

24. SURS Monthly Volumes I and II

25. SURS Quarterly Volumes I, II, and III

26. Online Pend Resolution System

27. Online Pend Resolution Supervisor User Manual

28. Online Pend Resolution Clerk User Manual

29. OLMS Volumes I and II

30. Electronic Media Claims Entry Volumes I and II

31. EOMB and CDSR

32. Lombardi

33. Forms

34. MOAS

35. MOAS Online Application Entry Subsystem User Manual

36. MOAS Online Application Medical/Professional Review Subsystem User Manual

37. MOAS Online Inquiry Subsystem User Manual

38. PACES User Manual

39. Procedure Enhanced Fee User Manual

40. Scope of Benefits User Manual

41. Electronic Claim Submission System (ECSS)/Document Retrieval System (DRS)

42. Teleprocessing Magnetic Media Inquiry System Documentation/User Manual

43. Computer Services Manual

44. Production Control Documentation Manual

45. Provider Relations Standard Operating Procedures Manual Volumes I and II

46. Data Management Procedure Manual

47. Edit Decision Table

48. Data Entry Program Listings

49. Miscellaneous

C.2 - Electronic Medicaid Eligibility Verification System/ Telecommunications Contract

1. RFP to take over, operate, and turn over the New York State Electronic Medicaid Eligibility Verification System (previous procurement)

2. RFP questions and answers

Systems Documentation - EMEVS

3. Deluxe Electronic Payment Systems proposal to previous procurement

3.1 Presentation
3.2 Volume I
3.3 Volume II
3.4 Volume III
3.5 Volume III (Continued)
3.6 Volume IV
3.7 Resource Material

4. Current EMEVS agreement (including amendments)

5. Turnover Plan

6. System Flowcharts/Network Diagrams

7. EMEVS User Guide

8. EMEVS Provider Manual

9. ProDUR/ECC Manual

10. ProDUR/ECC Standards Manual

11. Execution Instruction Manual

12. Subsystem Manual

13. Terminal Management System (TMS) User Guide

14. Terminal Management System (TMS)/Voice Center User Guide

15. Terminal Management System Internal Reports

16. EMEVS Terminal Specifications

17. EMEVS Telecommunication Access Methods

18. Medicaid Release 8 Manual (InterVoice Documentation)

19. Data Center Utilization Statistics

20. Network Traffic

    20.1 Dial-up Access Statistics
    20.2 CPU Volumes by Hour

21. DB2 Tables

22. List of assets used to run the EMEVS

    22.1 Hardware and Software Components
    22.2 Fixed Asset Report

23. Monthly Compliance Reports (8/96-7/97)

24. Medicaid Operator Logs (8/96--7/97)

C.3 - Medicaid Data Warehouse Data Elements

1. Three and one-half inch (3-1/2”) diskette in Microsoft Excel containing spreadsheets of data elements desired by QA&A

2. Three and one-half inch (3-1/2”) diskette containing the data elements desired by BPDA to be included in the data warehouse

New York State
Department of Health
Offeror Identification Form A

NYSDOH/FMG Use	Offeror #
Date Received	
DE By/Date	

FIRM/Provider					
Address					
City		**State**		**Zip**	
If Outside U.S.A.: *Providence*		Country			

Employee ID Number (Required)	Additional PIN	Telephone	Fax Number

Authorized Person (Name/Title) Signature

Please answer the following about your organization type. Instructions, including definitions, are provided on the reverse. Check *only one* answer for each question.

1) For-Profit _____ Not-For-Profit _____ Municipality _____

Meets definition of "Small Business concern" Yes _____ *or* No _____

2) MBE or MCBO ** _____ Women-Owned Business** _____ Neither _____

If MBE or MCBO, check one of the following: Black _____Hispanic ____ Asian/Pacific ____ American/Alaskan Indian ____

* This information is required for reporting purposes and to assure equal opportunity to bid.
** If checked, is your organization certified as a For-Profit Minority or Women-Owned Business by New York State? Yes _____ No _____

Offerors are hereby notified that if their principal place of business is located in a state that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act of 1994 amendments (Chapter 684, Laws of 1994) require that they be denied placement on offerors mailing lists and contracts for which would otherwise obtain. Offerors of construction services must be denied the award of a contract if their principal place of business is located in a state that discriminates or imposes a preference against New York State firms listed jurisdiction.

A current list of states which penalize New York State firms is available from the Procurement Assistance Unit, Empire State Development Office, Albany, New York (518) 474-7756.

INSTRUCTIONS FOR FORM A

OFFEROR IDENTIFICATION FORM

GENERAL PURPOSE:

To identify those qualified, potential offerors of services and goods who may be interested in responding to related, competitively bid, Requests for Proposals (RFPs), as issued by the Department.

EMPLOYER PAYEE ID:

Federal Payee Id number of Social Security number used for your federal income tax report.

RETURN THE COMPLETED FORM WITH YOUR TECHNICAL PROPOSAL TO:

Bureau of Accounts Management
NYS Department of Health
Room 1315 Corning Tower
Albany, New York 12237-0016

CONTRACTOR TYPE:

Payment categories as established by the State Comptroller

A Not for Profit Corporation is defined as an incorporated organization chartered for other than Profit-making activities. Most such organizations are engaged in charitable, educational, or other civic or humanitarian activities although they are not restricted to such activities.

A Small Business Concern is defined as a business which is resident in New York State, independently owned and operated, not dominant in its field, and employs one hundred or less persons. A Not for Profit organization may be considered a Small Business Concern if it meets the preceding criteria.

A Minority Business Enterprise (MBE) is defined as any business which is at least fifty-one percent owned by, or in the case of a publicly owned business, at least fifty-one percent of the stock of which is owned by, United States (U.S.) Citizens or permanent residents aliens who are:

a) Black persons having origins in any of the black African racial groups; and/or
b) Persons of Mexican, Puerto Rican, Dominican, Cuban, other Caribbean Island, Central or South American origin and/or national or community identification, whether of Indigenous, Hispanic, Portuguese, French, Dutch, or other descent, and regardless of race; and/or
c) Asian and Pacific Islander persons having origins in any of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands; and/or
d) American Indian or Alaskan Native persons having origins in any of the original peoples of North America and maintaining identifiable tribal affiliations through membership and participation or community identification;

and such ownership interest is real, substantial and continuing. The minority ownership must have and exercise the authority to independently control the business decisions of the entity.

A Minority Community Based Organization (MCBO) is defined as a Not-for-Profit, local human services organization that has its origins in the geographic area comprised of one or more neighborhoods that it serves. A representative MCBO is therefore keenly aware of community needs as well as local resources to meet those needs. Generally, the governing bodies and personnel of community-based organizations reflect the racial, ethnic and cultural make-up of the community(ies) being served. A MCBO is characterized by majority representation of American Indians, Asian Americans, Blacks and/or Hispanics in both policy formulation and decision-making regarding management, service delivery and staffing reflective of the catchment area it serves.

A Women-owned Business Enterprise(WBE) is defined as any business enterprise which is at least fifty-one percentum owned by, or in the case of publicly owned business, at least fifty-one percentum of the stock of which is owned by citizens or permanent aliens who are women, and such ownership interest is real, substantial and continuing. The women-owned ownership must have and exercise the authority to independently control the business decisions of the entity.

(To meet the definition of an MBE or WBE, an non-profit organization must be controlled by a Board of Directors which consists of at least fifty-one percentum minority individuals or women, respectively.)

NEW YORK STATE CERTIFIED MINORITY or WOMEN OWNED BUSINESS - Limited to for Profit organizations which have been certified by the New York State Empire State Development Office as meeting the criteria for a Minority or Women Owned Business. Contact the Empire State Development Office, Division of Minority and Women business Development at 212-383-1718 or 518-474-6346 for certification assistance.

FORM B

New York State Department of Health
Contractor/Subcontractor Background Questionnaire

Instructions:

Offerors are required to complete this form and to submit as part of their technical and financial proposals. The form must also be completed by any proposed subcontractor if the value of that subcontract will be in excess of $10,000.

NOTE:
Please indicate whether you believe that any of the information supplied herein is confidential and should be exempt from disclosure under the Freedom of Information Law:
YES_____ NO_____

If you checked "yes" you must identify the information you feel is confidential by placing an asterisk in front of the appropriate question number(s) and you are requested to attach an additional sheet(s) upon which the basis for such claim(s) is explained.

1. General Information
   Fed. ID. No. _____
   Name of Firm _____
   Mailing Address _____
   Actual Location _____
   City _____ State _____ Zip _____
   Fax # (___) _____ Phone # (___) _____

2.

(a) a civil or criminal investigation of the New York State Ethics Commission involving a violation(s) of Section 73 and Section 74 of the Public Office Law. **YES_____ NO_____**

(b) a judgment of conviction for any business-related conduct constituting a crime under state or federal law? **YES_____ NO_____**

(c) a criminal investigation or indictment for any business-related conduct constituting a crime under state or federal law? **YES_____ NO_____**

(d) a grant of immunity for any business-related conduct constituting a crime under state or federal law? **YES_____ NO_____**

(e) a federal or state suspension or debarment? **YES_____ NO_____**

(f) a rejection of any bid for lack of qualifications, responsibility or because of the submission of an informal, non-responsive or incomplete bid?
YES_____ NO_____

(g) a rejection of any proposed subcontract for lack of qualifications, responsibility or because of the submission of an informal, non-responsive or incomplete bid? **YES_____ NO_____**

(h) a denial or revocation of prequalification? **YES_____ NO_____**

(I) a voluntary exclusion from bidding/contracting agreement? **YES_____ NO_____**

(j) any administrative proceeding of civil action seeking specific performance or restitution in connection with any public works contract except any disputed work proceeding? **YES_____ NO_____**

(k) an OSHA Citation and Notification of Penalty containing a violation classified as serious? **YES_____ NO_____**

(l) an OSHA Citation and Notification of Penalty containing a violation classified as willful? **YES_____ NO_____**

(m) a prevailing wage or supplement payment violation? **YES_____ NO_____**

(n) a State Labor Law violation deemed willful? **YES_____ NO_____**

(o) any other federal or state citations, Notices, violation orders, pending administrative hearings or proceedings, or determinations of a violation of any labor law or regulation? **YES_____ NO_____**

(p) any criminal investigation, felony indictment or conviction concerning formation of, or any business association with, an allegedly false or fraudulent women's, minority or advantaged business enterprise? **YES_____ NO_____**

(q) any denial, decertification, revocation or forfeiture of Women's Business Enterprise, Minority Business Enterprise or Disadvantaged Business Enterprise status? **YES_____ NO_____**

(r) rejection of a low bid on a State contract for failure to meet statutory affirmative action or M/WBE requirements? **YES_____ NO_____**

(s) a consent order with the NYS Department of Environmental Conservation, or a federal, state or local government enforcement determination involving a violation of federal or state environmental laws? **YES_____ NO_____**

(t) any bankruptcy proceeding? **YES_____ NO_____**

(u) any suspension or revocation of any business or professional license?
YES_____ NO_____

(v) any citations, Notices, violation orders, pending administrative hearings or proceedings or determinations for violations of:
- federal, state or local health laws, rules or regulations
- unemployment insurance or workers compensation coverage or claim requirements
- ERISA (Employee Retirement Income Security Act)
- federal, state or local human rights laws
- federal or state security laws?

YES_____ NO_____

CERTIFICATION

The undersigned 1) recognizes that this questionnaire is submitted for the express purpose of inducing the New York State Department of Health to award a contract or approve a subcontract; 2) acknowledges that the Department may in its discretion, by means which it may choose, determine the truth and accuracy of all statements made herein; 3) acknowledges that intentional submission of false or misleading information may constitute a felony under Penal Law 210.40 or a misdemeanor under Penal Law 210.35 or 210.45, and may also be punishable by a fine of up to $10,000 or imprisonment of up to five years under 18 U.S.C. 1001; 4) states that the information submitted in this questionnaire and any attached pages is true, accurate and complete and 5) acknowledge that submission of false or misleading information will constitute grounds for the Department to terminate its contract (or revoke its approval of a subcontract) with the undersigned or the organization of which s/he is an officer.

_____
Signature of Officer

_____
Title

_____
Date

FORM C

RESPONSIBLE OFFICERS

NAME	TITLE	RESPONSIBILITY

USE ADDITIONAL SHEETS IF NECESSARY

FORM D

SUBCONTRACTOR ORGANIZATION

1) Name of subcontractor organization:_____

2) Address of subcontractor organization:_____

_____

Please identify all of the Terms below which apply to the subcontractor's organization:

	YES	NO
Non-Profit Organization	___	___
Small Business	___	___
Minority Business	___	___
Women-Owned Business	___	___

3) List responsible officers including those individuals authorized to negotiate for subcontractor.

4) Describe services/materials to be supplied by the subcontractor under the project and mechanisms for assuring effective and efficient operations.

5) List any financial interest subcontractor has in the offering organization.

6) List any financial interest offeror has in proposed subcontractors.

7) Provide evidence of potential subcontractor willingness to participated or enter into subcontractual arrangements.

USE ADDITIONAL SHEETS IF NECESSARY

FORM E

LITIGATION

Offerors are required to complete this form and to submit as part of their technical and financial proposals.

1) Describe any litigation in which the offeror is presently involved.

2) Identify possible effects on this project.

FORM F

STANDARD CONTRACT/BID INSERT FORM

OFFEROR'S NAME:_____ RFP NUMBER:_____

This form must be completed and returned with your response to this proposal. If awarded to you, the contract will incorporate this form as completed by you.

NONDISCRIMINATION IN EMPLOYMENT IN NORTHERN IRELAND: MacBRIDE FAIR EMPLOYMENT PRINCIPLES

Note: Failure to stipulate to these principles may result in the contract being awarded to another offeror. Governmental and non-profit organizations are exempted from this stipulation requirement.

In accordance with Chapter 807 of the Laws of 1992 (State Finance Law Section 174-b), the offeror, by submission of this bid, certifies that it or any individual or legal entity in which the offeror holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership interest in the offeror, either:

o has business operations in Northern Ireland: **YES___ NO___**

o if yes to above, shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such Principles:
YES___ NO___

OMNIBUS PROCUREMENT ACT OF 1992

Is the Offeror a New York State Business Enterprise? **YES___ NO___**

The State Finance Law defines a "New York State Business Enterprise" as a business enterprise, including a sole proprietorship, partnership, or corporation, which offers for sale or lease or other form of exchange, goods which are sought by the department and which are substantially manufactured produced or assembled in New York State, or services which are sought by the department and which are substantially performed within New York State. The Department of Health considers "substantially" to mean "over 50%".

FORM F (CONTINUED)

o It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority- and women-owned business enterprises as offerors, subcontractors and suppliers on its procurement contracts.

o Information on the availability of New York State subcontractors and suppliers is available from:

Empire State Development Office
Division for Small Business
(518) 474-7756

o A directory of minority- and women-owned business enterprises is available from:

Empire State Development Office
Minority and Women's Business Development Division
(518) 474-1979

FOR ALL CONTRACTS WHERE THE TOTAL BID AMOUNT IS $1 MILLION OR MORE

The Omnibus Procurement Act of 1992 requires that, by signing this bid proposal, contractors certify that whenever the total bid amount is greater than $1 million:

1. The contractor has made all reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors on this project, and has retained the documentation of these efforts to be provided upon request to the State;

2. The contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

3. The contractor agrees to make all reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The contractor agrees to document these efforts and to provide said documentation to the State upon request;

4. The contractor acknowledges notice that New York State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

FORM F (CONTINUED)

CHECKLIST TO DETERMINE "REASONABLE" EFFORT BY OFFERORS/CONTRACTORS FOR CONTRACTS OF $1 MILLION OR MORE

A copy of this form should be completed and retained on file by the Contractor. The completed form should be available for review for the duration of the contract.

The contractor:

1. has a copy of the NYS Directory of Certified Minority and Women-Owned Business Enterprises? **YES___ NO___**
2. has solicited quotes from firms listed in the Directory? **YES___ NO___**
3. has contacted the Empire State Development Office to obtain listings of NYS subcontractors and suppliers for products and services currently purchased from out-of-state/foreign firms? **YES___ NO___**
4. has utilized other sources to identify NYS subcontractors and suppliers (such as Thomas Register, in-house vendor list)? **YES___ NO___**
(If YES, Source: _____)

5. has placed advertisements in NYS newspapers? **YES___ NO___**
6. has participated in vendor outreach conferences? **YES___ NO___**
7. has provided New York State residents notice of new employment opportunities resulting from this contract through listing any such positions with the Job Service Division of the NYS Department of Labor, or providing such notification by another method? **Y __ N__**

THIS PAGE INTENTIONALLY LEFT BLANK

Appendix E
Summary of Performance Standards

Replacement Operations Phase Requirements

Client Eligibility Data Repository

7.2.4.1 Update the Client Eligibility Data Repository at least daily on a schedule approved by the Department.

Provider Enrollment and Data Maintenance

7.3.4.1 Mail provider enrollment packets within two (2) business days of the contractor's receipt of request. The contractor shall maintain a log, by date, of all requests made and enrollment packets sent by date. The log will be used to monitor compliance with this standard. The contractor shall prepare and submit a monthly report summarizing information maintained in this log.

7.3.4.2 Process to completion ninety-eight percent (98%) of all clean provider applications and updates within five (5) business days of receipt. Process to completion the remaining two percent (2%) within ten (10) business days of receipt. For "non-clean" applications (e.g., the applications are missing information), the provider shall be notified of what is required to complete the application within two (2) business days of determining that information is missing. The contractor shall complete processing of "non-clean" applications within five (5) business days of receipt of the requested information. The contractor shall maintain a log to support the monitoring of compliance with this standard and shall prepare and submit a monthly report summarizing the information maintained on this log.

7.3.4.3 Send notification letters of acceptance/rejection as New York State Medicaid providers, subject to approval by the Department, within one (1) business day of determination.

7.3.4.4 Staff provider relations hotline toll-free phone lines from 7:30 a.m. to 6:00 p.m., Eastern time, Monday through Friday (excluding Department-approved contractor holidays).

7.3.4.5 Maintain a sufficient number of telephone lines and personnel to staff the lines so that no more than ten percent (10%) of incoming calls ring busy and

no more than ten percent (10%) remain on hold for more than two (2) minutes.

7.3.4.6 Respond to all requests or questions via telephone within two (2) business days. Requests of an unusual nature requiring significant research must be answered as expeditiously as possible. The contractor must send the requesting party, within two (2) business days of receipt of the request, an acknowledgment, including an estimate of how long it will take to answer the question or to provide the requested information.

7.3.4.7 Respond to ninety-eight percent (98%) of all written provider correspondence (inquiries) with a written response within ten (10) business days of receipt of the provider's correspondence by the contractor. Respond to the remaining two percent (2%) within fifteen (15) business days of receipt by the contractor.

7.3.4.8 Provide toll-free lines for providers to access the electronic bulletin board. The bulletin board must be available twenty-two (22) hours a day and compatible with a wide range of computer configurations, modem speeds, and communications protocols (to be determined by the Department).

7.3.4.9 Respond to legislative or executive-level (e.g., Governor) inquiries within three (3) business days of receipt of the inquiry by the contractor. Submit all responses to the Department for approval.

7.3.4.10 Mail, or post electronic mail for, claim forms and other billing documents to providers within two (2) business days of request for the forms. Perform automated claim form distribution in accordance with a schedule established by the Department.

7.3.4.11 Prepare, and send to the Department for approval, drafts of provider manuals and revisions within ten (10) business days of the Department request.

7.3.4.12 Mail provider manual revisions and provider bulletins within eight (8) business days of approval by the Department, or sooner, as requested.

7.3.4.13 Develop and submit to the Department an annual provider training plan within ten (10) business days of the beginning of the contract year.

7.3.4.14 Update and distribute approved revisions to the Operating Procedures Manual within thirty (30) calendar days of Department approval.

7.3.4.15 Maintain, at a minimum, a ninety-five percent (95%) accuracy rate for processing provider applications and entering provider information into the Replacement Medicaid System.

7.3.4.16 Update all manuals, including Provider Manuals, internal procedure manuals, and Operating Procedures Manuals, every quarter to include information sent to providers in the provider bulletins and to reflect changes made during the quarter.

Reference Data Maintenance

7.4.4.1 Process the annual HCPCS procedure code tape update within five (5) business days of receipt.

7.4.4.2 Process monthly NDC drug file updates within two (2) business days of receipt.

7.4.4.3 Manually update DRGs within two (2) business days of receipt.

7.4.4.4 Correctly apply updates to the Reference tables within two (2) business days of the update processing.

7.4.4.5 Manually update ICD-9 procedure and diagnosis codes within five (5) business days of receipt.

7.4.4.6 Manually update limits and restrictions associated with NDC file updates within two (2) business days of receipt.

7.4.4.7 Generate, and disseminate to providers, a bulletin outlining all HCPCS procedure code changes thirty (30) calendar days in advance of the effective date of the HCPCS codes.

7.4.4.8 Provide listings of the Reference files (i.e., HCPCS procedures, modifiers, formulary, diagnoses) to the Department within seven (7) calendar days of receipt of the request.

7.4.4.9 Ensure that new and revised copies of edits are sent to the Department within five (5) business days of the update.

7.4.4.10 Support State rate-setting activities by providing copies of the pricing file and other files specified by the Department on electronic or paper media within five (5) business days of the date of the request.

Electronic Commerce

7.5.4.1 Maintain the electronic interface (EVS, ARU, POS, RJE, PC dial-up, and CPU to CPU) for inquiry, verification, and adjudication purposes for twenty-four (24) hours a day, seven (7) days a week.

7.5.4.2 Provide operator assistance for providers in using the electronic commerce functions from 7:00 a.m. to 10:00 p.m., Eastern Time, Monday through Friday. Provide operator assistance on weekends and Department-approved holidays from 8:30 a.m. to 5:30 p.m., Eastern Time.

7.5.4.3 Provide sufficient in-bound access lines so that Medicaid providers are connected with the automated inquiry system within two (2) telephone rings at least ninety-nine percent (99%) of the time; initial response shall be within ten (10) seconds ninety-nine percent (99%) of the time.

7.5.4.4 Ensure that the response time for provider-submitted transactions is not greater than two (2) seconds for ninety percent (90%) of the transactions and no response time is greater than five (5) seconds.

7.5.4.5 Ensure less than one percent (1%) of incoming telephone calls receive a busy signal and all calls on hold are answered in less than fifteen (15) seconds.

7.5.4.6 Notify the State immediately when the inquiry system is down.

Claims and Encounter Processing

7.6.4.1 Assign a unique claim reference number to every paper claim, CCF, and adjustment within one (1) business day of the date received in the mail room. Attachments should receive the same unique number as the document to which it is attached. Process/archive every claim and attachment within three (3) business days of receipt at the contractor's site.

7.6.4.2 Provide on-line notification to providers, within twenty-four (24) hours of transmission, regarding any transmission or claim data errors or acceptability for further processing.

7.6.4.3 Assign a unique claim reference number to electronic media capture claims, CCFs, and adjustments within one (1) business day of the date received in the mail room. Process/archive every claim and attachment within one (1) business day of receipt at the contractor's site.

7.6.4.4 Return claims missing required or unreadable data within five (5) business days of receipt. Any attachments must be returned with the claims. Instructions for the providers on how to correct and resubmit the returned claims must be included when the claims are returned.

7.6.4.5 Maintain data entry keying accuracy standards of ninety-seven percent (97%) for claims and other transactions.

7.6.4.6 Load claims submitted electronically by tape, diskette, and batch transmissions, including encounter claims, within one (1) business day of receipt by the contractor.

7.6.4.7 Produce, reconcile, and submit balancing and control reports that reconcile all claims, including encounter claims, entered into the system to the batch processing cycle input and output counts. The reports shall be provided on a weekly basis. Include management-level reports to account for all claims at all times.

7.6.4.8 Retrieve hard-copy claim documentation, client and provider data sheets, and reports within three (3) business days of receiving the request.

7.6.4.9 Provide on-line response notification to providers within five (5) minutes of receipt of incoming electronic claim transactions.

7.6.4.10 Update the claims entry files daily with all claims.

7.6.4.11 Ensure POS access is available for claim editing for pharmacy claims twenty-four (24) hours a day, seven (7) days per week.

7.6.4.12 Edit and adjudicate claims and encounters five (5) times per week.

7.6.4.13 Correctly adjudicate ninety percent (90%) of all claims within thirty (30) calendar days of receipt by the contractor and ninety-nine percent (99%) of all claims within ninety (90) days of receipt by the contractor. Time during

which claims are under review by the Department will not count toward the adjudication standard.

7.6.4.14 Update claims data with CCF responses within three (3) business days of receipt.

7.6.4.15 Pay, deny, or suspend paper claims within thirty (30) calendar days of receipt by the contractor.

7.6.4.16 Pay, deny, or suspend electronically submitted claims within twenty-one (21) calendar days of receipt by the contractor.

7.6.4.17 Reprocess erroneously denied claims within ten (10) business days of discovery of erroneous denial.

7.6.4.18 Enter, within one (1) business day of receipt, Department and local office requests for client and provider history printouts. Deliver history printouts within five (5) business days of receipt of the request.

7.6.4.19 Generate and submit claims inventory and operations reports after each claims processing cycle.

Financial Management

7.7.4.1 Perform up to two (2) payment cycles weekly on a schedule approved by the Department.

7.7.4.2 Produce and provide through electronic transmission a check register, EFT register, and all shares reports to the Department by 7:00 a.m. on Monday of each week. Provide hard copy shares reports by 11:00 a.m. on Monday of each week. This is to be followed for all regularly scheduled payment cycles. For any extraordinary or additional payment cycles, produce and provide check and EFT registers and all shares reports to the Department within 24 hours of payment cycle completion.

7.7.4.3 Produce provider payment accounts receivable balance reports after each weekly financial cycle and submit electronically to the Department.

7.7.4.4 Produce and submit to the Department monthly, all accounts receivable reports, including provider, TPR, and Drug Rebate reports in aggregate and/or individual accounts, as directed by the Department.

7.7.4.5 Execute and perform retroactive and mass adjustment processing within ten (10) business days of receipt of the request or LTC rate change notice.

7.7.4.6 Review and adjudicate ninety percent (90%) of all requests for adjustments within thirty (30) calendar days of receipt. The remaining ten percent (10%) must be adjudicated within forty-five (45) calendar days of receipt.

7.7.4.7 Deposit returned or problem checks into the contractor's bank account within twenty-four (24) hours of receipt.

7.7.4.8 Produce and mail (or transmit electronically to some providers) provider 1099 earnings reports in accordance with Federal and State regulations.

7.7.4.9 Produce and mail Federal and State 1099 tapes in accordance with Federal and State regulations.

7.7.4.10 Produce a monthly summary, by provider, detailing provider assessments and add-on rate calculations, based on information in the Public Goods Pool files, made during the month.

7.7.4.11 Produce, and submit to the Department, the HCFA-64 within ten (10) business days after the end of the quarter

Service Utilization Management

7.8.4.1 Enter all requests for prior authorization into the system within the time frame specified by the Department during the Business Design Task.

7.8.4.2 Generate and mail ninety-five percent (95%) of PA notices to requesting providers and clients within seven (7) days of receipt of request. Generate and mail the remaining five percent (5%) within ten (10) days of receipt.

7.8.4.3 Load PAs submitted electronically within one (1) business day of receipt by the contractor.

7.8.4.4 Maintain a sufficient number of toll-free PA phone lines and qualified personnel to staff the phone lines so that no more then ten percent (10%) of incoming calls ring busy or remain on hold for more than one (1) minute.

7.8.4.5 Staff phone lines from 7:30 a.m. to 6:00 p.m., local time, Monday through Friday (excluding Department-approved contractor holidays).

7.8.4.6 Provide monthly reports regarding phone statistics, within fifteen (15) calendar days following the end of each month.

Third-Party Resources

7.9.4.1 Accurately exchange TPR information with the WMS on a schedule to be determined by the Department.

7.9.4.2 Generate client claims history listings within twenty-four (24) hours of request.

7.9.4.3 Provide copies of micromedia claims to the Department within one (1) business day of request.

The Child/Teen Health Plan (EPSDT)

7.10.4.1 Provide access to the on-line case management system, Monday through Friday, from 7:00 a.m. to 6:00 p.m., Eastern time.

Managed Care Support

7.11.4.1 Conduct daily updates of member enrollments and disenrollments.

7.11.4.2 Process encounter claims daily.

7.11.4.3 Process test encounter claims daily and provide results on the provider bulletin board or Web site.

Drug Rebate

7.12.4.1 Load and process the HCFA Drug Rebate tape within five (5) calendar days of receipt.

7.12.4.2 Prepare and mail invoices for all rebate amounts identified within fifteen (15) business days of receiving the HCFA drug rebate tape.

7.12.4.3 Collect ninety percent (90%) of the dollar amount of rebates invoiced by the end of the fiscal quarter following the period for which the rebate was issued.

7.12.4.4 Require drug utilization tape and letter to be returned to HCFA within thirty (30) days of receipt of original tape from HCFA.

Surveillance and Utilization Review (SUR)

The monthly SUR reports shall be delivered on a schedule to be approved by the Department, but in no case later than thirty (30) days past the end of the monthly period.

Prospective Drug Utilization Review (ProDUR)

The Prospective DUR component shall meet the response times specified in Section 11.10.2.3.3.

Retrospective Drug Utilization Review (RetroDUR)

7.15.4.1 Update the database monthly to ensure that new drugs are added appropriately.

7.15.4.2 Deliver DUR reports and outputs within the time frame specified by the State.

Systems Operations and Integrated Testing Facility

7.16.4.1 Execute cycles in accordance with established schedules.

7.16.4.2 Maintain and back up daily all data and software.

7.16.4.3 Support immediate restoration and recovery of lost or corrupted data or software.

7.16.4.4 Establish and maintain in electronic format a weekly back-up that is adequate and secure for all computer software and operating programs; tables; files; and system, operations, and user documentation.

7.16.4.5 Establish and maintain in electronic format a daily back-up that is adequate and secure for all computer software and operating programs, tables; files; and systems, operations, and user documentation.

7.16.4.6 Provide test outputs within the time periods determined by the Department.

7.16.4.7 Provide a written report before production promotions, in a Department-approved format, on the results of integrated test cycles within seven (7) business days of running the cycles and include a comparison of the expected impact of edit and pricing changes against actual processing results.

7.16.4.8 Produce, review, and submit, by noon the next business day, control reports generated for each test update and processing cycle run.

Management and Administrative Reporting (MAR)

The contractor shall meet the following performance standards for MAR report production:

- Monthly and quarterly reports shall be delivered to the Department no later than the fifteenth (15th) day of the month following the end of the report period.

- Annual reports shall be delivered to the Department no later than the fifteenth (15th) of the month following the end of the applicable year (State fiscal, Federal fiscal, or calendar). The schedule for 1099 forms shall be in accordance with Internal Revenue Service guidelines.

- Financial/funding reports (MR-O-30, MR-O-31, and MR-O-39) must reconcile in local, State, and Federal shares and total expenditures.

- Operations reports (MR-O-08, MR-O-09, MR-O-40, MR-O-41, and MR-O-42) must reconcile to each other in terms of total claims adjudicated, paid, and denied.

Appendix F
Management and Administrative Reporting Subsystem (MARS) Reports

The following table presents the list of the MARS reports generated by the existing New York State MMIS. Following the table is a listing of the reports by required media.

Report #	Report Title
MR-0-1	**Medical Assistance Financial Status**
	• Companion to MR-50
	• Payments by Dollar Volume, Monthly, YTD
	• Claims Activity, Monthly, YTD
	• Changes in Recipient Counts
	• MA Payments by Month of Service
	• Most Detailed Provider Service Categories
MR-0-1A	**Medical Assistance Program Status**
	• Companion to MR-50
	• Payments by Dollar Volume, Monthly, YTD
	• Claims Activity, Monthly, YTD
	• Changes in Recipient Counts
	• MA Payments by Month of Service
	• Most Detailed Provider Service Categories
MR-0-6	**HCFA-416 C/THP Report**
	• Aid Category by Categorically Needy (CN) or Medically Needy
	• Age Groups
	• Participation Ratio
	• Number of Eligibles for EPSDT
	• Total Number of Exam Services
MR-0-7	**Statistical Report on Medical Care**
	• Unduplicated Number of Recipients
	• Eligibles by Race/Ethnicity
	• Eligibles by Maintenance Assistance Status
	• Eligibles by Age and Sex
	• Eligibles by Category of Service
	• Total Capitation Payments
MR-0-8	**Operational Performance Summary**
	• Total Claims Processed
	• Percent Approved
	• Percent Approved Without Suspension
	• Percent Denied
	• Average Errors Per Claim
MR-0-9	**Claims Processing Performance Analysis**
	• New Claims Entered
	• Total & % Approved
	• Total & % Denied
	• Total & % Pended
	• Total Claims Processed

Report #	Report Title
	• Pending Claim Balance Month-End
	• Pended Balance From Last Month
MR-0-10	**Claims Processing Thruput Analysis**
	• Days to Payment by Category of Service
	• Average Days Required
MR-0-11	**Error Distribution Analysis**
	• Ten Most Prevalent Conditions-Paid Claims
	• Ten Most Prevalent Conditions-Denied Claims
	• Error Codes
	• Number of Errors
	• Percentage of Error Conditions
MR-0-14	**Rate Adjustment Report**
	• Provider Name/Number
	• Rate Variation (-/+)
	• Patient Days
	• Adjusted Amount (-/+)
	• Federal, State, Local Shares
MR-0-15	**Provider Claim Filing Analysis**
	• Total Claims Approved
	• Total Amount Paid
	• Average Days to Filing
	• Days Since Last Service Date
	• Total Claims Entered Processing
MR-0-16	**Provider Claim Filing Details**
	• Provider Name and Number
	• Average Days to Filing: 1-30, 31-60, 61-90, 91-120, More Than 120 days
	• Number of Claims, Amount Paid
MR-0-17	**Third-Party Payment Analysis**
	• Provider Name and Number
	• Claims With Third-Party Payment
	• Third-Party Payment Dollars
	• Third-Party Dollars as a Percent of Total Claims Dollars
MR-0-18	**Error Frequency Analysis**
	• Provider Number
	• Number of Claims Paid
	• Percent of Claims With This Error
	• Number of Claims With This Error
	• Number of New Claims Suspended This Month
	• Number of Rejected Claims
	• Number of Denied Claims
	• Number of Claims Overridden
MR-0-19	**Provider Ranking List**
	• Provider Name/Type
	• Claims This Provider
	• Retroactive Dollars
	• Total/Average Payments
	• Rank by Payment

Report #	Report Title
MR-0-20	**1099 Med for Providers**
	• Provider Name and Number
	• Social Security Number
	• Employer Identification Number
	• Total Annual Payments
MR-0-24	**County Expenditure Analysis**
	• Claims by Service Listing
	• Dollars by Service Listing
	• Claims by Aid Category
	• Dollars by Aid Category
MR-0-26	**Drug Usage by Eligibility Classification**
	• Aid Category
	• Generic Code
	• Number of Beneficiaries
	• Dollar Amount of Usage
	• Percent of Usage by Aid Category
MR-0-28	**Home- and Community-Based Waiver-Waived Services Report**
	• Total Expenditures
	• Federal/State/Local
	• Months of Service Over 36 Months
MR-0-30	**Analysis of Assistance Payments**
	• Service Type
	• Total Expenditures
	• Refunds/Cancellations
	• Total Federal Financial Participation
	• Total Federal Non-Participation
CAP-30	**Child Assistance Program Payments**
	• Service Type
	• Total Expenditures
	• Net Reimbursable
	• Total Federal Financial Participation
	• Total Federal Non-Participation
MR-0-31	**Statement of Medical Assistance Expenditure for the Medical Assistance Program**
	• Service Listing
	• Total FP Expenditures
	• Total Federal Reimbursement
CAP-31	**Statement of the Expenditures for the Child Assistance Program**
	• Service Listing
	• Total FP Expenditures
	• 50%, 90%, 100% Reimbursement Shares
	• Total Federal Reimbursement
MR-0-35	**C/THP Participation Summary**
	• Number of Eligibles During Month
	• Number of Clients No Longer Eligible This Month
	• Number of C/THP Exams
	• Cost for C/THP Exams

	• Cost for Related Services

Report #	Report Title
	• C/THP Exam Results
	• Eligibles Under Age 1,1-2, 3-5, 6-9, 10-13, 14-20
MR-0-36	**MA Statistical Report**
	• Dollars and Service Units by Aid Category
	• Recipient Count by Aid Category
	• Dollars and Service Units by Service Listing
	• Recipient Count by Service Listing
MR-0-39	**Breakdown of Medical Payments by Month of Service**
	• Service Month
	• Total Expenditures
	• State Share
	• Category of Service
MR-0-39A	**Breakdown of Medicaid Payments to Providers by Month of Service**
	• Service Month
	• Provider Name and Number
	• Federal/State/Local Shares
	• Total Expenditures
	• Paid Claims/Denied Claims
MR-0-41	**Claims Processing Analysis by Month of Receipt**
	• Number of Claims Processed
	• Number of Claims Denied
	• Number of Claims Approved
	• Number of Claims Pended
MR-0-47	**HCFA-350 Annual Report on Provider Participation in the Medicaid Program**
	• Type of Provider
	• Number of Providers Reimbursed by the State Medicaid Agency
MR-0-50	**Medical Assistance Program Statistics**
	• This Month Beneficiaries
	• Last Month Beneficiaries
	• % Change
	• Same Month Last Year Beneficiaries
	• Fiscal Year to Date
MR-0-51	**Breakdown of Medicaid Services by Month of Service**
	• Service Month
	• Total Expenditures
	• Beneficiaries
	• Average $ Per Unit
	• Average $ Per Beneficiary
MR-0-52	**MA Program Statistics Report**
	• Aid Category
	• Dollars
	• Beneficiaries
	• Service Units
	• Claims
	• 12-Month Total

Report #	Report Title
MR-0-53	**Drug Frequency and Utilization Analysis**
	• NDC Code and Drug Name
	• Number of Prescriptions
	• Total Amount Paid
MR-0-54	**Total Analysis of Assistance Payments**
	• Total Expenditures
	• Refunds/Cancellations
	• Non-Reimbursable
	• Net Reimbursable
MR-0-55	**Statement of Medical Assistance Expentitures for the Medical Assistance Program-FP Positive**
	• Service Listings
	• Total FP Expenditures
	• 50%, 90%, 100% Reimbursement
	• Total Federal Reimbursement
MR-0-56	**Statement of Medical Assistance Expenditures for the Medical Assistance Program-FP Negative**
	• Service Listings
	• Total FP Expenditures
	• 50%, 90%, 100% Reimbursement
	• Total Federal Reimbursement
MR-0-57	**Statement of Medical Assistance Expenditures for the Medical Assistance Program-FP Negative-Month**
	• Service Listings
	• Total FP Expenditures
	• 50%, 90%, 100% Reimbursement
	• Total Federal Reimbursement
MR-0-58	**Lombard/Malpractice Retroactive Rate Adjustment Report**
	• Category of Service
	• Non-Reimbursable
	• Net Reimbursable
	• Total FFP
	• Total FNP
MR-0-59	**Drug Frequency and Utilization Summary**
	• Generic Code
	• Number of Prescriptions
	• Total
	• % of All Drugs
	• Average Quantity Dispensed
	• Total Amount Paid
MR-0-60	**Lombardi/Malpractice Non-Retroactive Rate Adjustments Report**
	• Total Expenditures
	• Refunds/Cancellations
	• Non-Reimbursable
	• Net Reimbursable
MR-0-61	**Repatriated American Citizen Detail Report**
	• Recipient Number

	• Service Date
	• Payment Amount

Report #	Report Title
MR-0-62	**Lombardi/Malpractice Total Payments Report**
	• Service Listing
	• Total Expenditures
	• Refunds/Cancellations
	• Non-Reimbursable
	• Net Reimbursable
	• Total FFP, Total FNP
MR-0-63	**Methadone Maintenance Treatment Program**
	• Provider Type
	• Provider Name
	• Total Claims
	• Retro Dollars
	• Other Dollars
	• Total Payment
	• Average Payment
MR-0-64	**Overburden Quarterly Computation of Federal, State, and County Share for the Mentally Disabled**
	• Services to Federal Share
	• Family Planning Service
	• All Other Services
	• Total Federal Share
MR-0-65	**Recipient Specific Overburden Aid Report for the Mentally Disabled**
	• Recipient ID
	• Total Payment
	• Federal/State/Local Shares
MR-0-66	**Overburden Qualifying Service Report for the Mentally Disabled**
	• Recipient ID
MR-0-70	**Rate Adjustment Summary**
	• Service Type
	• Grand Total
	• Withheld, Paid
	• Net Federal Share
	• Net State Share
	• Net Local Share
	• Net-Reimbursable
MR-0-71	**HR Copay Report**
	• Dollars, Claims by Aid Category
	• Dollars, Claims bt Service Listing
MR-0-72	**Medical Assistance Expenditures by Source of Funds**
	• Compare to MR-0-01A
	• Payments by Dollars, by Month, Current 12 Months, Previous 12 Months, Year to Year
	• Federal, State, Local Shares by Service Listing
MR-0-73	**Medical Assistance Expenditures by Source of Funds (Retro-Payments)**
	• Compare to MR-0-01A

Report #	Report Title
	• Payments by Dollars, by Month, Current 12 Months, Previous 12 Months, Year to Year
	• Federal, State, Local Shares by Service Listing
MR-0-74	**Medically Supervised Substance Abuse Treatment Program**
	• Category of Service-Specific Dollars
	• Provider Ranking by ID #
	• Claims Retro Dollars
	• Federal, State, and Local Shares
MR-0-75	**Home Care Services Report**
(currently not in distribution)	• Aid category dollars and recipient
	• Service Category Dollars and Recipient Service Units
	• Federal, State, and Local Shares
	• Recipient Demographic Utilization
	• Provider Activity Section
MR-0-76	**Medical Assistance Managed Care Report**
	• Family Planning/Non-Family Planning
	• Aid Category Dollars, Beneficiary Count Service Units Claims
	• Federal, State, and Local Shares
MR-0-77	**Consolidated Copay Report**
	• Companion to MR-0-712
	• Aid Category Summarization Dollars, Beneficiaries
	• Service Categories Summarized Dollars, Beneficiaries, Claims
MR-0-78	**Durable Medical Equipment and Supplies Report**
	• Breakout by Generic Code
	• Therapeutic Code Subcategories
	• Dollar Amount
	• Total Quantity Dispensed
	• Number of Prescriptions
CWR596A	**Weekly Computation of Federal, State, and County Share**
	• Claim Reference Number
	• Federal/State/Local Share
	• Aid Category
	• Payment Amount
	• Service Date

Report Media

Hard Copy

MRP001SO
MARM9999 CROSSWALK, DETCAT
MARQ0053-MR-0-16, 19, 52, 53, 59, 61
MARM001A-MR-0-01, 01A, 30, 54, 58, 60, 62, 36, 70, 71, 72, 73, 76, 77
MARM001B-MR-0-50, 78, 96

MARM0250-CAP-30, 31
MARM0500-MR-0-17, 28, 39, 41, 39A, 51, 63, 74
MARM0600-MR-0-08, 10, 11, 15, 09, 18, 43, 75
MARM0700-MR-0-35

Print Tapes

MARM001-
MARM0008-
MARM0009-
MARM0014-
MARM0017-
MARM0018-
MARM0024-
MARM0030-
MARM0031
MARM0035
MARM0036
MARM0039
MARM0043
MARM0050
MARM0051
MARM0063
MARM0071
MARM0072
MARM0074
MARM0075
MARM0076
MARM0077
MARM0078
MARM009A

Data Files

MARM001B-MR-0-01A, 50, 72, 73
MARM001A-MR-0-54, 36, 76
MARM0600-RESEARCH DATATAPE-OVERBURDEN
MARM0600-(MARCH, JUNE, SEPTEMBER, DECEMBER)

LAN Data Files

MARM001B-MRP11AAO, MRS136CO, MRS136DO

LAN Nomenclature Files

MAR0400-MRP197AO, MRP197BO, MRP197CO, MRP197DO

CAP Tapes

MARM000C
MARM001C

CAP Reports

MARM00C
MARM001C

Matrix Update

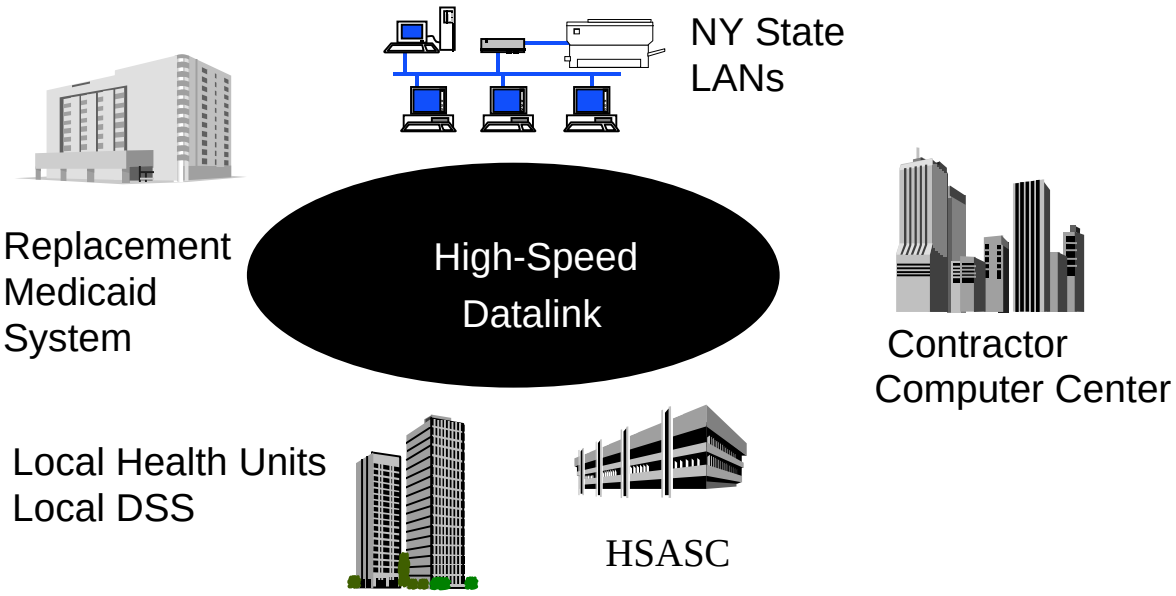
MARM9999

HCFA-2082 Report and MSIS Data Tape Set

HCFA 419

1099 Provider Payment Report

Appendix G
DOH Datalink Configuration



Appendix H
Data Elements for the Medicaid Data Warehouse

The data elements representing some of the data elements for the Medicaid data warehouse and summarized in the following pages were provided by OMM staff. The data elements all come from Medicaid systems and are organized by:

- Bureau of Program and Data Analysis
- Quality Assurance and Audit (QA&A)
- EMEVS DB2 files

These data elements are available in greater detail electronically through the Procurement Library.

Bureau of Program and Data Analysis Data Element List

Data Element #	Description	Size (in Bytes)
1010	RECIPIENT ID NUMBER	11
1020	PRIOR RECP ID NUM	10
1050	RECP NAME	28
1120	RECP ZIP CODE	5
1180	RECP DOB	7
1190	RECP RACE	1
1210	RECP SEX	1
1220	RECIPIENT COUNTY CODE	2
1221	COUNTY OF RESIDENCE	2
1221	TRANS DIST	2
1230	RECP LOCAL OFF NUM	2
1240	RECP AID CAT	2
1240	RECP AID CAT/$ PAY TYP2	2
1240	RECP AID CAT/$ PAY TYP3	2
1240	RECP IAD CAT/$ PAY TYP4	2
1270	RECP DEATH IND	1
1280	RECP OTHER INSURANCE	2
1330	RECP EXCP CODE	2
1340	RECP MEDICARE CODE	1
1380	RECP COV CODE	1

Data Element #	Description	Size (in Bytes)
1550	RECP PAT PAY CODE/ LTC	1
1560	PATIENT PAY AMOUNT	7
1560	RECP PAT PAY AMT	7
1580	RECP MEDI REIM CODE2	2
1580	RECP MEDI REIM CODE3	2
1580	RECP MEDI REIM CODE4	2
1580	RECP REIM CODE	2
1840	RECP REST CODE	2
1844	CASE MANG ID NUM	8
2001	PROVIDER ID NUMBER	8
2002	PROV TYPE CODE	3
2003	PROV NAME	29
2006	PROV OUT OF STATE/CONF CODE	1
2017	PROV CTY CO	2
2019	CATEGORY OF SERVICE	4
2045	PROVIDER GROUP ID NUMBER	8
2047	PROV TYPE PRAC ORG CODE	2
2048	PROVIDER SPECIALTY CODE	3
2053	# OF BEDS/ FED DRG	4
2055	PROV COF CODE	2
2078	RATE CODE	4
2195	LOMBARDI REG CODE	2
3001	CRN	15
3004	REFERRING PROVIDER ID	8
3005	PRES LICENSE NUMBER	8
3006	DIAG CODE ENCT 4 OCCR	24
3006	PRI DIAG CODE	6
3007	SEC DIAG CODE	6
3010	BILLING/INVOICE DATE	6
3011	ADMIT DATE (INP)	6
3012	ADMISS HOUR	2
3013	SERVICE DATE	6
3015	END DATE OF SERVICE	6
3016	PLACE OF SERVICE	1
3017	LOCATION OF SERVICE	2
3017	PROVIDER LOCATOR CODE	2
3018	NUM OF REF AUTH	1
3028	MEDICARE PT A BLD DED NUM PTS	1
3029	PROC CODE UNITS ENCT 6 OCCR	30
3029	QUAN UNITS	4
3031	OTH INS PD	7

Data Element #	Description	Size (in Bytes)
3031	THIRD PARTY PAID	7
3033	MEDICARE AMT PD	7
3034	MEDICARE A COV AMT CHRG	5
3046	PRIOR APPROVAL NUMBER	8
3054	DATE ADJUD	6
3055	ADJ STATUS	2
3092	DATE OF PRIN PROC	4
3093	THERAPEUTIC LEAVE DAYS	2
3099	RX NUMBER	6
3100	OPER PHYS ID NUM	8
3101	NAT OF ADMISS	1
3108	DISCH DATE INP	6
3110	INVOICE NUMBER	8
3112	TOOTH/QUAD CODE	2
3113	SURFACE CODE	2
3134	MEDICARE PART A COV DAYS	2
3135	MEDICARE PART A CO INS DAYS	2
3136	MEDICARE PT A LIF RES CO-INSD	2
3137	MEDICAID ONLY NUM DAYS	2
3139	MEDICARE PT A BLD DED RATE	4
3146	NUMBER OF ATTACHMENTS	1
3148	ACC/INJURY CODE	1
3150	PAY DATE	6
3157	AMT DUE	9
3167	HOSPITAL LEAVE DAYS	2
3169	SPEC CONSID CODE	1
3174	IMM DPT	2
3174	IMM DPT BOOST	2
3174	IMM MEASL	2
3174	IMM MUMPS	2
3174	IMM POLIO	2
3174	IMM POLIO BOOST	2
3174	IMM RUBEL	2
3174	IMM TD BOOST	2
3174	LAB GC	1
3174	LAB HEMAT HGB	1
3174	LAB LEAD SCRN	1
3174	LAB PAP SMEAR	1
3174	LAB SICKLE CELL	1
3174	LAB TUBERC	1
3174	LAB URIN CUL	1

Data Element #	Description	Size (in Bytes)
3174	LAB URINAL	1
3174	LAB VDRL	1
3174	MUSCO SKELEL	1
3174	PHYS B P	1
3174	PHYS BEHAVE	1
3174	PHYS CARDIOVAS	1
3174	PHYS DENT	1
3174	PHYS DENT STATUS	1
3174	PHYS EAR	1
3174	PHYS EYE	1
3174	PHYS GI	1
3174	PHYS GRTH AND DEVELP	1
3174	PHYS HEAD AND NECK	1
3174	PHYS HEAR	1
3174	PHYS HIST	1
3174	PHYS N/T/M	1
3174	PHYS NEURO	1
3174	PHYS RESP	1
3174	PHYS SKIN	1
3174	PHYS SPEECH	1
3174	PHYS UROG RECT	1
3174	PHYS VISION	1
3174	SEX DEVELP	1
3180	MEDICARE PART A COIN RATE	
3185	EMERG CODE	1
3191	OTH DIAG CODE 1	6
3191	OTH DIAG CODE 2	6
3191	OTH DIAG CODE 3	6
3191	OTH DIAG CODE 4	6
3191	OTHR DIAG CODES 5-8	24
3196	OTHER PROC CODE	4
3196	OTHER PROC CODE 2	4
3199	AMT CHARGED	7
3200	PATIENT STATUS	1
3203	FAM PLAN INDC	1
3204	SCREENING REF CODE	1
3206	PROV REF TO ID NUM	8
3207	DATE OF APPT	6
3214	ABORT/STER CODE	1
3227	PROC CODE MOD	2
3227	PROC CODE MOD 1	1

Data Element #	Description	Size (in Bytes)
3227	PROC CODE MOD 2	1
3227	PROC CODE MOD 3	1
3227	PROC CODE MOD 4	1
3231	RX SOURCE	1
3232	DAYS SUPPLY	3
3233	REFILL IND	1
3234	BRAND NECESS IND	1
3235	TOT MEDICARE APP	7
3246	TYPE OF PRES/REF PROV TYPE	2
3247	DATE ORDERED	6
3249	ADJ/VOID IND	1
3250	ORGN CRN	15
3251	QUAN DISP	4
3253	MEDICAL RECORD NUMBER	10
3254	ADMIT NUMBER	10
3264	OTHER PROC DATE	4
3264	OTHER PROC DATE 2	4
3266	MEDICARE BENE EXH DATE	6
3270	BC FULL DAY RATE1	2
3271	BC FULL DAY RATE2	2
3272	BC PART EXT 1	7
3273	BC PART EXT 2	7
3276	SPEC FED FUND IND	1
3279	PATIENT PART. AMOUNT	7
3279	REC MONTH	7
3282	CHAMPUS IND	1
3288	MEDICAID OTHER	7
3289	CARVE OUT DAYS	2
3290	DISCH HOUR	2
3291	PATIENT STATUS	2
3297	TYPE ALT CARE REQ	1
3298	TYPE ALT CARE DATE	6
3299	ADMISS DENIED	1
3301	INVOICE TYPE	2
3302	INVOICE CLASS	2
3309	CODING METH	1
3318	BC MINUS ADJ CODE	1
3319	BC MINUS ADJ AMT	7
3321	SURP,CATA,MONTH INC CODE	1
3322	SURP,CATA,MONTH INC	7
3323	POSTED CHRGS DAYS	2

Data Element #	Description	Size (in Bytes)
3324	POST CHRGS AMT	7
3326	MEDI B PAT RESP	5
3336	DRG CODE	4
3337	SERVICE INTENS WGHT	6
3338	OUTLIER PCT	3
3339	TOT DAYS PD	2
3340	DRG PAY TYPE IND	1
3341	SHORT OUT ALC DAYS	7
3342	AVERAGE LNGTH OF STAY	3
3343	DRG GROUPER NUM	2
3348	COST PER DISCH	7
3354	HOSP TYPE	1
3367	BRTH WGHT	4
3403	CLAIM MEDIUM TYPE	1
3404	THRU DAY BLOCK BILL	2
3405	PAYMENT SOURCE MEDICARE	1
3406	PAYMENT SOURCE OTHER	1
3411	PAC WGHT NUM	6
3412	PAC GROUPER VER NUM	2
3421	COST OUT IND	1
3424	RECEIPT OF ORD DATE	6
3425	DRG CAP ADD ON	7
3426	SA EXCPT CODE FORM A	1
3426	SA EXCPT CODE FORM C	1
5003	DIAG CLASS CODE1	2
5003	DIAG CLASS CODE2	2
5014	FORM CODE	11
5016	COPAY AMT	7
5022	ALLOW REF IND	1
5024	FORM THER CODE	5
5026	FORM ITEM TYPE CODE	2
5035	FORM GEN CODE	5
5054	PROC CLASS CODE	2
5055	PROC CODE	5
5055	PROC CODE ENCT 6 OCCR	30
5058	CLIN PROC CODE 1	5
5058	CLIN PROC CODE 2	5
5058	CLIN PROC CODE 3	5
5076	SPEC PRG CODE	1
5084	PROC FREQ CODE	2
5085	PEND/DENY IND	1

Data Element #	Description	Size (in Bytes)
5086	MED SERV LIMIT CODE	1
5112	FORM UNIT COST MRA	8
5127	DOSAGE FORM	3
5132	FORM PACK IND	1
5165	PCP PLAN TYPE	1
5166	PCP PLAN CODE	1
7041	BIRTH MONTH-DAY	4
7041	YEAR OF BIRTH	2
C037	ITEM NUM	2
C044	CHECK NUM ASSIGN	8
C047	MEDI XOVER IND	1
C056	EDIT KEY	4
C062	DIAG TYPE	1
C063	POSS DISAB CODE	1
C063	POSS DISAB IND	1
C064	REF SPEC CODE	3
C066	FOLLOW UP IND	1
C072	SERV BUREAU NUM	3
C086	1ST RECYCLE DATE	4
C087	2ND REC DATE	4
C089	CART NUM	4
C092	AUTO REC COUNTER	1
C093	TOT NUM OF REASONS	2
C094	CURR NUM OF REASONS	1
C096	ERROR REASON	5
C096	HIST ERROR REASONS	5
C165	HANDICAP	1
C188	CLAIM STATUS TYPE	1
C188	CLAIM STATUS TYPE	1
C198	SERVICE ID/LICENSE NUMBER	8
C201	REMIT NUM	11
C214	DAILY REC NUM	2
C215	WEEKLY REC NUM	1
C216	RECIPIENT SUFFIX	1
C217	APP ERROR	5
C219	STATE PEND DATE	6
C235	FED SHARES %	5
C235	FED SHARES PAID	5
C236	STATE SHARES %	5
C236	STATE SHARES PAID	5
C237	CITY SHARES %	5

Data Element #	Description	Size (in Bytes)
C237	LOCAL SHARES PAID	5
C239	SERVICE PROVIDER ID TYPE	2
C240	NUM OF LINES	1
C241	CALC MEDICAID DAYS	2
C242	OTH COV DAYS	7
C243	MEDI GROSS	9
C244	RED AMT	7
C245	CALC MEDI DAYS 2	2
C246	CALC MEDI DAYS 3	2
C247	CALC MEDI DAYS 4	2
C251	RENTAL FLAG	1
C268	COMM IND	1
C269	CS19 FLAG	1
C272	BC IND	1
C279	CLAIM CLASS	2
C280	ORIG CLERK ID	4
C281	PROC CODE SOURCE	1
C282	PROV REF TO TYPE	2
C284	CALC CO INS DAYS	2
C287	PREV PEND REL STATUS	2
C288	ORIG CYCLE NUM	3
C289	RETRO RATE ADJ IND	1
C290	PA REQ FLAG	1
C291	DIAG EXT SWITCH	1
C291	FORM EXT SWITCH	1
C291	FUTURE EXT SWITCHES	7
C291	PAPP EXT SWITCH	1
C291	PROC EXT SWITCH	1
C291	PROV EXT SWITCH	1
C291	RATE EXT SWITCH	1
C291	RECP EXT SWITCH	1
C300	HIC NUM IND	1
C307	FED FIN PART IND	1
C308	RACE CODE	1
C309	INTERPETOR IND	1
C310	STER WAIT PER	1
C317	MEDICARE PART A LIFE RES RT	
C318	BC FULL DAY RATE1 IND	1
C319	BC FULL EXT AMT	7
C345	GRP PAY FLAG	1
C348	BRADFORD REC FLAG	1

Data Element #	Description	Size (in Bytes)
C500	NO DEBIT ADJ IND	1
C502	ORIGIN OF CLAIM	1
C503	STAY APP/DEN DATE	6
C504	DATE CODE STAY APP/DEN	1
C505	SEX CODE	1
C508	NET AMT MO INCOME	7
C508	NET AMT OF MONTH INC	7
C511	MAX ALLOW FEE	7
C538	SPEC FUND IND	1
C539	RATE LINE CONV IND	1
C556	DIAG EDIT TYPE IND	1
C557	JULIAN DATE PROV PEND	4
C558	PROV PEND DATE IND	1
C567	BATCH PROV PEND	4
C568	BLOCK BILL EXP IND	1
C573	TYPE OF SERVICE	1
C600	E1115 IND	1
D040	LEV OF COMPLEX	2
D041	RECYCLE WORKED FLAG	1
F303	FUNDING GRID SERVICE KEY	10
F304	RECIP-KEY	3
F305	RECP AGE IN MONTHS	6
F312	ADD ON IND	4
F437	THIRD PART PAYMT	8
F450	RECD TYPE 2	2
F450	RECD TYPE MOD	1
F451	SPEC FND	1
F452	STERABOR	1
F473	RPT DATE	4
F484	FAMILY PLAN	1
F485	CLAIM CNT	1
F487	UNITS	4
F488	RECP CNT	1
F490	DETAILCAT	10
F491	MAID CAT	5
F494	MFFPX	1
F902	FED AMT	10
F903	STATE AMT	10
G030	MED LENGTH OF STAY	3
G040	TLOS	3
G046	SUR SUBCOS	3

Data Element #	Description	Size (in Bytes)
H001	SURS COS	2
H054	ENCT TYPE	1
H056	PLAN ID	8
H074	ENCT STATUS TYPE	1
H076	PROV LIC NUM	6
H077	NDC UNITS	8
H078	PRES LIC NUM	9
H084	FILE TYPE	1

QA&A Files

Note: These files represent a series of Microsoft Excel files with detailed descriptions of the data elements. These files are available electronically in the Procurement Library.

File	Description
audit1	Audit actions
com97q2	Common data for second quarter of calendar year 1997
combad	Common parts of records that error off during the load process
errorlog	All error records
forma97q1	Detail for Form A type records
formabad	Detail for Form error records
formb97q2	Detail for Form B type records
formbbad	Detail for Form B error records
formc97q1	Detail for Form C type records
formcbad	Detail for Form C error records
inpat97q1	Detail for inpatient claims for first quarter of calendar year 1997
inpatbad	Detail for inpatient error records
pharm97q2	Detail for pharmacy claims for second quarter of calendar year 1997
pharmbad	Detail for pharmacy error records
readme	Information file
rowct	Record counts per invoice type
stmt1	Statement audit option map
system1	System privilege map
tablepriv1	Table privilege map
tables1	Table privilege map
user1	User profile

EMEVS DB2 Tables

Config File (VeriFone Tranz 330s)

Column Name	Data Type	Length
TDF_PROVIDER_NUM	CHAR	12
TDF_SCAN_ID	CHAR	12
TDF_DEVICE_SERIAL	CHAR	12
TDF_DEVICE_TYPE	CHAR	8
TDF_DEVICE_STA_CDE	CHAR	6
TDF_ORDER_DATE	CHAR	6
TDF_SHIP_DATE	CHAR	6
TDF_RECEIVE_DATE	CHAR	7
TDF_AREA_CODE	CHAR	4
TDF_PHONE_NUMBER	CHAR	7
TDF_PHONE_EXTENSION	CHAR	5
TDF_SHIP_NAME	CHAR	21
TDF_SHIP_ADDRESS_1	CHAR	21
TDF_SHIP_ADDRESS_2	CHAR	21
TDF_SHIP_ADDRESS_3	CHAR	21
TDF_FGD_IND	CHAR	3
TDF_APPLICATION	CHAR	11
TDF_DOWNLOAD_DTE	LOGICAL	9
TDF_APPROVAL_NUMBR	CHAR	9
TDF_ROM_VERSION	CHAR	7
TDF_ACQ_IND	CHAR	3

Verification Transactions

Column Name	Data Type	Length	
HVM_RECORD_TYPE*	CHAR	1	* This field identifies the type of transaction information on the record
HVM_DEVICE_CODE	CHAR	8	N = Non-verification transaction
HVM_TRM_SERIAL_NUM	CHAR	12	E = EMEVS-only verification transaction

Column Name	Data Type	Length	
HVM_RECIPIENT_NUM	CHAR	16	D = EMEVS and DUR verification transaction
HVM_PERSON_NUMBER	CHAR	4	
HVM_TRAN_CODE	CHAR	4	
HVM_TERMINAL_NUM	CHAR	4	
HVM_TSID_POS_TYPE	CHAR	3	
HVM_TSID_VERSION	CHAR	4	
HVM_ENTRY_DATE	DECIMAL	5	
HVM_ENTRY_TIME	DECIMAL	7	
HVM_ELG_RSPNSE_RBA	DECIMAL	3	
HVM_UT_RSPNSE_RBA	DECIMAL	3	
HVM_PC_RSPNSE_RBA	DECIMAL	3	
HVM_PROVIDER_NUM	CHAR	12	
HVM_PROVIDER_CNTY	DECIMAL	3	
HVM_LICENSE_NUM	CHAR	12	
HVM_PROVIDER_CAT	DECIMAL	4	
HVM_PROVIDER_SPEC	DECIMAL	4	
HVM_PRO_PROCES_IND	CHAR	1	
HVM_POS_PROMPT_ID	CHAR	2	
HVM_AQC_IND	CHAR	1	
HVM_VR_ENTRY_TYPE	CHAR	1	
HVM_VR_ACCESS_IND	CHAR	1	
HVM_VR_REQUEST_DTE	CHAR	6	
HVM_VR_REL_PRV_NUM	CHAR	12	
HVM_REL_PRV_AQC	CHAR	1	
HVM_VR_RS_UNIT_1	DECIMAL	3	
HVM_VR_RS_UNIT_2	DECIMAL	3	
HVM_VR_RS_UNIT_3	DECIMAL	3	
HVM_VR_AS_UNIT_1	DECIMAL	3	
HVM_VR_AS_UNIT_2	DECIMAL	3	
HVM_VR_AS_UNIT_3	DECIMAL	3	
HVM_VR_AS_UNT_1_PC	DECIMAL	3	
HVM_VR_AS_UNT_2_PC	DECIMAL	3	
HVM_VR_AS_UNT_3_PC	DECIMAL	3	
HVM_VR_PRI_SRV_CAT	CHAR	2	
HVM_VR_SERVICE_TYP	CHAR	1	
HVM_VR_EFFCT_UNITS	DECIMAL	3	
HVM_VR_CLEAR_UNITS	DECIMAL	3	
HVM_VR_SRVCAT_FOR	CHAR	2	

Column Name	Data Type	Length
HVM_VR_SRVCAT_AMT	DECIMAL	5,2
HVM_VR_COPAY_TNU1	CHAR	3
HVM_VR_COPAY_TNU2	CHAR	3
HVM_VR_COPAY_TNU3	CHAR	3
HVM_VR_COPAY_TNU4	CHAR	3
HVM_RECIPIENT_AGE	DECIMAL	3
HVM_CD_AC_STATE	DECIMAL	3
HVM_CD_AC_FDR	CHAR	1
HVM_CD_PD_SEX	CHAR	1
HVM_CD_PHOTO_IND	CHAR	1
HVM_MD_COUNTY_NUM	DECIMAL	3
HVM_EVEVS_PROV_8	CHAR	12
HVM_SCAN_PROV_9	CHAR	12
HVM_CUSTODIAL_SYS	SMALLINT	
HVM_VR_REF_PRV_NUM	CHAR	12

Verification Response

Column Name	Data Type	Length
HVD _PROVIDER_NUM	CHAR	12
HVD_RECIP_NUM	CHAR	16
HVD _TRAN_CODE	CHAR	4
HVD_ENTRY_DATE	DECIMAL	5
HVD_ENTRY_TIME	DECIMAL	7
HVD_CLAIM_NUM	DECIMAL	1
HVD_UT_RSPONSE REA	DECIMAL	3
HVD_PC_RSPNSE_REA	DECIMAL	3
HVD_UP_RSPNSE_REA	CHAR	2
HVD_REL_PRV_NUM	CHAR	12
HVD_REL_PRV_AQC	CHAR	1
HVD_VR_RS_UNIT_1	DECIMAL	3
HVD_VR_RS_UNIT_2	DECIMAL	3
HVD_VR_RS_UNIT_3	DECIMAL	3
HVD_VR_AS_UNIT_1	DECIMAL	3
HVD_VR_AS_UNIT_2	DECIMAL	3
HVD_VR_AS_UNIT_3	DECIMAL	3
HVD_VR_AS_UNT_1_PC	DECIMAL	3

Column Name	Data Type	Length
HVD_VR_AS_UNT_2_PC	DECIMAL	3
HVD_VR_AS_UNT_3_PC	DECIMAL	3
HVD_VR_CLEAR_UNITS	DECIMAL	3
HVD_VR_REF_PRV_NUM	CHAR	12
HVD_RX_NUM	DECIMAL	7
HVD_NEW_REFILL_CD	DECIMAL	2
HVD_METRIC_QTY	DECIMAL	5
HVD_DAYS_SUPPLY	DECIMAL	3
HVD_NDC	CHAR	11
HVD_DAW	CHAR	1
HVD_DATE_WRITTEN	DECIMAL	8
HVD_DENIAL_CLARIF	CHAR	2
HVD_OVR_CONFLICT	CHAR	2
HVD_OVR_OUTCOME	CHAR	2
HVD_REJECT_CODES	CHAR	40

DUR Response Table

Column Name	Data Type	Length
HVDR_PROVIDER_NUM	CHAR	12
HVDR_RECIPIENT_NUM	CHAR	16
HVDR_TRAN_CODE	CHAR	4
HVDR_ENTRY_DATE	DECIMAL	5
HVDR_ENTRY_TIME	DECIMAL	7
HVDR_CLAIM_NUM	DECIMAL	1
HVDR_RESPONSE_NUM	DECIMAL	1
HVDR_CONFLICT_CD	CHAR	2
HVDR_SEVERITY_CD	CHAR	2
HVDR_PREV_RX	CHAR	2
HVDR_PREV_FILL_DT	DECIMAL	8
HVDR_PREV_FILL_QTY	DECIMAL	5
HVDR_FREE_TEXT	CHAR	30

Appendix I
Mandatory Requirements Checklist

This appendix identifies the mandatory requirements for the Technical and Cost Proposals. Failure, in whole or in part, to respond to a specific mandatory requirement may result in rejection of either proposal during the evaluation phase.

MANDATORY REQUIREMENTS CHECKLIST	RESULTS	
TECHNICAL PROPOSAL	**Pass (Yes)**	**Fail (No)**
PROPOSAL SUBMISSION REQUIREMENTS **(as defined in RFP Section 2.2.7)** 1. Was the proposal received by the New York State Department of Health (DOH) no later than 5:00 p.m., Eastern Time, on Friday, June 19, 1998?		
2. Did the offeror submit separate, sealed packages containing the Technical Proposal (and all required documents).		
3. Were one (1) original and twelve (12) copies of the Technical Proposal submitted under sealed cover?		
4. Was one (1) copy of the Technical Proposal submitted unbound?		
TECHNICAL PROPOSAL REQUIREMENTS **(as defined in RFP Section 9.2)** 6. Does the Technical Proposal include ten (10) separate sections and assorted subsections, presented in the following order: • Transmittal Letter? • Table of Contents and RFP Cross-Reference? • Executive Summary? • Response to Mandatory Requirements? • Approach to Replacement of the Medicaid System? • Approach to Operations of the Replacement Medicaid System? • Approach to the Medicaid Data Warehouse? • Approach to Implementation of Optional Components • Approach to Quality Management and Customer Service? • Systems Integrator and Subcontractor Capabilities?		
TRANSMITTAL LETTER REQUIREMENTS **(as defined in RFP Section 9.2.1)** 7. Is the Transmittal Letter on the official business letterhead from the entity submitting the proposal as the prime contractor?		
8. Is the Transmittal Letter signed by an individual authorized to legally bind the offeror?		

MANDATORY REQUIREMENTS CHECKLIST	RESULTS	
TECHNICAL PROPOSAL	**Pass (Yes)**	**Fail (No)**
9. Does the Transmittal Letter include a statement addressing each of the items bulleted in Section 9.2.1 of this RFP: • Statement of acceptance of Terms and Conditions? • Statement that the proposal is valid for a period of one hundred eighty (180) days? • Description of conflict of interest or statement that none exists? • Statement that the offeror will be responsible for work specified in this RFP?		
10. If subcontractors are proposed, has each subcontractor submitted a statement, on official letterhead, signed by an individual authorized to legally bind the subcontractor: • Description of the subcontractor scope of work? • Statement that the subcontractor will abide by the Terms and Conditions?		
TABLE OF CONTENTS AND RFP CROSS-REFERENCE **(as defined in RFP Section 9.2.2)** 11. Is there a Table of Contents that includes beginning page numbers for each section and subsection of the proposal?		
12. Is there a cross-reference from each section, and subsection of the offeror's Technical Proposal back to the appropriate subsection of sections 5, 6, 7, and 8 of the RFP and Addenda?		
EXECUTIVE SUMMARY **(as defined in RFP Section 9.2.3)** 13. Does the offeror's Executive Summary include a clear and concise summary of the proposed approach to the scope of work and the proposed staffing structure?		
APPROACH TO REPLACEMENT OF THE MMIS **(as defined in RFP Section 9.2.5)** 14. Has the offeror described the overall approach to replacement of the Medicaid systems?		
15. Is the description of the approach to replacement of the Medicaid systems organized around two (2) major areas: 1) description of the proposed replacement system(s) capabilities and 2) approach to design, development, and implementation?		

MANDATORY REQUIREMENTS CHECKLIST	RESULTS	
TECHNICAL PROPOSAL	**Pass (Yes)**	**Fail (No)**
16. Does the offeror describe the replacement system capabilities, including: • The system components to be used in the replacement? • The source system of each component? • The major areas of proposed modifications, enhancements, or additions to each component? • Anticipated problems or issues and proposed solutions to the implementation of each component?		
17. Does the offeror's proposal provide a section on Approach to Implementation?		
18. Does the offeror's proposal provide a section on Approach to Transition?		
APPROACH TO OPERATIONS OF THE REPLACEMENT MEDICAID SYSTEM **(as defined in RFP Section 9.2.6)** 19. Does the offeror's Approach to Operations of the Replacement Medicaid System section include the following: • Location of Operations? • Organization and Staffing? • Approach to Operation of Functional Areas? • Approach to Evolution?		
20. Has the offeror included in the proposal a description of the location of operations?		
21. Does the offeror's Organization and Staffing section address each of the bulleted items listed in Section 9.2.6.2 of this RFP?		
22. Does the offeror's Approach to Operation of Functional Areas include a description for each of the bulleted items in Section 9.2.6.3 of this RFP?		
23. Does the offeror provide a description of the Approach to Evolution?		
APPROACH TO THE MEDICAID DATA WAREHOUSE **(as defined in RFP Section 9.2.7)** 24. Does the offeror's approach describe how it will implement and operate the Medicaid data warehouse?		

MANDATORY REQUIREMENTS CHECKLIST	RESULTS	
TECHNICAL PROPOSAL	**Pass (Yes)**	**Fail (No)**
APPROACH TO IMPLEMENTATION OF OPTIONAL COMPONENTS (as defined in RFP Section 9.2.8) 25. Does the offeror provide a response to each of the optional components: • Front-End Electronic Fraud, Waste, and Abuse Prevention Module? • Medical Review Utilization (MUR?) • Client Repository Enhancement		
APPROACH TO QUALITY MANAGEMENT AND CUSTOMER SERVICE (as defined in RFP Section 9.2.9) 26. Has the offeror described its approach to quality management?		
27. Has the offeror described its approach to customer service?		
SYSTEMS INTEGRATOR AND SUBCONTRACTOR PREVIOUS CAPABILITIES (as defined in RFP Section 9.2.10) 28. Has the offeror provided offeror identification information for the organization acting as prime contractor by completing each of the forms required in Section 9.2.10.1: • Form A? • Form B? • Form C? • Form D?		
29. If subcontractors are proposed, has the offeror provided subcontractor identification information for the subcontractor(s) by completing each of the forms for each subcontractor?		
30. Has the offeror presented its previous experience and references as required in Section 9.2.10.2?		
31. If subcontractors are proposed, are the subcontractor's previous experience and references presented as required in Section 9.2.10.2?		

MANDATORY REQUIREMENTS CHECKLIST	RESULTS	
PRICE PROPOSAL	**Pass (Yes)**	**Fail (No)**
PROPOSAL SUBMISSION REQUIREMENTS **(as defined in RFP Section 2.2.7)** 1. Was the proposal received by the State of New York's State Department of Health (DOH) no later than 5:00 p.m., Eastern Time, on Friday, June 19, 1998?		
2. Did the offeror submit separate, sealed packages containing the Price Proposal?		
3. Were one (1) original and six (6) copies of the Price Proposal submitted under separate sealed cover?		
4. Was one (1) copy Price Proposal submitted unbound?		
5. Has the offeror submitted a proposal bond as required in Section 2.2.7.2?		
GENERAL CRITERIA **(as defined in RFP Section 9.3)** 1. Is there audited financial statements for the past three (3) years for both the primary offeror and all proposed subcontractors?		
2. Has the Offeror demonstrated the ability to secure the Letter of Credit requirements contained in Section 11.7.5?		
3. Is there a completed Pricing Schedule A?		
4. Is there a completed Pricing Schedule B?		
5. Is there a completed Pricing Schedule C?		
6. Is there a completed Pricing Schedule D for each contract year? (Except year 1)		
7. Is there a completed Pricing Schedule E for each contract year? (Except year 1)		
8. Is there a completed Pricing Schedule F for each contract year? (Except year 1)		
9. Does the distribution of staff in Pricing Schedule F comply with the rules specified in Section 6.3.2.1?		
10. Has the offeror provided a Pricing Schedule G?		

MANDATORY REQUIREMENTS CHECKLIST	RESULTS	
PRICE PROPOSAL	**Pass (Yes)**	**Fail (No)**

Appendix J
Reprocurement Suggestions

The table in this appendix provides a cross-reference to the RFP from the suggestions and issues raised by stakeholders of the Medicaid systems replacement project. The table contains the following information:

- **Suggestion** - Requested functionality in user terminology

- **RFP Cross-Reference**

  WMS Redesign - The suggestion relates to the WMS and should be addressed in the WMS Redesign.

  JAD - The requirement is included at a high level in the RFP; the details of the requirement will be appropriately addressed in the JAD sessions.

  Cost Issue - The suggestion is under Department consideration but may be limited by cost.

  Removed on Department Request - The suggestion was removed from the RFP based on Department instructions that it was not desired or would no longer be needed in the new system.

  Future Option - The suggestion is not considered a part of the scope of work of the Replacement Medicaid System. However, offerors may propose solutions for Department consideration. Proposal format should follow the requirements of Section 9.2.8, and offerors should provide an estimated price in Pricing Schedule G.

  Separate Procurement - The suggestion is being addressed through a separate procurement.

Suggestion	RFP Cross-Reference
Develop system support to result in **one** system capable of supporting: • Eligibility determination (the current WMS) • Provider verification of recipient eligibility (the current EMEVS) • Claims processing (the current MMIS)	1.1.3 WMS Redesign
Allow entry of "recipient" information on a master file for non-Medicaid eligible individuals to allow claims processing for non-Medicaid-eligible individuals. Unique identities will be necessary to allow only authorized services. Since this typically will be for non-Medicaid services delivered by non-Medicaid-enrolled providers, it will be necessary to develop a file, perhaps by license number, of non-Medicaid providers unless the universal provider identification number concept is implemented. In order to appropriately cost-allocate funding, the systems effort will need to be identifiable. This would eliminate some of the manual claims payment currently done through comptroller vouchering as well as potentially address the use of Medicaid systems to pay all OMH claims (private plus Medicaid) and to pay claims such as EPIC, ADAP, etc.	7.2 (Client) 7.3 (Provider) 7.4 (Pricing) 7.6 (Claims)
Create a Medicaid utilization review process that will allow provider inquiry capability to the system to identify frequency of service delivery. This may reduce the number of prior approval requests.	Future Option 9.2.8.2
Allow Internet/Intranet access to New York Medicaid information as well as a Web site to disseminate information to support EDI transactions for claims and remittances and possibly Reference file transmission. Consideration must be given to the need for confidentiality.	7.5.6.10
Create an effective data warehouse to support storage and retrieval of records as well as to allow reorganization and integration of data to support analysis of trends. (Consider existing data warehouse.)	Section 8
Consider the integration or combination of the drug rebate collection process with the EPIC processes.	7.12.3.4.3
Provide data files in directly readable formats. (Currently, fields are packed and/or the dollar fields are signed.)	JAD
Direct links to the mainframe computer (or electronic interchange of information) are necessary to eliminate the current reliance on cartridge transfer of large files.	JAD
Data element synchronization is required whether or not one system is maintained. Complete and easy access to that information is also necessary.	6.2.1.1 6.2.10.2 8.4.1
Development of client/server and decision support systems are necessary to allow ease in file queries as well as system changes.	8.5 JAD
Develop an "intelligent" prior authorization system that could process requests based on entry of specific information.	Removed on Department Request
Develop ability to directly change multiple appropriations.	7.6.3.2.34 7.7.3.3.1
Develop SURS processing to produce information that could be downloaded to PC-based applications. The information would be manipulated based on user-defined parameters and output options.	JAD
Enhance the RetroDUR process to provide the flexibility to produce information for ad hoc reports, special population studies, and varied criteria for profiling.	7.15.3 JAD
Identify Partnership program participants when they become eligible for Medicaid and are put on the MMIS for analysis of Partnership participants.	7.2.3.1 7.11.3.1.6 JAD
Increase transmitting speed of county updates through the WMS.	WMS Redesign
Consider making the Application Development Environment at CSC compatible with the ADE being selected by DSS.	6.3.2

Suggestion	RFP Cross-Reference
Provide for the processing of all claim and payment transactions through the MMIS.	7.6.1 7.7.3.2.6 Exhibit 7.2
Provide for the processing of split payments to providers.	7.6.3.2.34 7.7.6.19
Provide for pull-back payments with electronic funds transfer (EFT) to providers in the event a provider's payment needs to be pulled before OSC sign-off.	3.2.3.3 JAD
Provide for multi-function workstations that provide access to fiscal agent systems, WMS inquiry (upstate and NYC), EMEVS, and State Reference files, such as TIP production for upstate and NYC.	7.5 JAD
Maintain all provisions for audit requirements in the RFP for the current contract adjusted for technology enhancements which have been, or will be, installed.	3.2.3.3
Provide an electronic load of District 98 eligibility and coverage data.	7.2.3.4.2 JAD
Provide more claim, provider, and recipient data overall. Expedite paid data extract information earlier.	JAD
Provide for over ten (10) years of data broken out by category of service, by program and by agency, showing State and local share with direct on-line access.	Section 8 Cost Issue
Provide for on-line tracking of recoveries and automated tracking of agency budgets through claims expenditures.	7.7.3.2.11 7.7.6.20 7.7.6.22
Provide incurred rather than cash-out data (current two- [2-] week lag). Would like reports on a biweekly or weekly basis rather than monthly.	7.7.3.3 JAD
Provide for more responsive turnaround time to legislative policy changes.	Section 8
Provide the ability to merge mainstream managed care, fee-for-service, and HIV SNPS data.	8.4
Identify managed care recipients to determine whether they are also HIV clients.	7.2.3.2.14 7.2.3.2.16
Provide coordination within networks to identify complete scope of services which clients have received.	Future Option
Provide for an electronic WIC/Medicaid application with the ability to make electronic referrals between the two (2) programs.	Future Option
Improve the system's ability to handle garnishments and tax liens. Retain on-line access to county liens on individuals, and obtain amount of lien determined by county DSS.	7.7.3.2.7 JAD
Provide for the ability to collaborate with DOH front-end fraud detection as well as back-end fraud detection. Share information, tools, and methodologies between QA&A and MFCU in a feedback loop. Provide timely referrals from QA&A per MOU with DOH.	8.3 9.2.8.1 JAD
Provide a more efficient way to process currently off-line adjustments (manual payments) such as MR systems payments not processed through the MMIS.	7.7.3.2.6 7.7.3.2.8 Exhibit 7.2
Interface encounter data, capitation data, and fee-for-service. Integrate data and provide more information on what the data elements contain.	6.2.1.1 7.6.3.1 8.4
Consider development of multiple paths for system development wherein the State assumes responsibility for errors rather than imposing fiscal penalties on the contractor when there is minimal risk. This could reduce the extensive testing, and therefore development time, for some projects. Any downside of this should be considered.	6.3.2
Develop the ability to support part-time work by Evolution staff as long as a full complement of FTEs is available. This may permit retention of knowledgeable staff who may otherwise be lost.	6.3.2

Suggestion	RFP Cross-Reference
Ensure that turnover does not negatively impact the timeliness of file and data tape production.	6.3.2.1 11.10.2.4.2
Require fiscal agent staff to be experienced in client/ server PC applications, Powerbuilder, Web authorizing, Java, and other PC/technology that may be useful.	Appendix K
Require system development equipment to be compatible with Department equipment, particularly for file transfer and e-mail.	JAD
Contractor should process all provider manuals using the same word processing package as the Department. Manuals should be posted electronically for providing access via the Internet or through a bulletin board.	6.2.1.4 6.2.1.10
Provide a terminal and limited inquiry access to Medicaid expenditures data by HRA/MAP budget divisions.	7.5.3.2.21 7.7.6.22 8.3.3
Allow the City to request an agreed-to number of reports each year to complete research and program changes.	JAD
Drop the requirement for most of the intensive paper claim review that is redundant with systems edits, and leave it with proper claim form, copy-legible, and signed properly.	JAD
Provide for space and equipment for the MMIS Audit Unit at the fiscal agent site.	3.1
Replace the current microfilm system for archiving and on-line pended claims with imaging processes. (Any legal considerations for original claims retrieval needs should be considered.) The imaging system must be interactive with the prior approval system.	Separate Procurement
Allow interactive rate update to the rate file using a security-protected process based on receipt of all approvals.	7.3.3.4.7
Create sufficient ports in the communications controller to allow direct line access to the claims processing system by providers, vendors, and users.	7.5.1
Receive and process encounter data for managed care plans.	7.6.3.1.2 7.11.3.2.7
Include technical assistance to plans.	7.3.6.4
Create same-day electronic reports to define data submissions for submitted encounter records.	7.6.3.3.1
Provide monthly files of accepted encounter data submissions in formats/media to allow processing into the MEDS data warehouse having ensured connectivity to the MEDS data warehouse server.	8.3 8.4
Construct encounter records from Medicaid claims data for the purpose of comparison between fee-for-service and managed care delivery systems. This will also be used by MEDS to compile a complete longitudinal service perspective for managed care clients.	8.4
Require Control files, such as the MARS crosswalk and matrices, to be available in database format to facilitate cross-references.	JAD
Develop a core PC-based LAN system environment to allow the fiscal agent to create the same tools created on the DOH LAN that will allow requests to be shifted from mainframe- to PC-based technology.	JAD
Create applications that are capable of analyzing Medicaid and claims data to produce HEDIS measures and other appropriate quality and episode-of-care measures.	8.4 JAD
Continue or complete the EFT project, including enrollment, file maintenance, and data security.	7.3.3.2.13 7.5.2 7.7.3.2.1
Allow for on-line claim adjudication rather than post on-line claim capture.	7.5.3.2.12
Allow load of DOH program data to create comparison of health care delivery systems. This will require consideration of a wide variety of context as well as format.	8.4.1

Suggestion	RFP Cross-Reference
Require the fiscal agent to have responsibility for the Special Payment Account under direction of DOH Finance. Include requirements to account for, and return, any interest earned on that account.	7.7.6.24
Ensure that the archiving processes are sufficient to prevent premature erasure of files. This is particularly important as longitudinal studies increase.	6.2.5 7.2.3.2.12 7.6.3.2.23 8.4.3
Create a direct prior-approval file load rather than relying on a creation at DSS.	7.8.3.2.1 7.8.3.2.2 7.8.3.2.3
Develop the ability to process audit transactions.	7.7.3.2.8
Develop the ability to process only selected claims.	JAD
Create an automated crossover for Medicare claims for both Part A and Part B.	7.6.3.2.11 7.6.6.26
Consider an ability to supply providers with a listing of all edits that result in denial.	7.6.3.2.26 7.7.6.9
Develop the ability to pay partial cycles based on available money: • By invoice type • By COS • By partial high volume This will be needed to pick up the difference in the next cycle.	7.7.3.2.15
Staff will need to have easier access to MMIS information and should be able to request all reports with unique parameters, as made by the requester. It is anticipated that program staff should be able to access and produce from one's PC: • Claim detail reports (recipient and provider) • Summary reports • Exception reports	7.5.1 7.13 JAD
The prior approval system for transportation and personal care is labor- and paper-intensive. When a request is made to the district for prior authorization, a paper prior approval request form is filled out. This document is then data-entered into the prior approval system. Over each weekend, these prior approvals are transmitted to CSC in order to update the Master File. A roster of these new prior approvals is printed out, and each provider is mailed those prior approvals data-entered by that district. No copy of these rosters is kept. This issuance of prior approvals can be streamlined. Districts and providers should have electronic access to new and old prior approvals, with some reference to the prior approval's status and claiming history.	7.8.3.2.1 7.8.3.2.2 7.8.3.2.3 7.8.3.2.4 7.8.3.2.8 7.8.6.6
Provide a receivable system for drug rebates.	7.12.3.2.5
Provide the ability to track drug rebates to the National Drug Code (NDC) level according to HCFA guidelines.	7.12.3.2.5
Provide easier access to more detailed information on the weekly shares report, i.e., cases of large variances.	7.7.3.3.3 7.7.3.3.4 JAD
Provide the capability to access on-line reports available through MARS/SURS as well as various provider summary screens. Current information is calculated manually.	7.13 7.17 JAD
Improve the turnaround time for requested financial data.	JAD
Provide easier access to retroactive shares information.	7.7.3.3.3 7.7.3.3.4
Medicaid managed behavioral health care be supported via EDI.	1.4.4.3 3.2.2
Provide additional audit software packages such as ACL and PANAUDIT.	7.16.6.6

Suggestion	RFP Cross-Reference
Encounter data must be tied to rate-setting. Provide interfaces to collect encounter data. Integrate the various systems such as the Rate-Setters system and Budget Staff system.	7.3.3.4.7 7.6.3.4.5
Include Retro rates from all rate-based providers in MAR reports.	7.17
Provide for MUR (Medical Utilization Review).	Future Option 9.2.8.2
Provide OMH (Licensing agency) with the on-line capability to enroll providers and update rates.	7.3.3.2.5 7.3.6.13
Provide for date-specific eligibility for State and local shares splits and the manner in which costs appear in MMIS reports.	7.2.3.2.1 7.7.3.3.3 7.7.3.3.4
Develop an ability to process denied and voided claims to allow them to appear in history. This is necessary in order to ensure that providers do not fraudulently void claims or resubmit after rate increases are posted to the file and then also be recipients of automatic rate increases, therefore receiving double payment for claims.	JAD
Create an on-line cross-invoice capability to ensure that claims for like services are not reimbursed to providers for recipients on the same date of service. For instance, since they are different invoice types, it is possible to pay for both clinic and physicians services rendered for a recipient on the same date of service.	7.6.3.2.16 7.6.3.2.31
Allow access to expanded history for use in manual pended claims resolution. This should include paid and denied claims as well as a usable profile of claims that resulted in failures by providers.	7.6.6.32
Develop a preadmission certification process for elective surgical procedures wherein evidence of the certification/approval is identifiable before payment. (It is expected that this process may exist on a demonstration basis under the current contract.)	Future Option
Automate the monthly selection process for the Explanation of Benefits program.	7.13 JAD
Add specific information to remittance messages for insurance and/or Medicare denials: • 131 - Insurance code or name, insurance company claiming address, policy number, and group number • 152 - Medicare Health Insurance Claim Number (HIC)	7.7.6.9 JAD
Provide addition of real-time submission of claims (electronically) with up-front editing capabilities.	7.5.3.2.12
Add preliminary and final payment buckets.	JAD
Develop improved EPIC/Medicaid eligibility file matches (currently run semi-annually) to include Medicaid spenddown status.	1.4.4.1
Integrate audit findings, improving referrals.	JAD
Provide the ability to handle copayments/deductions for third-party insurers (other than Medicare; Medicare is currently done).	7.6.3.2.19
TPL/Medicare data needs to be passed to the fiscal agent/EMEVS on a daily basis. The same WMS TPL/Medicare criteria should be carried on the MMIS/EMEVS (current two hundred fifty- [250-] character limitation on the EMEVS).	7.2.3.1.2
Allow for direct computer access to the SED file. Develop the capability to end-date or post the effective date of an end-dated license. (Also, incorporate at status 16 enhancement for deceased or create an exception code indicator.)	7.3.3.4.2 JAD
Automate an indicator on Provider OOS status element 2006 as well as additional COSs for the fiscal agent to automatically send provider manuals and claim forms. Maintain fiscal agent responsibility for providing claim forms once the provider is approved, including future effective dates.	7.3.6.30 7.3.6.38 JAD
Consider the capability of a “mirror” system to be used in all areas of claims processing.	7.16

Suggestion	RFP Cross-Reference
Reengineer CICS claims inquiry to provide for any inquiry period of at least two (2) years.	7.6.6.32
Provide for verification that claims for dual-eligible recipients have been processed by Medicare first.	7.6.3.2.33
Provide for Integrated Test Facility (ITF) capabilities, allowing OSC MMIS Audit Unit staff to do ITFs of either provider- or recipient-based transactions.	7.16
Provide for the ability to have OSC's programs be included in the fiscal agent's production run streams. This would allow the claims audit to preaudit claims prior to payment processing.	7.16.6.6
Develop a system to track Medicare Lifetime Reserve Day balances to ensure that those benefits are exhausted before Medicaid payment is made.	JAD
Provide for regular (weekly) and special meetings for consultation and interaction.	6.3
Provide for state-of-the-art alternate back-up site procedures.	3.2.5
Ensure secure conditions for physical assets of the MMIS (UPS, fire, cooling).	3.2.3.1
Provide for point-to-point data connections for high-volume submitters.	7.5.3.2.1
Increase utilization data (i.e., units of service).	JAD
Provide for quicker rate adjustment (retrospective and prospective) implementations for providers to get paid (currently takes six [6] weeks).	7.3.3.2.31 7.3.3.2.32
Need information on budget impact.	Section 8
Provide data on number of claims paid and dollars paid by facility.	7.3.3.2.15
Provide a reporting mechanism of paid amount for managed care health plans and services provided per benefit package.	7.11.3.2.12
Allow for counting of visits under a managed care plan, and then roll over into fee-for-service category.	7.11.3.2.13
Ensure information systems support in such areas as roster development and posting.	7.11.3.2.3 7.11.3.3.3
Due to mandatory managed care initiatives, transition resources to managed care information support either within the MMIS contract and/or to DOH information systems.	7.11
Provide for prospective nursing home reimbursement.	JAD
Transfer managed care member plan numbers to the EMEVS--crosswalk to the MA ID number and entry into ProDUR on the EMEVS. (Only works for Medicaid Rxs; will require an entry as a query rather than a claim.)	JAD
Add information to the provider verification specific to third-party insurance: insurance company name, policy number, group number, and insurance company's claiming address.	7.5.3.1.2 7.5.3.2.1 JAD
Expedite updates of client coverage.	7.2.3.4.1
Notify local districts when coding and messages are updated or changed on the Verifone Tranz 330.	6.3.2.3
Provide additional data display space on the POS devices, such as sanction information; surplus amount; expanded categories of assistance; and expanded third-party health information, including insurer's name, policy number, and additional client demographics in full, not by coded reference.	7.5.3.2.1 JAD
Provide expanded methods of inquiry. If access by SSN or other demographic information continues to be prohibited by HCFA, initiate dialog to reopen this issue.	7.2.3.2.3
Propose cost-effective solutions to mailroom services (automated insertion and posting equipment affecting postal discounts).	JAD
Provide for download of reports to customer terminals.	JAD

Suggestion	RFP Cross-Reference
Medicaid fraud detection, related needs, and data warehouse - Provide an on-line relational database that: • Is accessible through Windows-based, conventional desktop software from remote sites • Allows sophisticated queries to be run against large portions of the data (ad hoc) • Is fully documented with full, current documentation available to all users • Has central administration of all field names, etc. • Allows end users to easily link Medicaid data to other data source via common key fields • Uses the standard statewide connection to the system • Has Certification of Claims records for prosecution available The system needs to include at least five (5) years (or bid multiple levels) of claims and: • Detailed eligibility data (WMS or single eligibility repository) • Up-to-date and current managed care encounter data for all providers • Denied claims (not available for managed care) • Outcome data (not available for fee-for-service)	Section 8
Reduce turnaround time to twenty-four (24) hours for Medicaid coverage information. Reduce issuance of Temporary Medicaid Authorizations (DSS-2831A).	WMS Redesign
MMIS can be different than what was input into the WMS. If worker error, provide notification to alert worker at time of data entry that potential problems may occur.	7.2.6.2 7.2.6.3 7.2.6.4
Enhance client name change integrity; update should not expunge previous information.	7.2.3.1.1 JAD
Provide a system whereby MARS reports and the use of MDAS are more user-friendly. Possibly a simple spreadsheet and easy method of massaging data could be developed for commissioners and high-level local staff.	7.17
Key local staff could be told what edits exist in the MMIS. In turn, district staff may be able to make significant suggestions related to what they think should be included in these edits.	Department Responsibility
The MMIS contractor should develop some interface with local districts, since providers too often look to the county for assistance in resolving billing problems.	7.5.1
Develop educational sessions for local staff to learn more about the MMIS and the use of reports available from the MMIS via State DOH.	6.2.8.2.13
Revise (Section 3.3 of the MMIS Provider Manual) billing procedures for date of service when it is a monthly service coordination (first day of subsequent month).	JAD
The weekly share reports should agree with the monthly MR reports. Federal, State, and local shares on the weekly share report for one (1) month do not agree with monthly MR totals for the same period.	7.7.3.3.2
Provide reliable help desk, especially for claim capture and utilization threshold.	7.5.6.6
The managed care/PCP should have a separate field; instead, it is currently combined with insurance coverage. This is confusing and results in many calls to the LDSS.	JAD
Provide easier access to more detailed information on the weekly share reports, i.e., cases of large variance.	7.7.3.3.3 7.7.3.3.4 JAD
Provide easier access to more detailed information on retroactive shares reports.	7.7.3.3.3 7.7.3.3.4 JAD
Create managed care reports through the MMIS.	7.11.3.3.4 7.11.3.3.5 7.11.3.3.6

Suggestion	RFP Cross-Reference
Provide easier access to year-to-date provider expenditure information.	1.4.5.5 7.3.3.2.15
Incorporate an "employment sanction" code and dates with message "client ineligible" for individuals ineligible for MA because work requirements.	WMS Redesign
Create a special reports unit to respond to counties' report requests.	6.3.3.2
Provide counties the ability to check adjudicated claims directly on-line.	7.5.3.2.21 7.6.3.2.10
Provide the name of the client on the EMEVS.	7.5.3.2.1 JAD
Provide transportation approvals eligibility on the EMEVS.	7.5.3.2.1 JAD
Provide easier-to-understand EMEVS messages.	7.5.3.2.1 JAD
Add the ability to request adjudicated claims data by provider ID via BICS (currently available by recipient ID).	7.5.6.10 7.6.3.2.10
Enable local districts to obtain provider payment detail the same way that client detail reports are available.	7.5.3.2.21 7.6.3.3.25
Simplify prior approval screens for home care and transportation.	JAD
Give local districts EMEVS access.	7.5.3.2.21
Improve provider on-line eligibility history inquiry.	7.3.3.2.6 JAD
Offer two (2) options for claims submission: 1) on-line real time and 2) batch submission via system-to-system transfer. Each provider should be able to readily submit claims, regardless of whether it is equipped with a mainframe system, a freestanding PC, or networked PCs, without having to make significant new hardware acquisitions.	7.5.3.2.12 7.6.3.2.11 JAD
Providers should be able to "see" a claim form on their screen for data-entry purposes and to print out a paper version of the form (in official format) on demand.	7.5.3.2.13 JAD
Replace the paper transmittal form with an electronic transmittal record.	7.5.3.2.12
Standardize the claim form to meet relevant standards of ANSI, HCFA, and other authorities, so that it is compatible to claim forms used by other payors and is less likely to need to be revised again in the near future.	3.2.2.1 7.6.3.2.11
Provide instantaneous acknowledgment of claim receipt.	7.5.3.2.20 7.6.4.9
Incorporate up-front edits to ensure submission of complete and proper claims. The edits should check for missing fields, mathematical errors, and other prevalent error conditions.	7.5.3.2.19 7.6.3.2.3
Work with Medicare fiscal intermediaries to construct a clearinghouse for Medicare and Medicaid claims. This would obviate the need for separate claims and Medicare maximization edits, while improving system responsiveness and accountability.	7.6.3.2.11 JAD
Make Medicaid payments to providers via EFT.	7.5.2 7.7.3.2.1
Electronically transmit remittances, without delay, in standardized ANSI-compatible format.	3.2.2.1 7.7.3.2.5
Give providers the ability to print out the electronic version in a paper version.	JAD
Allow providers to sort and total retroactive adjustments (dollars and days) by month, by year, or according to other sorting criteria.	JAD
Transmit remittance data in a format that will allow providers to automatically post the amounts into their accounting systems.	7.7.3.2.5 JAD
Include status codes on the remittances that indicate whether the Medicaid rates that were paid were interim or final.	7.7.3.2.5 JAD

Suggestion	RFP Cross-Reference
Build an interface between the MMIS and Medicaid rate system, so that changes in Medicaid rates will result in automatic and more expedited claims adjustments (and reason codes on remittance statements to differentiate adjusted claims from initially paid claims).	7.3.3.4.7 7.7.3.2.13 7.7.3.2.14
Build an interface between the MMIS and the Medicaid eligibility systems, so that routine changes made by the local district (e.g., dates of service, age, sex, etc.) that resolve claim edits will automatically trigger claim activation and payment.	7.2.3.4.1 JAD
In addition, allow providers to electronically reactivate pending or denied claims (including two- [2-] year claims) to minimize the need for duplicative rebilling and/or manual billing.	JAD
Institute procedural changes that will more readily allow positive and negative Medicaid rate adjustments occurring within a relatively short time period to be automatically combined and offset against each other.	7.7.3.2.13 7.7.3.2.14 JAD
Incorporate a query function to allow providers to check the status of any current claim (paid, pended, or denied) on demand.	7.5.3.4.1 7.6.3.2.10 JAD
Allow providers to pull up histories of previous claims and to electronically obtain and print out past remittances and billings.	7.3.6.1 7.5.3.4.1 7.6.3.2.10
Offer providers read-only access to selected Medicaid eligibility information for those patients for which they have already submitted claims. This will protect inpatient privacy by limiting inquiry capability to a provider that furnished services to the client.	7.5.3.4.1 JAD
Enable providers to produce customized reports that will compare billed claims to paid claims.	7.5.3.4.1 JAD
Produce periodic settlement reports for providers (similar to Medicare settlements) that identify days and amounts paid that can be sorted according to multiple criteria (by rate, by month, etc.).	7.17 JAD
Enhance the capability to identify the total dollar amounts of pended and denied claims.	JAD
Enable providers to query dollar amount and release date of their next payment.	7.5.3.4.1 JAD
Provide query to current Medicaid rate in effect as well as prior time periods.	7.5.3.4.1
Include on-line help function with dictionaries of reason codes, provider manuals, etc.	6.2.1.4
Offer menu-driven software formats.	6.2.1.1
Facilitate routine communications through the MMIS or via e-mail (e.g., Medicaid Updates, “Dear Provider” letters, etc.).	7.5.3.4.1
Provide all software needed for claim generation and submission, data transmission, and retrieval free of charge to all Medicaid providers	7.5.3.2.5 7.5.3.2.6
Maintain sufficient number of phone lines to support peak usage of electronic claims submission as well as other data transmissions. Claims submission software should readily allow for preprogrammed, time-delayed transmission of claims during non-peak hours.	7.5.4.3
Provide a liaison program that designates a representative for each provider and works with vendors that supply accounting/financial software packages to Medicaid providers to ensure compatibility.	7.3.6.17
Identify if local district input has failed either MMIS or EMEVS/CSC edits in a timely manner.	7.2.6.2 7.2.6.3 7.2.6.4
MA coverage should show up immediately after full data entry.	WMS Redesign
System should avoid current problems encountered when “stacking” different MA coverages for an individual.	WMS Redesign
MARS reports should be the same time frame as shares reports.	7.17

Suggestion	RFP Cross-Reference
Stack eligibility dates.	WMS Redesign
Require nursing home providers to bill first day of month to ensure NAMI deduction.	JAD
The WMS is extremely slow when transmitting, which impacts worker productivity.	WMS Redesign
The EMEVS takes three (3) days to show client coverage; expediting would benefit all users.	JAD
Local districts should be notified when coding or messages are changed or updated on the EMEVS.	Department Responsibility
When a court order stipulates an absent parent's responsibility to pay all or a portion of their child's medical expenses, the unit relies on the MA21 printouts to track expenditures. It would be helpful if there was a notation on the printout indicating TPHI was billed and denied payment. Currently, the only notation occurs when TPHI makes a payment.	JAD
Provide increased compatibility between the weekly shares reports and monthly MARS reports, especially as they relate to categories of service.	7.7.3.3.2 7.17
Add local shares retroactive rate adjustments by category of service to the weekly shares reports.	7.7.3.3.3 7.7.3.3.4 JAD
Identify Medicaid costs for certain subgroups on MARS and weekly shares reports: • Prenatal Care Assistance Program (PCAP) • Documented and undocumented aliens • OASAS (Alcohol and Substance Abuse) • Overburden • Smoking and related illnesses • AIDS/HIV treatment • Emergency medical	7.7.3.3.3 7.7.3.3.4 7.17 JAD
With regard to open/close codes, open codes must reach the EMEVS/MMIS based on order of transaction.	JAD
Provide a referral list of who responds to providers.	7.3.6.20
Disable coverage code 16.	JAD
Add code to provide user with name, address, and phone number of recipient's primary care provider.	JAD
The EMEVS should allow for multiple transaction types (1 and 2) transmission, eliminating the need for a separate phone connection for each transaction.	JAD
A delay in release of Medicaid payment should not affect issuance of corresponding remittance statement (should be weekly).	JAD
Weekly remittance statements should have a unique numeric order for each provider to determine if a check or statement was lost in the mail.	JAD
The MMIS should allow for EFT.	7.5.2 7.7.3.2.1
Medicaid recoupment statements should be generated upon provider satisfaction of funds, showing original amount, interest charges, and a listing of the amount recovered from each check.	7.7.3.2.9 JAD
Establish minimum standards for EMEVS transmission time.	7.5.4.3 11.10.2.3.3
Enable providers to secure coverage information through the EMEVS when a patient's Medicaid ID number is not available.	JAD
Eliminate the lag time for posting new or changed LDSS information.	WMS Redesign
The MMIS should eliminate the need for modem linkage/eliminate busy signals.	7.5.4.3
When a patient changes status to managed care, the system should advise of date of enrollment (generally the following month); status is known by Medicaid but not indicated in the EMEVS message.	7.2.3.2.14 7.5.3.2.1
Provide extension of displays on the EMEVS terminal for restricted recipients, surplus amount, etc.	7.5.3.1.2.1 JAD

Suggestion	RFP Cross-Reference
Change of provider for restricted recipients should be updated overnight, not just on weekends, to permit greater flexibility for these clients.	7.2.4.1
Some consideration should be given to allowing for restriction to one (1) pharmacy for AIDS medication and a local pharmacy for other medications.	Future Option
Prior approvals for personal care and transportation should be able to be transmitted from a local district PC-based program directly to the MMIS and still allow for roster production by NYSDOH.	7.8.3.2.2 7.8.3.2.3 7.8.6.6
Counties should have the ability to access lists of current MA providers on line by category of service (COS) within ZIP code.	7.5.3.2.23 JAD
Counties should have the ability to extract reports from the MMIS that will assist in the analysis necessary to provide effective service delivery and control costs. Counties should be able to tailor these reports to meet their needs.	Section 8
Provide enhanced reconciliation between the weekly share reports and the monthly MARS reports, regarding dollars, number of beneficiaries, and categories of services.	7.7.3.3.3 7.7.3.3.4 JAD
Provide a complete breakdown for retroactive shares and other adjustments by categories of services.	7.7.3.3.3 7.7.3.3.4 JAD
Provide improved availability of data on the MA Access system, i.e., monthly data loaded in a more timely manner, availability of information on a share-by-share basis.	7.5.3.4.2 JAD
Develop improved methods for obtaining provider expenditures information on a real-time basis.	7.5.3.4.1
Add the ability for local districts to identify Medicaid costs for specific subgroups on MARS and weekly share reports, by provider and recipient of services, i.e., Overburden, OASAS, PCAP, OMH Restorative and Rehabilitative Services, etc.	7.7.3.3.3 7.7.3.3.4 7.17 JAD
Develop report for managed care, detailing beneficiaries, expenditures, eligibility categories, enrollment periods, etc.	7.11.3.3
Establish periodic training sessions between the MMIS fiscal agent and local districts under the auspices of State DOH for effective use of the new management and information system.	6.3.8.2.13
Use on-line terminals to obtain assignment of blocks of prior approval numbers.	Removed on Department Request
For transportation, eliminate the payment edit that requires the provider number of the doctor or clinic for recipients who are restricted.	JAD
Eliminate specific prior-approval fields that are not considered for transport purposes: primary and secondary diagnosis and applicable codes, reason description, recipient telephone, other income code, and accident code.	JAD
Since coverage code is limited to one (1) instance, the allowable codes should be expanded to provide coding combinations such as a code that would signify a penalty period for LTHHC and nursing homes (10) and excess income met outpatient coverage (02) or emergency services (07) and excess income (06).	JAD
Eligibility entered into WMS should provide MA coverage in the MMIS without a time lag.	7.2.4.1
Provide all client/case information through a PC-based environment.	JAD
Standardize the presentation of systems-based information, and use a Windows-based environment so multiple screens regarding the case can be accessed.	3.2.6
Develop a matrix to include all client information across case types (include all PA/MA/FS/services; use function keys to bring up specific information [i.e., F5] to bring up PA budget).	JAD
Allow the LDSS to see Melrose Project in operation (is this the prototype for the anticipated statewide system?).	Not Applicable
Increase MABL/ABL so more budget history can be stored.	JAD

Suggestion	RFP Cross-Reference
Allow the LDSS to easily reactivate a deceased case.	WMS Redesign
Consolidate information on clients across benefit programs.	JAD
Revise the TPHI system so activation or discontinuance of buy-in is timely.	JAD
The PCP edit for coverage 31/33 should be revised so coverage cannot be allowed after the intended guarantee period.	JAD
AutoSDX should switch coverage codes 30 and 31 to 01 (difficult to correct).	WMS Redesign
Speed up interface between systems (MMIS/WMS).	7.2.4.1
Speed up provider inquiries through the EMEVS and eliminate confusing codes.	JAD
Utilize same language (codes) for all systems (i.e., MMIS/WMS).	6.2.1.1
Increase cross-district inquiry capacity.	WMS Redesign
Revise the chronic care budgeting system so a higher level of resources is allowed.	WMS Redesign
Modify report layouts to include necessary information without wasting paper.	JAD
Automatically generate PCP-guaranteed coverage at end of PCP enrollment.	WMS Redesign
Create a daily report of WMS transactions entered for PCP cases.	WMS Redesign
Allow the LDSS access to provider information, specifically rates, for interpretation of claim detail reports.	7.5.4.2
Allow expanded use of the bulletin board.	JAD
Allow retroactive disenrollments/enrollments for managed care.	7.11.3.2.2
Improve the WMS terminal security issue wherein automatic “shut down” of WMS screens requires workers to complete full sign-on after ten (10) to fifteen (15) minutes of inactivity.	WMS Redesign
Preprint the PA number on the PA form and increase the length of time it is valid.	JAD
Allow access to the third-party system from WMS screens directly.	WMS Redesign
Provide monthly receipt of detailed data on managed care expenditures by service category, sorted by aid category and age of beneficiary.	7.11.3.3
Provide a terminal and limited inquiry access to Medicaid expenditure data by HRA/MAP budget division.	7.5.4.2
Provide a report requirement allowing NYC to request an agreed-to number of reports each year to complete research and program changes.	JAD
Provide tighter integration of data flowing between the WMS, EMEVS, and MMIS.	JAD WMS Redesign
Provide additional data display space on POS devices such as sanction information, surplus amount, expanded categories of assistance, and expanded third-party health information (insurer’s name, policy number); client demographics in full are not coded.	7.5.3.2.1 JAD
Expand methods of inquiry to cover those other than CIN only. Access by SSN, DOB, and name.	7.2.3.2.3
Ensure Year 2000 compliance	3.2.1 11.7.8
Utilize the latest and most efficient data processing technologies, allowing for enhancement and upgrade while ensuring the ability to “talk” to legacy systems.	JAD
Provide the capability to electronically void adjudicated claims to allow submission of valid claims either by the same provider or another provider which claims have been inappropriately blocked.	JAD
Enhance on-line inquiry into provider, recipient, billing, remittance, diagnosis, etc., files.	7.2.3.2 7.3.3.2 7.4.3.2 7.6.3.2 7.7.3.2
Streamline testing procedures for new initiatives. The current process is cumbersome, with slow turnaround times.	6.3.2.3 7.16

Suggestion	RFP Cross-Reference
The system should automatically assign the appropriate recipient restriction code for new ICF residents upon entry into the Principal Provider subsystem, so that the EMEVS will reflect the correct coverage codes.	JAD WMS Redesign
The system should allow SERMA cases to remain open in the WMS and not generate an overlay SERMA line into the Principal Provider subsystem knocking out RTF eligibility for payment. Currently, the open SERMA case generates a line to the prior child care provider, overlaying the proper RTF provider. NYC policy is to keep the foster care case open until the child is in the RFT to avoid redetermining Title IV-D eligibility should they return to care.	WMS Redesign
To the extent possible, the system should accommodate date to date enrollment and payment in the Managed Long-Term Care (MLTC) programs.	JAD
Develop a system that automates the review and approval of day treatment services' claims for nursing facility residents	JAD
The new system should have a coverage code that, upon a recipient's discharge, will automatically restore the same coverage code a recipient had prior to entering the capitation plan.	JAD
To support the development of both MLTC and the development of coordinated LTC FFS systems, we will need to collect and maintain data for dually eligible, chronically ill recipients to properly place them within the LTC system, for appropriate provider payment and for cost analysis. The specifics of data collection requirements will be developed in conjunction with the implementation of IPRO-like reviews required by the MLTC legislation, the PAS project, RWJ-supported acuity rate development, and the Federal waiver evaluation.	JAD
The new fiscal agent should be responsible for establishing an automated procedure so that providers can obtain information on check amounts. There should be no need for either DOH or DSS to be involved in this automated process.	7.5.3.4.1 JAD
The EMEVS must be able to accept and process the Scope of Benefits file in order to give enhanced messaging, thereby lessening the number of calls to the plans and avoiding confusion and denied claims.	7.2.3.2.16
Diagnosis file. Automate the update process. Create an on-line update capability to allow for program specific changes to these codes as necessary. Also, since these codes all originate at HCFA, an electronic link should be established to load the annual additions, deletions, and changes to this file, thus eliminating the need for paper update documents.	7.4.3.2.9 7.4.6.27 JAD
Diagnosis file. Every data element on the file should be made date-specific.	7.4.3.2.3 JAD
Diagnosis file. Flexibility is needed so that the file can process claims for both fee-for-service and managed care claims, accommodating the specific needs and payment rules for each of the two (2) service delivery systems.	7.4.3.2.3 JAD
Formulary file. Create a retroactive reprocessing system to reprice claims impacted by a retroactive change to the State maximum reimbursable amount on the Formulary file.	7.7.3.2.13 7.7.3.2.14
Formulary file. Every data element on the file should be made date-specific.	7.4.3.2.5 JAD
Formulary file. Rather than permanently eliminating purged date segments, move them into some sort of archive file. This will maintain the necessary audit trail within the system to justify historical payment amounts.	JAD
Formulary file. Create an on-line update process that includes electronic links to the Federal government to update the file with the annual HCPCS additions, deletions, and changes. Security-controlled access to the Formulary file from any type of PC would be necessary to input NYS-specific file attributes.	7.4.3.2.9 7.4.6.27 JAD
Formulary file. There needs to a mechanism for the file to include new drugs using numbers of discontinued products (and for the older product to be archived for reference/research).	7.4.3.2.5 JAD

Suggestion	RFP Cross-Reference
Formulary file. The file should be made available through the Internet and/or the EMEVS contractor and the fiche requirement discontinued.	7.4.3.2.13 7.5.4.1
Formulary file. Should be advantageous if we can pass the Medispan file directly to the new fiscal agent (OMM may be able to use the Medispan generic and therapeutic codes). The file will need to be updated at least monthly.	7.4.3.2.9 7.4.4.2 7.4.6.15 7.4.6.27 JAD
Lombardi file. Situate the file with the fiscal agent only, and create an on-line capability to update and change the file.	7.7.3.2.16 JAD
Lombardi file. Create a simple inquiry function to view the information contained on the Lombardi file.	7.7.3.2.16 JAD
Prior Approval file. Two (2) solutions to help alleviate some of the labors of the paper system are the use of an electronic prior approval submission system and an optical scanning data entry system. Pharmacist and durable medical equipment dealers will be requested to submit their most simplified prior-approval requests--from a list of items/services as identified by DOH--via the EMEVS electronic system. Optical scanning will be used for the remaining paper documents for automated entry onto the electronic file, thereby bypassing the grueling manual entry process. Both services should improve the speed of file updating and its availability as a resource as well as freeing staff time to better concentrate and more efficiently handle complex prior approval issues/cases.	7.8.3.2.1 JAD
Prior Approval file. At the least, the file should hold authorizations for the full period providers have to bill (one [1] year) and should have the capacity to automate the search for previous services (the history file).	7.8.3.2.7 7.8.6.8
PCP file. Systems Development staff are currently looking at how the WMS, the EMEVS, and CSC's processing can be changed to accommodate enrollment in more than one (1) plan. However, this change will likely not occur under the current contract but will be needed in the next contract.	JAD WMS Redesign
Procedure file. Create a retroactive reprocessing system to reprice claims impacted by a retroactive change to the State maximum fee on the Procedure file. Similar to what currently happens to rate-based providers, claim-specific attributes would be used to extract paid claims from history in order to automatically reprocess using the new payment information.	7.7.3.2.13 7.7.3.2.14 JAD
Procedure file. Every data element on the file should be made date specific	7.4.3.2.2 JAD
Procedure file. Rather than permanently eliminating purged date segments, move them into some sort of archive file. This will maintain the necessary audit trail within the system to justify historical payment amounts.	7.4.3.2.2 JAD
Procedure file. Create an on-line update process that includes electronic links to update those codes that are promulgated by the Federal government (HCPCS and ICD-9-CM procedure codes). Security-controlled access from any type of PC would be necessary to input NYS-specific file attributes.	7.4.3.2.9 7.4.3.4.2 7.4.6.27
Procedure file. Make accommodations for multiple fees on file and link each fee to a particular specialty code. This would allow the MMIS to meet Federal common coding requirements but at the same time allow the State to differentiate payment amounts in accordance with program requirements.	7.4.3.2.2 JAD
Procedure file. As with the Formulary file, provisions should be made with the new contractor to allow complete and timely update to the Procedure file, incorporating all "outdated" codes as well as new codes to insure that managed care plan MEDS reporting remains accurate and truly reflects the services provided to recipients. The file will require, at a minimum, annual updating.	7.4.3.2.9 7.4.6.27 7.4.4.1 7.4.4.4 7.4.4.5
Procedure file. Provisions should be made to allow access to transportation procedure-specific information by both district of responsibility and by provider.	7.5.3.4.2 JAD

Suggestion	RFP Cross-Reference
Provider file. The updating of the Provider file, with new enrollments, as well as additional enrollment information, should be automated by the fiscal agent. State staff will continue to review the necessary documentation (e.g., license or ownership information) for compliance with policy, but actual inputting of changes should be done in an automated way, whether through a scannable form or other method.	7.3.6.2
Provider file. While Federal requirements are met for out-of-state enrollments, the process needs to be streamlined. Consideration should be given to the acceptance of universal claim forms by the fiscal agent for out-of-state providers that are not within the medical marketing area, to facilitate adjudication of their claims.	JAD
Provider file. The new system should allow for the transfer of provider data directly from the plans to the new fiscal agent. This data will need to include the new National Provider ID Number.	7.3.3.4.8
Provider file. An on-line, user-friendly Provider file by both provider type and geographic location would assist staff in responding to recipient calls.	7.3.3.2.36
Provider file. The current maximum of eighteen (18) locator codes per provider must be expanded.	JAD
Rate file. Change the update process so that rates will be automatically loaded into the Rate file. Given the technical skills and know-how required to perform an auto load of rates, letting the new contractor assume this role makes the most sense. Some sort of rate clearinghouse unit could be created that would be capable of translating the existing variety of rate formats and schedules into a common update record to be loaded on the rate file. A feedback loop would be established to allow the individual rate-setting areas to validate the rate update transactions prior to final loading into the system.	7.3.3.4.7 JAD
Rate file. The new system should be fully compatible with the rate calculation operating systems (mainframe, network, and PC) so that all rates may be transmitted via electronic medium. This integration of systems will eliminate the necessity of hard-copy rate transmittals and the use of antiquated cartridges as the automated mechanism. Approval of the rate calculation systems should trigger an electronic transfer automatically. The proper security edits would need to be installed to preserve the integrity of each system.	7.3.3.4.7 JAD
Rate file. For all DOH long-term care programs (NF CHHA, LTHHCP, ADHC, and hospice), the payment system must accept each provider's unique operating certificate number to identify them and their rates for transmission purposes. This recommendation should also be put in place for Article 28 hospitals and diagnostic and treatment centers.	JAD
Rate file. Rate changes should have an identifier that could be included on the provider payment invoice as well as the rate change notification providers receive from the Department. For example, the actual rate paid to provider for a specific patient/date of service could be included on the provider/s remittance statement. On-line accessibility should also be made available to DOH program areas.	JAD
Rate file. Allow staff to access payment data files, both past and current. Accessibility should be available to appropriate program areas via an extraction process to a PC or network environment for use with various spreadsheet software programs.	JAD
Rate file. Provide verification that the rates transmitted have been loaded on the rate file, and provide the date when payment will be made at the new rate. On-line accessibility should be available to DOH program area (as well as to providers).	JAD
Rate file. Rates should be made available to the public via electronic medium.	7.5.6.10
Rate file. All programs, CHHAs, and LTHHHCPs should have their own unique set of rate codes, with no possibility of crossover codes.	JAD
Rate file/claims. The payment should be able to process set dollar amount of reimbursement, and the proper edits should be built in to cease payment once these amounts are reached.	JAD

Suggestion	RFP Cross-Reference
Rate file/claims. The payment and adjustment systems need to be integrated to insure that proper adjustments are made to the MMIS payment to reflect bad debt and charity care add-on rate payment reconciliations.	7.7.3.2.16 7.7.3.3.13 7.7.4.10 JAD
Rate file/claims. The payment system should be able to accept retroactive activation of new rate codes without the requirement of rebilling. There is need to have more flexibility built into the new system so that the billing of rate codes may be altered or changed and retroactive adjustments can be made.	7.7.3.2.13 7.7.3.2.14 JAD
Service Intensity Weight (SIW) file. Although the role the SIW file plays in claims processing is performed in an acceptable fashion, the file itself could be streamlined so that processing efficiency would increase and the file update process would be simplified.	JAD
Third-Party Resource Claiming Address file. An on-line listing would provide easy access for local district workers. It would be easier to maintain and update and would therefore provide more current and timely information.	7.5.3.4.2 JAD
It is being proposed that the new contractor for the Medicaid payment system be required to put into place controls on payment of Medicaid claims necessary to support the State's utilization review initiatives. Retrospectively (postpayment), this would require that once a claim is adjusted or denied by the UR agent that hospitals would be unable to rebill for these claims without prior approval by the State or the its UR agent(s).	JAD
Prospectively (prepayment), controls are needed that could support a preadmission review, concurrent review, and prepayment utilization review systems. These controls should be flexible enough to be implemented on a sample of hospitals, on a region level or statewide for all claims or subset of claims, i.e., elective surgery.	JAD
The payment system should be able to accept authorization numbers as a condition of payment from our UR agent(s) electronically for all claims from all hospitals or a subset of claims from a subset of hospitals.	JAD
The contractor should be required to identify specific staff, both from a technical and policy standpoint, who would be responsible for coordinating UR activity with the State and its UR agent(s) and hospitals.	6.3
Create an electronic, user-manipulatable date file using GUI technology to allow custom-generatable, user-defined reports.	3.2.6
Since information for MA PCP enrollment is returned on the EMEVS in the insurer plan/coverage code fields, providers think that MA PCP coverage is third-party insurer coverage and report it as such on their claims being denied for the wrong reasons. MA/PCP should be reported in a different/clearer manner.	JAD
TPL subsystem issues include: • Cannot tell what last action was or who made the entry. • Most recent information does not always appear on input screen. • User is not always alerted when changes that are input are not accepted by system. • Difficulty accessing TPR on closed cases. • No way to change SSI Code 91 cases from upstate to NYC. • System only allows one (1) B1 transaction to be entered per month. • Reason codes for transactions that are rejected by HCFA do not always post to TPR.	JAD
System should allow for ability to enroll clients in more than one (1) managed care plan at a time, especially populations that have special needs and receive different types of services from different plans. Related to this is the need for health care-only Medicaid PCPs.	JAD
The new system design should provide for all districts to have on-line recipient-specific inquiry capability into the client's eligibility for, and benefit status in, various Federal programs (SSI, SSA, RSDI, Medicare, etc.).	7.5.3.4.2

Suggestion	RFP Cross-Reference
Documentation for systems/notification of changes needs to be accurate, current, and easily accessible.	6.3.2.3
The current process for updating the provider manuals is extremely lengthy and cumbersome. The RFP should provide for a more streamlined means of updating the manuals. Perhaps, we should be looking at an on-line link to the contractor where we can directly access the manuals to make any revisions. The contract should also provide specifications for number of updates per year per provider type. We may also want to include coordination/mailing of the Medicaid Update under the contract.	6.3.2.3
Ensure accessibility of data and information to analysts and policy makers through executive information and decision support systems.	Section 8
Develop infrastructure, support, and easier access to information for LDSS, including the managed care coordinators.	7.5.3.4.2
Ensure uniform processing logic across systems and users, including the fiscal agent, the EMEVS, and the WMS and ensure users are all analyzing the same versions of the database and are using the same data transformation algorithms.	6.3.1.1 WMS Redesign
Need to ensure business requirements for the development of health care quality and performance indicators are met. Therefore, the MMIS must include the capability to focus on health care quality in addition to its traditional transactional processing functions.	Section 8
Provide geocoding of all enrolled residence and provider locations. Capacity and access issues within small geographical areas will become an increasingly important area of analysis.	3.2.8 8.5.2.2
Need to develop a capacity in the EMEVS (and the WMS) to handle everyday enrollment and prorated capitation claims. Apparently, the current fiscal agent now has these capabilities, but the EMEVS and the WMS do not.	JAD
Develop the capability of the EMEVS to read the Scope of Benefits file and to provide enhanced messaging so that benefits can be verified and authorization is clearly displayed and understood.	JAD
Develop the capability to do cross-invoice editing, particularly for the purpose of ensuring that capitation payments will not be paid if a hospital claim has already been paid for newborn stay.	JAD
Ensure the processing of the exact date of birth on all claims, not just the year of birth, particularly on capitation claims for newborns (which still appear as unborn in the WMS) to ensure the correct rate code is assigned.	JAD
Provide same-day processing of MEDS (encounter) data. Feedback on encounter data submissions should not have to wait for monthly processing.	JAD
Need to ensure flexibility in processing encounter data to transform and clean/correct data not presently available in the claims processing environment. Presently, the CSC contract forbids making any changes to data submissions. The rigidity needed in claims processing is not necessary when processing encounters.	JAD
Be prepared to accept new encounter data segments to satisfy data element and reporting requirements of HIV/AIDS and Mental Health Special Need Plan initiatives.	JAD
Ensure compatibility with the MEDS data warehouse and decision support systems. The planned technology architecture of MEDS includes a Sun Enterprise 500 server and Sybase SQL Server/Sybase IQ database management system. MEDS can be viewed as a data mart to the larger MMIS data warehouse and a prototype for an MMIS decision support system.	8.3
Obtain and fully maintain complete and up-to-date ICD-9, CPT-4/HCPCS, and NDC Master files for encounter processing. CSC has only maintained diagnostic and procedure codes that the Medicaid program has authorized for payment.	7.4.3
Take over stop-loss billing functions, if necessary. We may be seeking outside resources for this function.	7.11.6.11 JAD

Suggestion	RFP Cross-Reference
Ensure EDI capability and adherence to national standards.	3.2.2
EMEVS Reporting - Provide the ability to download data files directly from the EMEVS contractor in Microsoft Access format, using the EMEVS workstation. Flexible file requests to accomplish this would be needed, including by service periods, by provider types, by procedure, etc.	JAD
EMEVS Reporting - Allow access to the EMEVS database using personal computers that run on the Microsoft NT platform. This would allow users the ability to access information using their personal computers and to integrate the EMEVS data into other software currently available to these users, to create reports, run targeting software, conduct studies, validate other information obtained through undercover investigations and audits/reviews, etc.	JAD
EMEVS Reporting - Provide standardized hot keys to access information. Currently, the same key is used to access different information on successive screens. Function keys need to be standardized.	JAD
EMEVS Reporting - On-line help screens are needed to instruct users on maneuvering through the system as well as to define specific fields. Currently, users must rely on manuals for every step.	JAD
EMEVS Reporting - Provide nomenclature, via on-line definition tables. This provides users with recognizable definitions for a number of fields, such as NDC codes, diagnoses, cardswipe/P&C codes, provider access methods, etc.	JAD
EMEVS Reporting - Provide provider names, recipient names, and other identifying information on-line.	JAD

THIS PAGE INTENTIONALLY LEFT BLANK

Appendix K
Key Personnel and Staffing Requirements

This appendix provides the general responsibilities, minimum qualifications, and relative start dates for key personnel and specialized staffing for the contract. The appendix is organized into two (2) sections:

- Implementation Phase Key Personnel
- Operations Phase Key Personnel

Appendix K.1
Implementation Phase Key Personnel

Key Personnel	General Responsibilities	Qualifications	Start Date	Special Requirements
Project/Account Manager	• Contract administration • Project management • Scheduling and provision of resources • Formal communication and correspondence with the Department • Quality assurance reviews	**Required:** Five (5) years of account management for a government or private-sector health care payor, Bachelor's degree, and previous experience with Medicaid and MMIS system development **Desired:** Master's degree in business administration, computer science, or related field	Contract signing	The Project/Account Manager may not serve in any other key position. The Project/Account Manager shall also serve as the Account/Contract Manager in the Operations Phase. The Project/Account Manager must be named in the proposal.
System Implementation Manager	Management of the planning, design, and implementation of the Replacement Medicaid System	**Required:** Four (4) years of experience with system design, development, and implementation efforts in a management capacity; a Bachelor's degree in computer science, business administration, or related field; recent experience of at least three (3) years with Medicaid systems; and technical training in proposed design methodologies and proposed technologies (including data warehouse)	Contract signing	Must be named in the proposal.
Database Administrator	• Design and maintenance of data elements and the database(s) for all components of Replacement Medicaid System • Design and maintenance of the Medicaid data warehouse database	**Required:** Minimum of five (5) years of experience in technical and database design; a Bachelor's degree in computer science or a related field; and technical training in proposed methodologies and technologies **Desired:** Experience in Medicaid systems databases	Must be named within three (3) months of contract signing	The Database Administrator must be full-time on-site in Albany if the data center is located in Albany; otherwise, the Database Administrator must be on-site forty percent (40%) of time.

Appendix K.1
Implementation Phase Key Personnel

Key Personnel	General Responsibilities	Qualifications	Start Date	Special Requirements
Systems Administrator	• Operation of the Replacement Medicaid System and the Medicaid data warehouse • Acquisition and implementation of all hardware and software required to operate the Medicaid systems • Implementation and maintenance of telecommunications network, including links to NYT • LAN linkages and maintenance	**Required:** Minimum of five (5) years of experience in systems operations, telecommunications networks, and LAN administration (LAN administration alone does not meet the requirement); a Bachelor's degree in computer science or related field; and experience with health insurance technologies, including EDI **Desired:** Experience with Medicaid systems	Must be named within three (3) months of contract signing.	The Systems Administrator must be full-time on-site in Albany if the data center is located in Albany; otherwise, the Systems Administrator must be on-site twenty-five percent (25%) of time.

Appendix K.2
Operations Phase Key Personnel

Key Personnel	General Responsibilities	Qualifications	Start Date	Special Requirements
Account/Contract Manager	• Contract administration • Scheduling and provision of resources • Formal communication and correspondence with the Department • Quality assurance reviews	**Required:** Five (5) years of account management for government or private-sector health care payor; a Bachelor's degree; and previous experience with Medicaid and MMIS system development **Desired:** Master's degree in business administration, computer science, or a related field	Contract signing	The Project/Account Manager may not serve in any other key position. The Account/Contract Manager shall be the same individual as the Project/Account Manager in the Implementation Phase. The Account/Contract Manager must be named in the proposal.
Operations/Claims Processing Manager	Responsible for the functional operation of the Replacement Medicaid System, including performance of contractor responsibilities	**Required:** At least four (4) years of experience in the management of claims processing and related functional operations **Desired:** Previous Medicaid experience	Must be named within three (3) months of contract signing.	The Operations/Claims Processing Manager may not serve in any other key position.
Systems Manager	• Primary technical contact with the Department • Management of the evolution team • Management of the overall change control over the Replacement Medicaid System	**Required:** Minimum of three (3) years of experience in health care systems development, design, and programming; Medicaid systems experience; and technical training in the proposed design methodologies and proposed technologies (including data warehouse)	Contract signing	Same individual as the Implementation Phase Systems Manager The Systems Manager shall be present in Albany during normal business hours and must be immediately available at Department offices when requested by the Department's Project Manager. The Systems Manager in the Implementation Phase shall become the Evolution Manager in the Operations Phase. Must be named in the proposal.

Appendix K.2
Operations Phase Key Personnel

Key Personnel	General Responsibilities	Qualifications	Start Date	Special Requirements
Database Administrator	Same individual and responsibilities as the Implementation Phase Database Administrator			
Systems Administrator	Same individual and responsibilities as the Implementation Phase Systems Administrator			
Provider Services Manager	Responsible for managing all provider service activities and primary point of contact with the Department for activities related to provider enrollment, training, provider manual production and distribution	**Required:** At least four (4) years of public relations experience, of which at least two (2) years must be in relations with medical providers **Desired:** Experience in managing Medicaid provider enrollment and relations	Must be employed at least six (6) months prior to start of the Provider Enrollment and Data Maintenance component.	May not serve in any other key position. Must be full-time on-site at the contractor's Albany facility.

Total Evaluated Price

PRICING SCHEDULE A

Pricing Element	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Contract Year 5	Contract Year 6	Total
Implementation - Replacement Medicaid System	$	$	$ N/A	$ N/A	$ N/A	$ N/A	$
Implementation - Data Warehouse Component	$	$ N/A	$ N/A	$ N/A	$ N/A	$ N/A	$
Operations - Data Warehouse Component	$ N/A	$	$	$	$	$	$
Operations - Fixed Administrative Fee	$ N/A	$	$	$	$	$	$
Operations - Fixed Fee Per Transaction	$ N/A	$	$	$	$	$	$
Operations - Evolution and User Support Staff Price	$ N/A	$	$	$	$	$	$
Total Evaluated Price	**$**	**$**	**$**	**$**	**$**	**$**	**$**

Implementation Price - Replacement Medicaid System

PRICING SCHEDULE B

IMPLEMENTATION PHASE

Component - Contract Year 1	**Fixed Price**
Client Eligibility Data Repository	$
Electronic Commerce	$
Service Utilization Management	$
Prospective Drug Utilization Review (ProDUR)	$
Systems Operations and Integrated Test Facility	$
Total Implementation Price for Contract Year 1 (Carry to Pricing Schedule A)	$

Component - Contract Year 2	
Provider Enrollment and Data Maintenance	$
Reference Data Maintenance	$
Claims and Encounter Processing	$
Financial Management	$
Third-Party Resources	$
The Child/Teen Health Plan (EPSDT)	$
Managed Care Support	$
Drug Rebate	$
Surveillance and Utilization Review (SUR)	$
Retrospective Drug Utilization Review (RetroDUR)	$
Management and Administrative Reporting (MAR)	$
Total Implementation Price for Contract Year 2 (Carry to Pricing Schedule A)	$

Implementation and Operations Price - Data Warehouse Component

PRICING SCHEDULE C

IMPLEMENTATION PHASE

Component	**Fixed Price**
Implementation of Data Warehouse	$
Implementation of Two (2) Data Marts	$
Total Data Warehouse Implementation Price (Carry to Pricing Schedule A, Contract Year 1)	$

OPERATIONS PHASE

Fixed Annual Fee for Operations (Carry to Appropriate Year on Pricing Schedule A)	
Contract Year 2	$
Contract Year 3	$
Contract Year 4	$
Contract Year 5	$
Contract Year 6	$
Total Data Warehouse Operations Price	$

Operations Price - Fixed Administrative Fee

PRICING SCHEDULE D.1

Contract Year 2 - November 1, 1999 Through October 31, 2000

Pricing Elements		
Personnel-Related Costs		
Total Direct Salary Expense	$	
Benefit Expense	$	
Other Expenses (Specify)	$	
Total Personnel Costs	$	$
Equipment Costs		
Software	$	
Depreciation	$	
Lease	$	
Maintenance	$	
Total Equipment Costs		$
Facility Costs		
Rent	$	
Utilities Expense	$	
Telephone Expense	$	
Rent Escalators	$	
Insurance	$	
Furniture and Fixtures (Depreciation)	$	
Furniture and Fixtures (Rental)	$	
Other (Specify)	$	
Total Facility Costs		$
Other Operations Costs		
Computer Operation Expense	$	
Letter of Credit	$	
Travel	$	
Public Relations	$	
Freight	$	
Insurance	$	
Other Expenses (Specify)	$	
Total Other Operations Costs		$
Subcontracts		$
Corporate Allocations @ _____%		$
Markup @ _____%		$
Total Annual Price (Carry to Schedule A)		$
New York City Office Operations (Included in Total Annual Price)		**$**

Operations Price - Fixed Administrative Fee

PRICING SCHEDULE D.2

Contract Year 3 - November 1, 2000 Through October 31, 2001

Pricing Elements		
Personnel-Related Costs		
Total Direct Salary Expense	$	
Benefit Expense	$	
Other Expenses (Specify)	$	
Total Personnel Costs	$	$
Equipment Costs		
Software	$	
Depreciation	$	
Lease	$	
Maintenance	$	
Total Equipment Costs		$
Facility Costs		
Rent	$	
Utilities Expense	$	
Telephone Expense	$	
Rent Escalators	$	
Insurance	$	
Furniture and Fixtures (Depreciation)	$	
Furniture and Fixtures (Rental)	$	
Other (Specify)	$	
Total Facility Costs		$
Other Operations Costs		
Computer Operation Expense	$	
Letter of Credit	$	
Travel	$	
Public Relations	$	
Freight	$	
Insurance	$	
Other Expenses (Specify)	$	
Total Other Operations Costs		$
Subcontracts		$
Corporate Allocations @ _____%		$
Markup @ _____%		$
Total Annual Price (Carry to Schedule A)		$
New York City Office Operations (Included in Total Annual Price)		**$**

Operations Price - Fixed Administrative Fee

PRICING SCHEDULE D.3

Contract Year 4 - November 1, 2001 Through October 31, 2002

Pricing Elements		
Personnel-Related Costs		
Total Direct Salary Expense	$	
Benefit Expense	$	
Other Expenses (Specify)	$	
Total Personnel Costs	$	$
Equipment Costs		
Software	$	
Depreciation	$	
Lease	$	
Maintenance	$	
Total Equipment Costs		$
Facility Costs		
Rent	$	
Utilities Expense	$	
Telephone Expense	$	
Rent Escalators	$	
Insurance	$	
Furniture and Fixtures (Depreciation)	$	
Furniture and Fixtures (Rental)	$	
Other (Specify)	$	
Total Facility Costs		$
Other Operations Costs		
Computer Operation Expense	$	
Letter of Credit	$	
Travel	$	
Public Relations	$	
Freight	$	
Insurance	$	
Other Expenses (Specify)	$	
Total Other Operations Costs		$
Subcontracts		$
Corporate Allocations @ _____%		$
Markup @ _____%		$
Total Annual Price (Carry to Schedule A)		$
New York City Office Operations (Included in Total Annual Price)		**$**

Operations Price - Fixed Administrative Fee

PRICING SCHEDULE D.4

Contract Year 5 - November 1, 2002 Through October 31, 2003

Pricing Elements		
Personnel-Related Costs		
Total Direct Salary Expense	$	
Benefit Expense	$	
Other Expenses (Specify)	$	
Total Personnel Costs	$	$
Equipment Costs		
Software	$	
Depreciation	$	
Lease	$	
Maintenance	$	
Total Equipment Costs		$
Facility Costs		
Rent	$	
Utilities Expense	$	
Telephone Expense	$	
Rent Escalators	$	
Insurance	$	
Furniture and Fixtures (Depreciation)	$	
Furniture and Fixtures (Rental)	$	
Other (Specify)	$	
Total Facility Costs		$
Other Operations Costs		
Computer Operation Expense	$	
Letter of Credit	$	
Travel	$	
Public Relations	$	
Freight	$	
Insurance	$	
Other Expenses (Specify)	$	
Total Other Operations Costs		$
Subcontracts		$
Corporate Allocations @ _____%		$
Markup @ _____%		$
Total Annual Price (Carry to Schedule A)		$
New York City Office Operations (Included in Total Annual Price)		**$**

Operations Price - Fixed Administrative Fee

PRICING SCHEDULE D.5

Contract Year 6 - November 1, 2003 Through October 31, 2004

Pricing Elements		
Personnel-Related Costs		
Total Direct Salary Expense	$	
Benefit Expense	$	
Other Expenses (Specify)	$	
Total Personnel Costs	$	$
Equipment Costs		
Software	$	
Depreciation	$	
Lease	$	
Maintenance	$	
Total Equipment Costs		$
Facility Costs		
Rent	$	
Utilities Expense	$	
Telephone Expense	$	
Rent Escalators	$	
Insurance	$	
Furniture and Fixtures (Depreciation)	$	
Furniture and Fixtures (Rental)	$	
Other (Specify)	$	
Total Facility Costs		$
Other Operations Costs		
Computer Operation Expense	$	
Letter of Credit	$	
Travel	$	
Public Relations	$	
Freight	$	
Insurance	$	
Other Expenses (Specify)	$	
Total Other Operations Costs		$
Subcontracts		$
Corporate Allocations @ _____%		$
Markup @ _____%		$
Total Annual Price (Carry to Schedule A)		$
New York City Office Operations (Included in Total Annual Price)		**$**

Operations Price - Fixed Fee Per Transaction

PRICING SCHEDULE E.1

Contract Year 2 - November 1, 1999 Through October 31, 2000

Type of Transaction	(A) Annual Volume	(B) Fixed Rate	Total Annual Price: (AxB)
Claim Transactions	0	**$**	**$0.00**
Encounter Transactions	0	**$**	**$0.00**
Eligibility Verification Transactions	140,000,000	$	$
Total Price (Carry to Pricing Schedule A)			$

Operations Price - Fixed Fee Per Transaction

PRICING SCHEDULE E.2

Contract Year 3 - November 1, 2000 Through October 31, 2001

Type of Transaction	(A) Annual Volume	(B) Fixed Rate	Total Annual Price: (AxB)
Claim Transactions	200,000,000	$	$
Encounter Transactions	50,000,000	$	$
Eligibility Verification Transactions	140,000,000	$	$
Total Price (Carry to Pricing Schedule A)			$

Operations Price - Fixed Fee Per Transaction

PRICING SCHEDULE E.3

Contract Year 4 - November 1, 2001 Through October 31, 2002

Type of Transaction	(A) Annual Volume	(B) Fixed Rate	Total Annual Price: (AxB)
Claim Transactions	200,000,000	$	$
Encounter Transactions	50,000,000	$	$
Eligibility Verification Transactions	140,000,000	$	$
Total Price (Carry to Pricing Schedule A)			$

Operations Price - Fixed Fee Per Transaction

PRICING SCHEDULE E.4

Contract Year 5 - November 1, 2002 Through October 31, 2003

Type of Transaction	(A) Annual Volume	(B) Fixed Rate	Total Annual Price: (AxB)
Claim Transactions	200,000,000	$	$
Encounter Transactions	50,000,000	$	$
Eligibility Verification Transactions	140,000,000	$	$
Total Price (Carry to Pricing Schedule A)			$

Operations Price - Fixed Fee Per Transaction

PRICING SCHEDULE E.5

Contract Year 6 - November 1, 2003 Through October 31, 2004

Type of Transaction	(A) Annual Volume	(B) Fixed Rate	Total Annual Price: (AxB)
Claim Transactions	200,000,000	$	$
Encounter Transactions	50,000,000	$	$
Eligibility Verification Transactions	140,000,000	$	$
Total Price (Carry to Pricing Schedule A)			$

Operations - Evolution and User Support Staff Price

PRICING SCHEDULE F.1

Contract Year 2 - November 1, 1999 Through October 31, 2000

Labor Category	(A) Daily Rate	(B) Number of Staff	(C) Annual Days	Total Annual Price A x B x C
Senior Systems Analyst (10+ years)	$		225	$
Systems Analyst (1-9 years)	$		225	$
Programmer Analyst (5+ years)	$		225	$
Programmer Analyst (2-4 years)	$		225	$
Programmer Analyst (0-1 years)	$		225	$
Documentation Specialists	$	4	225	$
Data Warehouse User Support	$	10	165	$
Optional Evolution Pool Programmer Analyst (5+ Years)	$	2	225	$
Total Annual Price (Carry to Pricing Schedule A)		87		$

The daily rate is a fully loaded rate and includes all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs.

Operations - Evolution and User Support Staff Price

PRICING SCHEDULE F.2

Contract Year 3 - November 1, 2000 Through October 31, 2001

Labor Category	(A) Daily Rate	(B) Number of Staff	(C) Annual Days	Total Annual Price A x B x C
Senior Systems Analyst (10+ years)	$		225	$
Systems Analyst (1-9 years)	$		225	$
Programmer Analyst (5+ years)	$		225	$
Programmer Analyst (2-4 years)	$		225	$
Programmer Analyst (0-1 years)	$		225	$
Documentation Specialists	$	4	225	$
Data Warehouse User Support	$	6	225	$
Optional Evolution Pool Programmer Analyst (5+ Years)	$	2	225	$
Total Annual Price (Carry to Pricing Schedule A)		83		$

The daily rate is a fully loaded rate and includes all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs.

Operations - Evolution and User Support Staff Price

PRICING SCHEDULE F.3

Contract Year 4 - November 1, 2001 Through October 31, 2002

Labor Category	(A) Daily Rate	(B) Number of Staff	(C) Annual Day	Total Annual Price A x B x C
Senior Systems Analyst (10+ years)	$		225	$
Systems Analyst (1-9 years)	$		225	$
Programmer Analyst (5+ years)	$		225	$
Programmer Analyst (2-4 years)	$		225	$
Programmer Analyst (0-1 years)	$		225	$
Documentation Specialists	$	4	225	$
Data Warehouse User Support	$	6	225	$
Optional Evolution Pool Programmer Analyst (5+ Years)	$	2	225	$
Total Annual Price (Carry to Pricing Schedule A)		83		$

The daily rate is a fully loaded rate and includes all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs.

Operations - Evolution and User Support Staff Price

PRICING SCHEDULE F.4

Contract Year 5 - November 1, 2002 Through October 31, 2003

Labor Category	(A) Daily Rate	(B) Number of Staff	(C) Annual Days	Total Annual Price A x B x C
Senior Systems Analyst (10+ years)	$		225	$
Systems Analyst (1-9 years)	$		225	$
Programmer Analyst (5+ years)	$		225	$
Programmer Analyst (2-4 years)	$		225	$
Programmer Analyst (0-1 years)	$		225	$
Documentation Specialists	$	4	225	$
Data Warehouse User Support	$	6	225	$
Optional Evolution Pool Programmer Analyst (5+ Years)	$	2	225	$
Total Annual Price (Carry to Pricing Schedule A)		83		$

The daily rate is a fully loaded rate and includes all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs.

Operations - Evolution and User Support Staff Price

PRICING SCHEDULE F.5

Contract Year 6 - November 1, 2003 Through October 31, 2004

Labor Category	(A) Daily Rate	(B) Number of Staff	(C) Annual Days	Total Annual Price A x B x C
Senior Systems Analyst (10+ years)	$		225	$
Systems Analyst (1-9 years)	$		225	$
Programmer Analyst (5+ years)	$		225	$
Programmer Analyst (2-4 years)	$		225	$
Programmer Analyst (0-1 years)	$		225	$
Documentation Specialists	$	4	225	$
Data Warehouse User Support	$	6	225	$
Optional Evolution Pool Programmer Analyst (5+ Years)	$	2	225	$
Total Annual Price (Carry to Pricing Schedule A)		83		$

The daily rate is a fully loaded rate Includes all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs

Estimated Implementation Price - Optional Components

PRICING SCHEDULE G

Optional Component	**Estimated Fee**
1) Implementation of the Front-End Electronic Fraud, Waste, and Abuse Prevention Module	$ _____
2) Implementation of Medical Utilization Review (MUR)	$ _____
3) Implementation of Client Repository Enhancement	$ _____

Do not carry these amounts to Pricing Schedule A.

Key Data Entry Services	**Fixed Rate**
Fixed rate per 1,000 key strokes for key data entry and verification	$ _____

Do not carry this rate to Pricing Schedule A.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 6, 1998

Question Number	RFP Reference	Page	Question and Response
1			**Is it permissible to propose upgrading the existing New York claims processing subsystem to be a component of the new MMIS?** The Department desires an MMIS that will add functionality, deliver economical performance, provide an efficient and cost effective application for ongoing modifications and enhancements, and facilitate expanded user information access to support Medicaid program administration. The Department believes the RFP reflects these objectives, both in the definition of needs and in the planned evaluation of responses. Offerors may select a baseline solution or components of multiple solutions to frame their approach to meeting the RFP requirements. No restrictions are placed on offerors in determining their approach to transferring an existing system or components of an existing system. As defined in the RFP, technical merit of the proposal has a significantly higher weight than price To the extent that the Department's objectives may be achieved by utilizing any existing claims processing subsystem as a transfer component, a proposal which incorporates that approach will be given consideration
2			**Where can offerors obtain additional information regarding NYT?** The NYT Request for Proposals and related information can be located on the Office for Technology web site at http://www.irm.state.ny.us/nyt/nyt.htm
3	General		**The RFP regularly requires the provision of information via multiple media. Would the Department stipulate that it will adopt a limited range of Media to lower overall administrative fees? One example would be the elimination of paper provider bulletins in deference to use of the World Wide Web. Such a change requires a firm position on the Department's part. Continued support of multiple media increase production costs and lowers adoption of the new communications method. Ultimately, the benefits - in this case more timely update distributed on an as-needed, pull-down basis - are diluted or lost.** The Department will consider limiting documents to a single media format if the limitation meets the Department's needs. For example, Section 6.2.1.4 identifies a number of media for systems documentation. The Department will consider limitations on the number of different media formats in that circumstance. However, for the example used in the question, the response is very different. Because not all New York State providers have access to the World Wide Web, the elimination of paper provider bulletins cannot be considered; at the same time, the Department wishes to make the bulletins and provider manuals available on the Web in order to reduce the overall paper and mailing costs. For each area, the media for the provision of information will be finalized in the JAD sessions.
4	General		**The RFP regularly uses the word *problem* and requires resolution at contractor expense. We assume the word *problem* to mean operation that is not in accordance with defined and approved specification or procedure; and is clarified in Part by Section 6.3.2 definition of maintenance and evolution. Would the Department confirm this assumption?** This is an acceptable definition of the term "problem". The source of "defined and approved specification or procedure" shall be the RFP as clarified or modified by formal JAD sessions and by Department-approved specifications and procedures.

5	General		**This question requests clarification of offeror's response structure. Our purpose in asking the question is to be responsive to the format requirements and more importantly to construct a work plan that best aligns with the Department's intended approach.** **Section 4 describes the EMEVS Takeover and Operations and Transition to the Replacement Medicaid System in two tasks: *takeover* and *operations*. It then goes on to provide further information concerning the Department's intent and concerns, Section 6 describes the Replacement Medicaid System scope of work stipulating use of a waterfall SDLC (systems development life cycle) consisting of 8 steps. The Operations phase is further decomposed into *Operations*, *Evolution* and *Turnover* Tasks. Section 7 describes Replacement Medicaid Systems component requirements excepting data warehouse that is described in section 8. Section 8 also details a different development methodology consisting of 6 stages.** **Would the State prefer work plans broken into phases (EMEVS Takeover, Replacement Medicaid System Implementation, Replacement Medicaid System Operations), and within phases use of the Tasks mentioned above, and within Tasks use of the SDLC for EMEVS and MMIS components and stages for the data warehouse? Should the redefined EMEVS components be addressed under the Implementation Phase of the Replacement Medicaid System or as part of Transition to Replacement Medicaid System section 4.5?** The Scope of Work for the Replacement Medicaid System implementation and fiscal agent operations is organized into phases and tasks to the extent possible, but recognizes that not all elements can be neatly organized. Offerors should consider the following: The overall scope of work is organized into three phases: (1) Takeover and operations of the existing EMEVS, (2) Replacement Medicaid System Implementation (including implementation of the Medicaid data warehouse), and (3) Operation of the Replacement Medicaid System, including the Medicaid data warehouse. The implementation of the Medicaid data warehouse component of the Replacement Medicaid System was given a different set of tasks (called stages) to recognize that the activities for the implementation of a data warehouse are different than those for implementation of the other components of the Replacement Medicaid System. The "waterfall" SDLC methodology is required for the implementation of all Replacement Medicaid System components except the Medicaid data warehouse. Takeover and operations of the existing EMEVS system are included in the same phase because it is considered to be a short-term activity.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 6, 1998

6	**1.1.3**	**1-3**	**This question is in regards to the timing of phasing in various functions.** **Section 1.1.3 on page 1-3 states that the Contractor will take over operations of the current EMEVS by March 1, 1999. Exhibit 1.1 appears to confirm this. Section 4.1.1 on page 4-1 seems to allow the Contractor until April 30, 1999 to complete the Takeover Phase, meaning operations would start on May 1, 1999. In order for the Contractor to propose appropriate staffing and computer resources for Takeover and Operations, a firm date must be established for the transition. Please provide that date.** The wording of the RFP reflects the Department's desire to ensure that there will be no disruption of service to the provider community in the transition of EMEVS from one contractor to another. Section 1.1.3 states, "By March 1, 1999, the contractor will takeover operations of the current EMEVS." Section 4.1.1 states, "The Takeover **phase** will begin on execution of the contract and will continue until completion of Takeover or April 30, 1999, whichever is earlier." As stated in Section 1.1.3, the contract with Deluxe Electronic Payment Systems (DEPS) terminates on October 31, 1998. The Department may exercise up to six (6) one-month extensions of the contract. Prudent project management dictates that a plan to start operations under the new contractor on May 1, 1998 does not permit any room for contingencies, therefore the Department is requiring a March 1, 1999 start of Takeover operations**.** **The following also addresses the subject of timing. In Exhibit 1.1 on page 1-4, what is the difference between a dotted and solid line? What is the significance of arrows that end in the middle of a period with no specific date? What is represented by the 6th line down which does not have a heading?** Offerors are cautioned that Exhibit 1.1 was prepared to provide an illustration of the overall timing of the EMEVS Takeover and Replacement Medicaid System implementation; it is not intended to provide definitive milestones. The Department's expectations for milestones are provided in the narrative or in tables in the RFP. The dotted lines in Exhibit have two different meanings. Dotted lines preceding a solid line indicates optional implementation periods. Dotted lines with no solid lines indicate system operations (as distinguished from implementation activities). The 6th line should have been labeled "Utilization Threshold/Post and Clear". Revised page enclosed.
7	2.2.8.1	2-12	**Will the Department give offerors at least two weeks' notice of intent to prepare for oral presentations and demonstrations, and to ensure that appropriate staff are available?** The Department recognizes that offerors have logistic and cost issues to consider for oral presentation and demonstrations. The Department will provide as much advance notice as possible regarding the schedule.
8	3.2.6	3-15	**The Replacement Medicaid System shall provide on-line inquiry, given appropriate access security and password protection, to all system maintained files and data. Access methods must include data element code (both primary and alternate index keys) or name (e.g. Soundex). Is Soundex search capability required functionality?** The requirement is that there be the capability to perform a name search. The contractor may use whatever software will meet that requirement.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 6, 1998

9	3.2.8	3-16	**All transactions accepted by the Replacement Medicaid System must be assigned standard geographic coding (commonly known as geocoding) to accommodate use of transactions by commercial geographic information systems (GISs). Are the geocoding values to use latitude/longitude coding or some other coding scheme (e.g. coordinates offset from a location point, etc.)**
10	3.2.8	3-16	**Has the commercial GIS to be used been chosen yet, and if so which is it?** The Department has not established a standard for a specific GIS; the contractor is expected to propose a GIS. Although latitude/longitude coding is the most popular form of geocoding, the contractor is expected to propose the geocoding that will meet the Department's presentation requirements.
11	3.3.1 Appendix K	3-17 K-2 K-3	**The list of key personnel for the EMEVS takeover and operations includes the Operations/Claims Processing Manager. Appendix K, however, does not provide a corresponding description for this position. Would the Department please clarify its requirements?**
12	3.3.1	3-17 K-2	**Section 3.3.1 Key Personnel for EMEVS takeover and operations includes the Operations/Claims Processing Manager. Appendix K does not include the Operations/Claims Processing Manager as key personnel during the EMEVS takeover (K-2). Does the Department intend to include the Operations/ Claims Processing Manager as Key during EMEVS Takeover and Operation?** Appendix K is correct. The Operations/Claims Processing Manager position was incorrectly included in Section 3.3.1. Revised page enclosed.
13	3.4.2	3-23	**The Department requires submission of a fraud detection and prevention plan 30 days from contract signing, and quarterly reporting thereafter. Would the Department detail its expectations regarding fraud detection and prevention while systems are being operated by incumbent contractors?** The requirement should be for the contractor to submit the fraud and detection and prevention plan within 30 days after start of full Replacement Medicaid System operations and submit quarterly reports thereafter. Revised page enclosed.
14	**3.1.3**	**3-3**	**"TIP" production development is mentioned in line 6, 2nd paragraph. What is TIP?** TIP is the software that the Department uses to access provider and client information in the current system. Under current procedures, OSC uses this software for accessing information about a provider or client. OSC expects to have equivalent capability in the new system.
15	**3.2.1**	**3-5**	**Will the Department consider a Replacement Medicaid System Year 2000 compliant if it utilizes a procedural approach, sometimes referred to as "windowing" as an alternative to including the century in all dates?** The Department expects the Replacement Medicaid System to be Year 2000 compliant in the fundamental architecture. However, the Department will consider alternative approaches to Year 2000 compliancy provided they are consistent with the warranty in Section 11.7.8.

16	3.2.2.5	3-8	**"The New York State Medicaid program will be required to implement policy changes to comply with new Federal requirements. To the extent that these requirements exist at the time of proposal submission, the Contractor will be required to implement these policies as an integral part of the Replacement Medicaid System. Examples include...". Is a full list of the requirements that currently exist or are expected to exist at submission time available, and where are the requirements documented?** The contractor is responsible for ensuring that the Replacement Medicaid System is in compliance with HCFA certification requirements and all other Federal Medicaid rules and regulations in effect at the time of proposal submission. The Department expects the contractor to be familiar with such rules and regulations and to be cognizant of anticipated changes. The known Federal requirements that are in process are the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997. If Congress passes legislation that impacts Medicaid between now and proposal submission, the contractor will be responsible for ensuring that the Replacement Medicaid System is compliant with that legislation.
17	3.2.2.4	3-8	**The Balanced Budget Act of 1997 requires that ... states must provide for electronic transmission of claims and encounter data consistent with the Medicaid Statistical Information System (MSIS).... The Replacement Medicaid System must incorporate those requirements. Where are these requirements documented?** The State Participation Requirements and the MSIS submission specifications can be obtained from the HCFA web site: http://www.hcfa.com/medicaid/m2082.htm.
18	4.2.4	4-3	**This RFP section states that all system hardware will be turned over by the incumbent EMEVS processor to the new contractor. This position conflicts with our understanding that major hardware components are actually owned by the incumbent contractor, and in fact will not be available for turnover. Please provide a comprehensive listing of hardware and software that will be available at turnover of the current EMEVS contract.** The list was provided at the Offerors' Conference and is published in RFP Amendment #1.
19	4.4.2	4-10	**Correction of deficiencies is a part of the contractor's system warranty requirements and is expected to be performed without the use of Department-funded evolution staff. What about existing bugs in code transitioned from the incumbent contractor that are discovered later?** To the extent that the contractor is required to use existing New York State Medicaid systems code (i.e., EMEVS Takeover) existing deficiencies are not subject to the system warranty. However, any component used as part of the Replacement Medicaid System is subject to warranty provisions.
20	**5.2**	**5-2**	**The entire functionality of the Replacement Medicaid System that is needed to achieve Federal certification as of November 1, 2000 must be operational. If HCFA does not certify the Replacement Medicaid System retroactive to November 1, 2000, the contractor shall be liable for the damages to the Department for lost Federal financial participation. The contractor will be liable even if the delay is due to state actions or state-requested scope changes?** The Department will be reasonable. If there is a legitimate reason for adjusting the anticipated certification date, a contract amendment to that effect will be executed.
21	5.3.2	5-3	**Please provide a complete list of the managed care functions that must be incorporated into the Replacement Medicaid System.** Managed care programs, including mandatory managed care has become an integral part of the Medicaid program. The Department expects the system architecture of the Replacement Medicaid System to accommodate managed care programs as readily as fee-for-service programs.

22	5.3.3	5-4	**Is this section a requirement?** **If so, it is unlikely that bidders will assume the same level of effort or expense, which may cause difficulty in evaluating proposals. Would the Department state its business needs and provide further details on the Department's expectations of offerors?** Yes, this section is a requirement. The Department expects the architecture of the Replacement Medicaid System to be able to accommodate multiple programs with different benefit packages in each program, including programs to be added in the future or services to be added to individual benefit packages in the future.
23	6.2	6-2	**The RFP states that the "EMEVS redesign must be completed not later than October 31, 1999 ... and includes elements of the Electronic Commerce component (Section 7.5)." Would the Department please identify these required elements? For example, is real-time adjudication of pharmacy and HCFA-1500 claims as discussed in Section 7.5.3.2.12 required by October 31, 1999?** The elements of the EMEVS redesign that must be operational by October 31, 1999 are, at a minimum, the functional equivalents to what is in the current EMEVS as defined in 7.5.1.
24	6.2.1.1	6-4	**The contractor may propose any design methodology, such as event-driven or object oriented programming, but it must use the system development life cycle (SDLC) as the development methodology. Is this the State's methodology, and if so , is the documentation on the methodology available for review?** SDLC is an industry standard and the contractor is expected to understand the principles of life cycle phasing. The specific phases required by the Department are specified in Section 6 of the RFP.
25	6.2.1.4	6-5	**Our experience suggests that language such as "or other method, at the Department's direction" has resulted in the offeror assuming work well beyond the scope of work. This in conjunction with the many instances of "any", "all", "as needed", "as required" found in the RFP, puts offerors in a position of providing a fixed price for variable scope of service As an alternative to this language, we suggest adding the phrase "as mutually agreed by the Department and the offeror."** **Or, would the Department strike this language and list only requirements that offerors can reasonably scope and price?** The Department recognizes that language such as "all", or "and others as required" create difficulty for offerors to scope and price and has made every effort possible to eliminate such indistinct phrasing. However, the Department is depending on the expertise of the offerors to recommend technologies that will meet the Department's requirements in a cost-effective manner. As the Department and the contractor work together through the Project Planning Task and the JAD sessions, many of the areas in which indistinct language which is necessary in the RFP can be clarified when the Replacement Medicaid System solution is more clearly identified.
26	6.2.1.5	6-6	**"The methodology, including the tasks for the development of the Replacement Medicaid System, are as follows: ...". If the contractor can show that their methodology covers at least as much as the State's methodology, will the Contractor be allowed to use their methodology?** The systems development methodology required in Section 6 is based on lessons learned from Medicaid systems implementations in other states. If the offeror can demonstrate that its methodology will meet the implementation standards and will provide the prudent project management required by this RFP, it will be given due consideration in the evaluation.
27	**6.2.1.5**	**6-6**	**Section 6.2.1.5, Project Management requirements, references Section 6.3.10 for details of the implementation approach for the data warehouse. Section 6.3.10 is not included in the RFP. Please clarify this reference**. The correct reference is Section 6.2.10. Revised page enclosed.

28	6.2.1.9 6.2.8 6.2.8.2.19 6.2.9.2.5	6-10 6-33 6-36 6-38	**The requirement to retain implementation phase staff until certification will greatly increase the implementation price to the Department. This results from the need to retain peak staffing levels, typically many times the maintenance staffing levels, beyond those required to meet certification needs. Would the Department consider amending this language to require that one contractor developer who was involved in the development of each of the 17 components be retained until certification is complete?** **This greatly reduces the number of staff, and cost, while supporting the Department's need during certification. Should additional resources be required the Department can obtain them using the provision of Pricing Schedule F.** **We suggest that this amendment also be incorporated in section 6.2.9.2.5 as the current "as necessary" language subjects the contractor to variable scope for a fixed price.** The Department expects the contractor to comply with the requirements of the RFP in a manner that meets or exceeds the performance standards set forth. In staffing for certification, as in all other areas, the offeror must determine the appropriate staffing that meets the performance standards. For certification, the contractor must provide enough staffing continuity to ensure that the Replacement Medicaid System is certified as of start of operations. None of the citations imply that the contractor retain **all** implementation staffing. The Department does expect, however that the contractor will retain, or make available, sufficient implementation staff to provide the continuity necessary to prepare for and participate in the Certification Review.
29	6.2.1.12	6-12	**Just as the Department is unfamiliar with the capabilities of proposed systems, contractors lack full information on the current system capabilities and must estimate the effort required to satisfy a requirement based on assumptions beyond the information communicated in the RFP and related information. Contractor assumptions are based on marketplace experience - without explicit user input.** **These assumptions and the corresponding work required to meet these needs are documented in the work plan. Our work plans reflect our commitment to properly scope the work and minimize requests for add-on business during implementation.** **However, unanticipated user input during JAD sessions could result in significant changes to the scope of work. To clarify to all parties what work is within the scope of the fixed implementation price, would the Department state that the scope of work defined as a result of JAD will not exceed the contractor assumptions leading to the price bid?** **This approach offers flexibility to make more significant changes than anticipated in one area when changes in another area are less extensive than anticipated. This approach, in conjunction with efforts of the Department, JAD facilitator, and offeror personnel to understand each other's assumptions and seek a mutually agreeable compromise during the JAD sessions, is critical to a fair and mutually beneficial working relationship.** It will require a joint effort by the Department, the contractor, and the JAD facilitator to assess whether the input results in a modification of a requirement, addition of a requirement, deletion of a requirement or clarification of a requirement. Unanticipated user input which occurs during JAD sessions must be addressed with a plan and tracking mechanism.
30	6.2.3	6-17	**Given that the Department is selecting the JAD facilitator, should the offerors assume that these costs are not to be included in their bids?** Yes

31	**6.2.5**	**6-23** **6-24**	**Data of the type mentioned in this task frequently needs validation and cleansing during a conversion process. Will this data be verified and cleansed prior to turning over to the Contractor?** As defined in Section 6.2.5.2.8, it is the contractor's responsibility to design and execute the data conversion process. This responsibility includes: (1) identification of the data to be converted, (2) design of all automated and manual processes for data validation and cleansing, value conversion, and table/file population, and (3) successful execution of these processes.
32	6.2.5.1.10 New	6-24	**Testing of the conversion and processing logic of the Replacement Medicaid System requires timely access to known test data in a non-production environment of interface systems such as WMS. Such test systems need to be partitioned consistently with the Replacement Medicaid System development environment (e.g. unit, system, user acceptance, parallel).** **We ask that the Department include the following responsibility:** **"Create, operate and enhance test environments as required by the offeror in interface systems for testing of the Replacement Medicaid System."** The Department will work closely with the contractor to obtain the resources necessary for a timely and quality conversion effort.
33	6.2.5.1.9 New	6-24	**We ask that the Department include the following responsibility.** **"Participate in definition of conversion logic in circumstances where logic or historic data is inadequate. For example, conversion of a current value into multiple subordinate values (one to many) where historic data does not contain the detail needed to select the appropriate subordinate value."** **We assume that the Department will work with the offeror to achieve a mutually agreeable compromise in such circumstances, and will not require work beyond the scope of offeror pricing assumptions without additional reimbursement.** The State agrees to the specific request to expand the definition of the Department's responsibilities to include participation in the definition of conversion logic where historical knowledge is required.
34	6.2.5.2.4 6.2.5.3.1 6.2.7 6.2.7.1.3 6.2.7.1.9 6.2.7.2.4 6.2.7.2.13 6.2.7.3.2	6-25 6-26 6-30 6-30 6-31 6-31 6-32 6-32	**Are offerors to assume that *test results* means a narrative of a test case, and indication that the test case was satisfactorily completed?** No, test results includes the narrative of a test case, the actual processing result compared to expected result, the changes in the transaction itself based on processing, and changes in files/tables resulting from processing the transaction. The documentation of test results may be provided through reports, screens/windows, and/or file/table queries. In any case, the Department and the contractor will define the contents and documentation of test results as a part of the project planning and definition.
35	6.2.6.3.3	6-29	**To protect the integrity of promoted code and thus system quality, would the Department amend this section to read as "a Department accessible *read-only* access ..."?** The Department will work with the contractor to ensure both system security and the integrity of promoted code. The Department expects the contractor to establish the procedures for code library access and code migration.

36	6.2.6	6-27	**Requiring the implementation manager in every walkthrough will consume that individual's time and effort as well as detract from project oversight and direction responsibilities. During work plan development, could the Department and the contractor agree on which walkthroughs the implementation manager is required to attend?** The Department does not feel that weekly walkthrough sessions are overly burdensome on the Implementation Manager's time. The Department further feels that part of the Implementation Manager's responsibility is to demonstrate to the Department's satisfaction that the implementation is proceeding on schedule and in a quality manner.
37	6.2.6 6.2.6.1 6.2.6.5	6-27 6-28	**Readiness, or likelihood to perform as desired, is best measured by outputs. Review of source code requires the very skills that the Department is acquiring through this procurement. To confirm that the offeror is completely prepared, we ask that the Department replace this paragraph with the following:** **"Each walkthrough will assert that the required modules have been constructed and unit tested through provision of checklists. Developers will demonstrate a number of test cases consistent with the time provided with the walkthrough and the available test resources."** **Would the Department also amend the State responsibilities to be consistent with the above recommendation?** In Section 6.2.6.6, the Department requires the contractor to conduct walkthroughs of deliverables. The Department expects the walkthroughs to be structured, informative and a mechanism for the Department and the contractor to assess adequacy of construction of the Replacement Medicaid System. The Department encourages the offerors to recommend the structure of the walkthroughs.
38	6.2.7	6-29	**The Department's desire to exercise previously undefined test case introduces the possibility for considerable project delay. It also discourages comprehensive definition and review of test cases when they are developed. In the spirit of the Department's acknowledged quality focus, and with the intent of "getting it right the first time." we ask that the Department remove this requirement or limit it to no more than 1 percent of defined test cases (genuinely overlooked test situations).** **Our experience also suggest that such new test case are frequently revisions to specification. Are the offerors supposed to assume that these circumstances will be flagged as out of scope in the tracking system? Incorporation of this functionality will then require additional reimbursement and schedule revisions without penalty or postponement to the Evolution task of the operations phase of the contract.** If the integrated system test is fully comprehensive, the contractor should have no concern over the introduction of previously undefined test cases. The Department expects the contractor to prepare a comprehensive test plan for the purpose of ensuring that the integrated system test is complete and comprehensive before start of testing.
39	6.2.7.2.8	6-32	**It is important that the acceptance test environment and related test data remain "in sync." With the number of testers and test cases expected, ad hoc execution of batch jobs can adversely effect other tester's results, which will lead to rework.** **We ask that the Department revise this section as follows:** **"Initiate batch job streams per the cycle schedule defined during acceptance test planning to support acceptance testing."** The original RFP language meets the Department's requirements.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 6, 1998

40	6.2.8	6-33	**Would the Department define *transaction history* as it is used in this section?** The term "transaction history" in this section and as used throughout the RFP is the same. When all processing steps are complete for a transaction (e.g., paid or denied claim), the electronic record of the transaction is stored in a history file/table.
41	6.2.8.2.9	6-35	**To comprehensively define possible media and prevent changes to media between conversion and implementation, we ask that the Department revise this section as follows:** **"Files/data may be magnetic tape or *cartridge*, disk, diskette, *electronic file transfer*, or paper as *defined during the conversion task*."** The original RFP language meets the Department's needs.
42	6.2.8.2.13 6.2.10.5.3	6-35 6-47	**Training is a critical element of the project, and one that can vary significantly in scope and cost. To facilitate the evaluation process, would the Department strike this language and list the training required and the numbers and skills of personnel to be trained? Offerors will then be evaluated on a consistent training expectation, and will have the opportunity to add value through training that exceeds the Department's requirements.** **We recommend that the Department ask offerors to describe their training plan in terms of numbers of attendees, prerequisite skills levels, number of classes, class abstract, and duration of classes.** **Would the Department incorporate similar changes into the Data Warehouse training section?** The details of the solutions to be proposed by the offerors are currently unknown to the Department. The contractor is expected to provide the expertise to determine the training requirements of the proposed solution(s). In addition, there are a wide variety of skill levels within the State, beyond the three skill levels defined for Medicaid data warehouse users; the contractor must develop a training plan for Department approval. The original RFP language meets the Department's requirements.
43	6.2.8.2.11	6-35	**Given changes incorporated during the development of the Replacement Medicaid System, it is unlikely that controls totals will balance to those of the systems being replaced in the sense that five transactions in the replaced system correspond exactly to five transactions in the replacement system. Are offerors to assume that *balance* means to demonstrate that data has been converted according to specification?** Although the Department recognizes that "five transactions in the replaced system [do not] correspond to five transactions in the replaced system", the contractor will be responsible for developing a balancing process that provides assurance that all data has been converted and that the new system is operating properly.

44	6.2.8.1.10 New	6-35	**Implementation is a particularly critical and demanding time in the systems development life cycle. As in any circumstance, different stakeholders have differing priorities and demands. It is critical that the Department take the lead in resolving conflicting interests since no other stakeholder has the authority to do so.** **We ask that the Department add the following responsibility:** **"Mediate and resolve with appropriate urgency conflicting demands of the incumbent contractor, Replacement Medicaid System contractor, contractors, and State personnel working on other State systems that interface with the Replacement Medicaid System."**
45	6.2.8.1.11 New	6-35	**Recent experience suggests that a large portion of implementation and post-implementation problems can be avoided when the Department and its contractor clearly communicate programmatic changes and engage stakeholders in adopting that change by promoting their understanding of the value it brings them.** **We ask that the Department add the following requirements:** **"Notify, with support from fiscal agent provider personnel, provider community, and other program stakeholders - other State agencies, legislative bodies, etc. - of changes in program policy and interface requirements."** The Department recognizes that clear and honest communication between the Department, the Replacement Medicaid System implementation contractor and the quality assurance contractor throughout the entire implementation phase is critical to success. The Department also recognizes that an adequate assessment and prioritizing of changes is a joint responsibility. That fact is recognized in the following quote from Section 6.2.1.12 of the RFP. *Without advance knowledge of the capabilities of the transfer base to be proposed by the successful offeror, the extent to which that transfer base can meet the requirements specified in this RFP without extensive modification is unknown. The contractor, by submitting a proposal in response to this RFP, is charged with presumptive knowledge of the level of effort to accomplish the tasks described in this RFP.* *The Department recognizes that, with the passage of time between proposal submission and completion of JAD and with the dynamics of the program, changes may occur in the scope of the Replacement Medicaid System as presented in this RFP. Such changes may include additions, modifications, or deletions of requirements. It shall be a joint responsibility of the contractor and the Department to maintain requirements traceability and change control tracking documentation to help in assessment of whether a modification to the contract is necessary*.
46	6.2.8.3	6-36	**Is this sentence intended to read "each Replacement Medicaid System *component* will be based ...".** Yes. Revised page enclosed.
47	6.2.9	6-37	**It is not uncommon for a contractor to be directed by a State to incorporate processing inconsistent with certification guidelines. As such, it is unreasonable to hold the contractor liable. To afford the Department the flexibility to proceed with the knowledge that there is certification risk, we ask that this paragraph be amended as follows:** **"The contractor shall ensure, *unless as directed otherwise by the Department,* the replacement Medicaid System ...".** The Department disagrees with the premise of the question. Because of the critical nature of Federal Financial Participation to the states for implementation of certifiable MMISs, states are especially concerned that such systems are certifiable. The Department expects the contractor to provide the expertise to ensure that the system at least meets HCFA certification requirements.

48	6.2.9.2.7	6-38	**The use of the word *any* subjects the contractor to liability for other parties' actions. We ask that this sentence be amended as follows:** **"Provide additional materials needed to resolve post-review corrective actions as a result of the contractor's failure. Other support related to post-review corrective action shall be provided as part of the evolution task or through mutual agreement of the Department and contractor."** The Department agrees that the use of the term "any" imposes excessive responsibility on the contractor. However, this question is related to the HCFA Certification of the Replacement Medicaid System for which the contractor is expected to provide the expertise for ensuring that the Replacement Medicaid System is compliant with HCFA requirements. The Department will change the wording of Section 6.2.9.2.7 to read, "Provide the materials needed to resolve post-review corrective actions." Revised page enclosed.
49	6.2.10 paragraph 1	6-39	**Having an accurate understanding of, and access to, source data is a critical success factor in the development of the data warehouse. Multiple parties will be involved in this effort and will likely have conflicting priorities. As such, the Department must assume the role of ensuring that other parties to the effort do not adversely impact the schedule or definition of the data warehouse.** **We ask that the Department amend this paragraph to read:** **"The scope of work ... . The Department shall take responsibility for providing policy direction and guidance to the contractor ... . The Department is also responsible for seeing that source data and definition is provided to the contractor in a timely manner by the Department's contractors and employees."** While the Department recognizes that a contractor cannot be held to a schedule unless all parties meet their respective schedules, the Department and the contractor both have a role in ensuring that the respective schedules are met. This recognition applies to other components of the Replacement Medicaid System, as well. The original RFP language meets the Department's requirements.
50	6.2.10	6-39	**The approach envisioned by the Department extends more than 15 months. During this time, systems that provide source data to the warehouse will undergo change. Would the Department agree that any change in source data after definition is finalized will be flagged as out of scope in the tracking system? Incorporation of this functionality would then require additional reimbursement and schedule revisions without penalty, or postponement to the evolution task of the operations phase of the contract.** The concern expressed here is not limited to the Medicaid data warehouse component of the Replacement Medicaid System as implied by the question; rather it applies to the entire Replacement Medicaid System implementation. As stated previously, both the contractor and the Department have a joint responsibility to manage requirements traceability and to assess the impact of any change in data definition or functional requirement and determine how to address that change.
51	6.2.10.1.1	6-40	**"The information and analytical needs include more than the Department staff involved in the day-to-day program analysis. In addition to Department staff and such users as OMH, OMR/DD, and OASAS, Medicaid data warehouse users will include...". Is this a complete list of additional user areas that will be providing SMEs [subject matter experts] and sponsors, and if not, is a complete list available?**
52	6.2.10.1	6-40	**Would the Department define the user groups by reference or by incorporation of a list?** The contractor must consider that everyone in New York State government who has a need for Medicaid data is a potential user of the Medicaid data warehouse. Specific requirements, such as the number of users and number of concurrent users are defined in Section 8.3.2.1.

53	6.2.10.1.4	6-43	**Where is the Replacement Medicaid System Business Design Deliverable defined?** Section 6.2.3.2.5
54	6.3.2	6-49	**The RFP makes a distinction between system maintenance and system evolution and further states that under certain circumstances, system maintenance will be the responsibility of the Contractor.** **Will the Department provide estimates of the amount of maintenance resource that has been used the current EMEVS and MMIS systems?** **Alternatively, would the Department agree to a fixed system maintenance staff?** The maintenance resources used in the current systems environment may not be relevant to the maintenance requirements of the Replacement Medicaid System since the operational environments will likely be different. Maintenance is a contractor responsibility and therefore the contractor should determine the resources required for maintenance.
55	6.3.2	6-49	**The Department defines systems maintenance as one of two conditions expressly using language *operational improvements* and *operational efficiency*. Would the Department elaborate on what it means by these terms specifically addressing *operations* - operation of the system, such as breaking a big job stream into component pieces that can run parallel to complete a cycle in the available window of time, or operations activities like keying claims?** Operations refers to operations of the Replacement Medicaid System and performance of fiscal agent contract responsibilities.
56	**6.3.2**	**6-49**	**Under System maintenance, the first bullet defines an example of system maintenance to be "Activities to correct a deficiency within the operational Replacement Medicaid System, including deficiencies found after implementation of modifications." This bullet further states that "Correction of deficiencies is a part of the contractor's system warranty requirements and is expected to be performed without the use of Department-funded Evolution staff.** **It is not clear what the Department's intent is for this stipulation. As a practical matter, it would seem to make more sense to allow the same staff that will be assigned responsibility for the Replacement Medicaid System, that is Evolution staff, to also be responsible for all changes to the system, regardless of the reason or cause for the change. This would provide the advantage of allowing experienced staff who are most knowledgeable of the system to respond to any and all needed system changes/corrections in the most efficient and timely manner as possible. It would also avoid the unnecessary procedure of having to coordinate and control systems changes stemming from two different sources.** **Would the Department consider a timecard differentiation between system maintenance and system evolution to allow Evolution staff to do all the work associated with the Replacement Medicaid System while tracking and accounting for maintenance separately? This solution would allow for maintenance effort to be deducted from monthly Evolution billings, requiring the financial burden of maintenance, as defined, to pass to the contractor.** The Department will consider recommendations that will meet the Department's objectives.

57	6.2.1.4	6-5	**"The electronic versions of the documentation shall be accessible to users on-line through a PC-accessible bulletin board, CD-ROM technology, Internet Web site or other methods, at the Department's direction... The contractor will maintain and update all documentation in accordance with Department defined criteria." Which of these methods of access are required, and where are the Department-defined criteria documented?** All of the methods mentioned may be required. The contractor's responsibility is to propose documentation design, content, accessibility and updating methods for Department approval. Criteria will be finalized during JAD.
58	6.2.1.4	6-5	**Would the Department provide the opportunity for offerors to suggest alternative media that enhance communication or improve cost/benefit performance?** The Department is relying on offerors to propose technologies that will improve the New York State Medicaid systems and operations in all areas, including systems documentation. Recommended documentation media and formats must be approved by the Department.
59	6.3.2 bullet 1	6-51	**Would the Department remove the word *substantial* since the first bullet of this section defines what constitutes a modification and the word *substantial* is highly subjective**? The RFP language meets the Department's requirements.
60	6.3.2.5.9	6-57	**Would the Department clarify why maintenance activities such as correction of a deficiency are incorporated in this evolution task section?** All documentation (systems, operation, and user) must be updated with all changes, whether due to maintenance or due to evolution.
61	6.3.4.4.3	6-60	**The requirement represents a substantial amount of work and thus cost. Would the Department revise this section by replacing the introductory phrase "As requested, but no less frequently than annually" with " No more than once during the base period of the contract"? Our thinking is that such information is needed for the purpose of turnover and that conducting this activity more frequently either adds cost or distracts resources from higher priority activities.** The RFP language meets the Department's requirements.
62	6.3.4.5	6-61	**Are the "turnover provisions" mentioned here those mentioned elsewhere in Section 6.3.4?** Yes.
63	7.1.3.3	7-26	**Reference is made to a file which is made available to the State by Medispan. Will the Contractor be provided with this Medispan file by the State, or should resource provisions be made in our proposal to procure such a file directly from Medispan?** We currently have a contract with Medispan (for the next three years). The files are sent to the State (DOH Pharmacy Unit) where they are manipulated and then sent to the contractor for processing. The contractor is expected to contract for these services as an agent of the State.
64	7.3.1	7-41	**The RFP states, "The contractor shall provide an increased emphasis on communication with providers through professionally developed and published provider manuals and bulletins."** **Does the Department intend this wording to require the use of an outside publisher, or can the contractor use appropriately qualified internal staff to meet this requirement?** The Department requires professional -looking communications. The offerors are encouraged to propose cost-effective means of meeting the requirement.

65	7.3.2	7-42	**Our understanding is that the file which contains the history of provider eligibility and Rate determinations are extremely large paper files which occupy nearly 300 full-size filing cabinets. Will the contractor be required to take over maintenance of these files, and to provide floor space, personnel and storage for these documents?** Yes.
66	7.3.2	7-42	**Our understanding is that current provider enrollment functions described in this RFP section are performed by state personnel. Please provide the number of full time equivalents of state personnel who have worked on this function, by month, for each of the past 12 months.** Ten (10) FTE staff are used to handle rate-based provider enrollment. For fee schedule-based providers, the Department has used eleven (11) full-time staff for the past twelve months supplemented by three (3) full-time contract staff and for the past quarter, and additional five (5) full-time contract staff were added. However, the Department expects the contractor to re-engineer these functions to be more efficient.
67	7.3.3.2.13 7.5.2	7-44 7-68	**In these sections and several others in the RFP, reference is made to an Electronic Funds Transfer approach for effecting provider payments, yet we do not seem to find any specific requirements for implementation of such a capability. Is the Contractor expected to include EFT as part of its Technical solution? What is the implementation date? Will participation by all enrolled providers be mandatory? If not, what portion of the enrolled providers should be assumed by bidders to be subject to continuing generation of manual checks?** The contractor is expected to include EFT as part of its proposed solution (see Section 7.7.3.2.1). The implementation date is concurrent with the implementation of the Claims Processing and Financial Management components of the Replacement Medicaid System. Participation by providers will <u>not</u> be mandatory. The expected degree of use by providers is unknown.
68	7.3.6.30	7-54	**Will all out-of-state providers be required to enroll in the NY Medicaid Program, and use N.Y.S. required claim/format/forms for submission for processing?** Yes.
69	**7.3.6.30**	**7-54**	**In order to process claims from out of state providers, does the Contractor need to establish a separate staffing resource to process these claims, or will such claims be subject to the same processing controls and procedures used for in state providers?** The out-of-state providers once enrolled, would submit claims via the normal payment process. The enrollment of such providers may be handled as a separate process at the contractor's discretion.
70	7.5.3.2.1 bullet 2	7-69	**In this section, the requirement is to provide information regarding prior authorization/service authorization information. Does this refer to on-line authorization of requests for special-situation medications and services, or does it refer to responding with the need to request the prior authorization for the pharmaceutical or service?** The Electronic Commerce component will be designed to meet the existing and future needs for supporting the Utilization Threshold, Post and Clear, and medical and other service authorization needs through direct electronic interaction with the providers.
71	7.5.3.2.5	7-70	**What types of communication lines must be provided at no charge? Is this referring to an 800-line for modem transmission of on-line real-time pharmacy claims?** There must be a toll-free access for ARU, PC dial-up, and POS devices (e.g., TRANZ 330). The cost of dedicated lines for CPU to CPU is a provider cost.
72	7.5.6.7	7-75	**Does this include switch or VAN charges to providers?** No.

73	7.6.3.2.22	7-82	**The RFP states that during Purge Runs the system processes claims over 2 years old against 6 years of claim history and 9 years of Clinic history. Does the State want to maintain 9 years of Clinic history?** Yes.
74	7.12.6.13	7-140	**Is this requirement intended to support dispute resolution for the past seven to eight years?** No, since dispute resolution will remain a Department responsibility. This requirement is to get historical data into electronic format for use by the Department.
75	7.14.1 Overview	7-141	**If a DUR warning ("alert") is sent does the claim deny or pay?** Warnings are merely that, and permit payments. "Denials" result from drug to drug Level 1 interactions, therapeutic duplications or exact claims. Pharmacists must utilize NCPDP overrides to fill the prescription in the presence of these "deny" messages.
76	7.14.3	7-142	**Who are the Department-approved PRODUR contractors?** ProDUR is comprised of First Databank data modules integrated into the EMEVS maintained by the current contractor, DEPS.
77	7.14.1 Bullet 8	7-142	**Will all user-defined additional ProDUR screenings be supported by commercial drug database, such as First DataBank?** Yes, all data modules are supported by commercial drug databases and selected and monitored by the State DUR Board.
78	7.14.3.3.7	7-144	**Will all sort capabilities be determined by data elements submitted on the NCPDP pharmacy claim form?** All sort capabilities will be based on data elements available in the Replacement Medicaid System.
79	7.14.3.3.5	7-144	**Would the Department define *service authorization*?** Service authorizations are defined in Section 7.8.
80	7.14.3.2.2 Bullet 10	7-144	**Will user-defined DUR alert modules be supported by a commercially available drug database?** Yes, user defined DUR modules will be supported by a commercial available drug database, (currently Medispan is used by NYS).
81	7.15.1 Paragraph 2 Bullet 10	7-147	**Will user-defined criteria be supported by a commercially available drug database?** That is the Department's expectation.
82	7.15.1 Paragraph 4 Bullet 14	7-147	**OBRA 90 does not include Micromedex drug database. Is it acceptable to use predetermined criteria and standards based on the OBRA 90 requirements - USPDI, AHFS, and AMA Drug Evaluations?** The Department will consider any recommendation that provides cost-effective opportunities to meet the Department's objectives. DUR reference requirements previously identified in OBRA '90 have been changed and currently include Drugdex (a component of MicroMedex).
83	7.16.6.6	7-157	**This RFP section makes reference to audit software packages that will be needed by the Department and the Office of the State Comptroller. Please provide a comprehensive listing of the software packages to be operated as part of the Replacement Medicaid System. Is the Contractor responsible for procuring these packages, or will they be provided by either the Department or OSC?** Under the current contract, OSC has access to Easytrieve Plus software which is used to read and extract information from the system. OSC expects the new contractor to provide OSC access to the software it uses to read and extract information from the data files/tables under the Replacement Medicaid System. OSC expects to have the same accessibility to data as is currently available and expects the contractor to provide the software.

84	8.3	8-7	**Facilitating the linkage of Medicaid enrollment data with other enrollment data on the same persons; for example, the data warehouse must enable the Department to follow children who move between Medicaid and other Health care programs. Do all of the systems to be linked use the same unique identifier for people, and if not, how will the matching be accomplished?** The contractor is expected to provide expertise in the design of solutions to this requirement. Certainly the individual identifier requirement of the Health Insurance Portability and Accountability Act will be a part of the solution.
85	8.3	8-7	**Under General System Requirements, the RFP requires bidders to "integrate" managed care encounter data and fee-for-service data. what are the requirements of this integration? Does this mean complete analytical processing and data mining capabilities between the new Medicaid Data Warehouse and the existing Managed Care Warehouse, or simply access capability to both?** The Medicaid data warehouse shall maintain analytically-ready data for all data processed by the Replacement Medicaid System, including both managed care encounter transactions and fee-for-service claim transactions. This analytically ready data must be available within the Medicaid data warehouse for all access, presentation, and data mining tools. The Medicaid data warehouse must also be able to be a source of data for the Managed Care data warehouse as specified during JAD. The contractor will not be required to provide access to both data warehouses simultaneously; each data warehouse will have its own access capabilities.
86	8.3.1	8-8	**Please provide a list of the user sites that will use the Medicaid data warehouse and the number of users for each site.** The user sites are unknown at this time and could change during the course of the contract. The number of users and number of concurrent users are identified in Section 8.3.1.2.
87	8.3.1.2	8-10	**Exhibits 8.2 and 8.3 indicate the concurrent number of users broken down by level of user. Are the numbers for each level provided for estimation purposes only, or is there an implied requirement that the number of concurrent users be capped by the system at the level of user even though the total number of concurrent users may not have been reached?** The estimate of users for each level were provided for offeror convenience. The Department expects to support up to the total number of users and concurrent users.
88	8.3.1.2	8-10	**Section 8.3.1.2 indicates the total authorized and maximum concurrent number of data warehouse users. What is the breakdown of users for the two required data marts?** That breakdown has not yet been determined
89	8.3.5	8-15	**The RFP states that "mirroring of detail data layer" is required. Can the offeror consider Raid-5 as an option instead?** The Department will consider any recommendations that meet the Department's needs and requirements.
90	8.4.3	8-18	**What are the retention requirements for data archived off the data warehouse and data marts? How long is archived data required to be retained? Also, what are the retrieval requirements for data that has been archived? Are there required retrieval time frames that must be met, such as 24-hours or 48-hours a week? And finally, what is the limit to the amount of data that can be recalled at any given time frame?** The Department has not specified time limits on the retention of archived data; therefore, the archives are retained indefinitely. The Department expects the contractor to propose retrieval time frames that are consistent with the Department's stated requirements and performance standards and that are consistent with efficient and effective operations.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 17, 1998

91	8.5.5.2 MAR	8-24 to 8-25	**Is it the intent of the Department that the DSS have the capability to produce MAR reports, or does the Department require that all MAR reports in Appendix F be produced by the contractor on day one of implementation?** The Department expects all MAR reports listed in Appendix F to be available as of day one of implementation. For that reason, the Department is requiring the contractor to takeover the existing MAR system. Because it is the Department's desire to migrate MAR reporting to the Medicaid data warehouse, the Department expects the contractor to develop a solid, workable plan for migration of MAR reporting.
92	8.5.6.1	8-27	**The contractor shall provide a methodology platform that is acceptable to both clinicians and administrators. Which clinicians and which administrators? How will acceptance be determined?** Acceptability for Medicaid data warehouse presentation requirements will be the same as all other aspects of the Replacement Medicaid System. The contractor will finalize requirements with users and propose final design elements to the Department. Upon approval of these design elements, the contractor will proceed with construction and implementation.
93	9.2 Appendix I	9-1 I-2	**Are we under the correct assumption that the technical Proposal will include 11 tabs, and that the Mandatory Requirements in Appendix I require the 11 tabs listed?** Section 9.2 requires the Technical Proposal to have 11 Sections (preferably tabbed as implied in this question). As a part of the review of mandatory requirements, using Item 6 on the checklist in Appendix I, evaluators will determine if the submitted proposal does have 11 Sections.
94	**9.2**	**9-2**	**The paragraph at the top of the page is a bit confusing. We believe your intent is for the bidder to include the Table of Contents and the RFP Cross Reference at the beginning of each section to facilitate the review process. Is our understanding correct?** Yes.

95	9.2.2 Appendix I	9-3 I-3	**Section 9.2.2 requires "a cross reference from each subsection of sections 6, 7, and 8 of this RFP and related RFP addenda to the appropriate section and subsection of the Technical Proposal."** **Appendix I: Mandatory Requirements Checklist, however, requires "a cross-reference from each section, and subsection of the offeror's Technical Proposal back to the appropriate subsection of sections 5, 6, 7, and 8 of the RFP and Addenda."** **Please clarify the cross-reference requirements, Is the RFP requesting two separate cross-references, one by RFP requirement and one by the organization of the proposal itself?** The second section of the Technical Proposal shall contain a Table of Contents of the Technical Proposal. It shall also contain a cross reference from each subsection of RFP Sections 4, 6, 7, and 8 to the appropriate section of the Technical Proposal. The "approach" sections of the Technical Proposal shall also have a cross-reference from appropriate subsections of RFP Sections 4 , 6, 7, and 8 to the appropriate subsections of the proposal section. The relevant proposal subsections are: Approach to Takeover and Operations of Current EMEVS Approach to Replacement of the Medicaid Systems Approach to Operations of the Replacement Medicaid System Approach to the Medicaid Data Warehouse Approach to Implementation of Optional Components Approach to Quality Management and Customer Service
96	9.2.4	9-4	**The tabbed section "Response to Mandatory Requirements," states that "the offeror shall use the mandatory requirements checklist in Appendix I of this RFP to facilitate a response.** **It appears that Appendix I is intended for evaluators only, as an initial checklist to be used in evaluating responses. Is including Appendix I in Tab 4 of the Technical Proposal intended only to facilitate an evaluator's initial review of an offeror's response, or are offerors required to provide any additional information on this form?** The form in Appendix I is intended as an evaluator's tool. The Department felt it was important for the offerors to see the actual tool for review of Mandatory Requirements. In preparing the Response to Mandatory Requirements section of the proposal, offerors may use any format they feel will accomplish the two objectives: (1) assure the offeror that all mandatory requirements are met in the proposal and (2) facilitate the evaluator's review of proposals for mandatory requirements.
97	9.2.6.2 Exhibit 9.1	9-9	**Does the Department envision that the design and scope of all MMIS components will be completed and approved prior to construction of any portion of the MMIS?** Yes. The overall design and scope of all Replacement Medicaid System components will be defined in the Medicaid System Business Design Document. Approval of this document by the Department as the final step in JAD will permit the contractor to proceed with the phased implementation. As described in Section 6, the Technical Design for any single component must be completed and approved before the contractor commits significant resources to construction. However, Technical Design of a late phase component (e.g., Claims and Encounter Processing) does not have to be completed before Construction of an earlier component (e.g., Service Utilization Management).

98	9.2.6.2 Final Paragraph	9-9	**We assume that where the RFP instructs bidders to "address the integration of the approach to transition (as required by Section 9.2.5.3) with the approach to implementation required by this section," the intended reference is Section 9.2.6.3. Is this assumption correct?** The correct reference is 9.2.6.3. Revised Page enclosed.
99	9.2.11.2	9-25	**One thought you may want to consider pertains to Section 9.2.11.2 on page 9-25 which simply asks for "List of all lawsuits within the last five (5) years related to any large systems implementation, any claims processing, or other operations...".** **Given the fact that many MMIS contract defaults are settled without a lawsuit, you might want to consider asking, as other states have learned to ask, for a "list ... of any contractual disputes, penalties imposed, out of court settlements, liquidated damages, contract defaults, cancellation of contracts or components of contracts for cause, lawsuits/litigation (pending or past) within the last six years related to MMIS or any claims processing or other operations or implementation including names of all parties, nature of the complaint, status or final disposition, and potential impact on the MMIS contract." (from Alabama 1998 MMIS RFP).** The proposal submission requirement listed in Section 9.2.11.2 meets the Department's evaluation requirements.
100	Appendix D	D-1 to D-12	**Will the Department allow offerors to reproduce Forms A through F for submission purposes?** Yes, provided the submitted forms appear identical to the forms included in the RFP.
101	Appendix D Forms E & F	D-9 to D-12	**Both Forms E and F include instructions that offerors are required to include these forms in their proposals. However, Section 9 contains no direction on where the completed forms should appear. Where are offerors to include these forms?** These forms shall be included along with Forms A through D as instructed in Section 9.2.11.1.
102	7.5.4.1 Appendix E	E-4	**The RFP states as a requirement "Maintain the electronic interface ... (24) hours a day, (7) days a week."** **Are bidders to assume that there will be agreed upon scheduled system downtime?** No, the electronic interface for inquiry, verification, and adjudication must be available to the provider twenty-four (24) hours per day, seven (7) days per week.
103	Appendix J	J-1	**Is there a complete list of detailed requirements and business rules from all the systems whose functionality will be incorporated into the Replacement Medicaid System (including the existing MMIS and EMEVS functionality)?** They will be found in the Request for Proposals for a Replacement Medicaid System and related materials found in the Procurement Library.
104	Appendix J	J-1	**In Appendix J, under the 2nd bullet under "Future Option", the RFP states that proposed format should follow the requirements of Section 9.2.8. This section describes the approach of the Medicaid Data Warehouse. Should the reference 9.2.8 be 9.2.9?** The appropriate reference is 9.2.9. Revised page enclosed.
105	**Appendix J**	**J-3**	**The item that states "Provide coordination within networks to identify complete scope of services which clients have received." is listed as a "future option" for which bidders are encouraged to provide "suggestions". Please clarify what "networks" are being referenced here, and how a bidder would obtain enough information about these networks to propose a solution.** The networks refer specifically to the capitated networks to be developed under HIV Special Needs Plans. The SNP RFA has not been released so a conceptualized response would be appropriate.

106	**Appendix J**	**J-6**	**Regarding the item: "Develop a preadmission certification process for elective surgical procedures wherein evidence of the certification/approval is identifiable before payment. (It is expected that this process may exist on a demonstration basis under the current contract)"** **Does this item imply that medical review staff would need to be provided for this function, or is it just an extension of the prior approval process? Please clarify the parenthetical sentence.** This is an extension of the prior approval process. The Replacement Medicaid System contractor would not be responsible for medical review of clinical decision-making with regard to preadmission review. System support is necessary to ensure that claims are not paid for admissions that were not reviewed or approved.
107	Appendix J	J-6	**The seventh item down from the top of the page calls for features which would generate postal savings. According to the RFP, this would be addressed in the JAD sessions. If this feature requires additional software and/or equipment, will the State provide this additional software/hardware to the Contractor? Also please address this issue on a broader base, will the financial impact of decisions made in JAD sessions be borne by the Department?** The Department expects the contractor to operate the mailroom services in a cost-effective manner as a part of the fixed administrative fee. The Department will work closely with the contractor to assess the impact of JAD decisions as specified in Section 6.2.1.12.
108	Appendix K	K-1	**There are several references in Appendix K to personnel that only have to be on-site part time in Albany if the data center is located elsewhere. It is not clear if these people still have to be full-time on the contract, but spending part of their time off-site, or if they can be part-time on this contract and part-time on other work? Please clarify.** All key personnel identified in Appendix K and other sections of the RFP must be full-time on the contract. If the contractor's computer facility is locate at a site other than Albany, certain key personnel must spend time at that site as well as the Albany business site. These references are intended to provide the contractor with flexibility to allow these personnel to perform their roles appropriately.

Question Number	RFP Reference	Page	Question and Response
109			**Retrievals. Is there a requirement to pull original paper claims for the OSP and if so what are the volumes and turnaround requirements?** Yes. Volumes for the period January 1997 through November 1997 are in the monthly operating reports. Performance standards are set forth in Section I.C.1.c of Appendix D of the MMIS contract. The operating reports and the MMIS contract are available in the procurement library.
110	General		**To assist offerors in assessing the current environment and the degree of change envisioned by the Department, would the Department provide a table of requirements indicating which requirements are within the current contractor's scope of work, which requirements exceed current scope, and which requirements are newly introduced with this procurement?** The documentation of the New York State EMEVS and MMIS, along with the previous RFPs are available in the Procurement Library.
111	General		**We have a question about the permissibility of direct and/or indirect charges to providers and switching companies. Specifically, does New York prohibit the MMIS contractor from charging providers for extra services or receiving secret rebates from switch vendors? It is the practice in some states to permit the MMIS contractor to provide additional services like electronic funds transfer or electronic remittance advices to providers for additional fees. Some states, perhaps unknowingly, permit the MMIS contractor to negotiate secret rebates from switch vendors in exchange for permitting the switch vendor access to the MMIS contractor's data files for eligibility inquiries, claims status inquiries, etc. Other states, realizing that excessive hidden costs to providers and switches can ultimately deter provider participation in Medicaid and so reduce access to health care for recipients, prohibit these extra charges and rebates. If New York wishes to attract adequate MMIS competition, it is important that these extra provider and switch charges be prohibited or at least limited and made public.** New York State prohibits such extra charges, fees, and rebates with providers or provider service organizations. No organization may have access to any data held by the contractor without express written permission from the Department.
112	1.1.3 Paragraph 1 Bullet 2 (4.5.2) 4.3.2 3.2.2.1 5.3.5	1-3 (4-17) 4-6 3-6 3-7 5-5	**HIPAA was to have published new standards for most transaction sets and related code sets in February 1998, but did not. The RFP requires that offerors meet those unpublished standards. Since it is unlikely that bidders will uniformly assume the same level of effort or expense from what is now an open-ended requirement, this requirement will ultimately complicate the State's evaluation of each proposal. In addition, this approach will force contractors to price for unknown and unforeseen situations. This ultimately will result in inflated pricing to the State. In the absence of specific HIPAA requirements, would the State please consider adding wording that quantifies these requirements? During the bidder's conference the intimation was that offerors' bids were required to accommodate HIPAA rules in effect at the time the bid was submitted. Will the State amend the RFP to incorporate this "in effect at the time of submission" thinking?** Section 3.2.2 states, "The New York State Replacement Medicaid System must be in compliance with the national standards as prescribed by the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 and any other Federal requirements that are effective as of the date of the offeror's proposal."

113	3.1.2 3.1.3 3.1.4 3.1.5 6.2.1.7	3-1 3-3 3-4 6-8	**These sections specify workstations for various State staff. In some cases, the number of workstations in the introductory paragraphs do not match the total numbers mentioned in the bulleted items. What are the exact counts of workstations to be provided by the Contractor for each of these five functional areas?** Contract Management Staff: 11 workstations for on-site staff (4 private offices, 6 partitioned work areas, and 1 secretarial); plus three work stations in a common area and one workstation in a conference room. Total workstations: 15. Office of the State Comptroller Staff: 30 workstations. Quality Assurance and Audit: 30 workstations Implementation Facility: 13 workstations for on-site staff (2 private offices, 11 partitioned work areas); plus three workstations in a conference room. Total workstations: 16.
114	3.1.2 3.1.3 3.1.4 3.1.5 6.2.1.7	3-1 to 3-4 6-8	**These sections refer repeatedly to "data lines" that must be provided for each workstation location in addition to LAN connections. What is meant by this term? Does it refer to a modem line? If so, can the requirement be satisfied by a shared modem facility through a server?** The requirement is that the State personnel assigned to the contractor site must be able to access Department and/or OSC LANs from the on-site workstations. The Department will consider contractor recommendations for meeting the requirement.
115	3.2.2.5	3-8	**Does the State expect to implement the Child Health Insurance Program (CHIP) in Medicaid?** The State's Title XXI plan as filed and approved by HCFA, does not implement the CHIP in Medicaid. However, pending legislation may move some portion of the CHIP eligibility to Medicaid.
116	3.2.3.3 bullet 4	3-10	**The execution of programs in the production environment puts the vendor's ability to meet response time performance standards outside of the vendor's control. Will vendors have the option to remove these programs in the event that such degradation is observed? Can we also assume that these programs will be subjected to all testing and promotion standards, and that the Department will review the test results with the vendor prior to promotion?** These programs will be subject to promotion standards proposed by the contractor and approved by the Department. The contractor may not unilaterally remove such programs for any reason without Department approval. The Department will work with the contractor to ensure that the Replacement Medicaid System operates efficiently and effectively.
117	3.2.5	3-12	**Does the Department intend that both the RMS and the Medicaid DW must be available at the alternate site in the event of a catastrophic event?** The Department does <u>not</u> require that both the Replacement Medicaid System and the Medicaid data warehouse reside at the same off-site location, but both must meet the off-site backup and disaster recovery requirements.
118	3.2.7	3-15	**Will the contractor be required to utilize an existing service agreement between the Department and an Internet Service Provider (ISP) or will the contractor be responsible for providing such access?** It is the contractor's responsibility to provide access as specified in Section 3.2.7. Thus, it is the contractor's responsibility, as an agent of New York State, to enter into a contract with an ISP. This and all other service contracts must be in a form that can be transitioned to a successor contractor or to the Department.

119	3.2.6	3-15	**The RFP states that the "contractor must offer graphical user interface (GUI) on-line access."** **Does this general requirement apply to the takeover subsystems (MAR and SUR)?** No.
120	(3.3.4) 3.3.3	(3-18) 3-18	**Can the Contractor have different Key Personnel (e.g., Database Administrator) for implementation and operations of the Medicaid DW than for the implementation and operations of the RMS?** Yes.
121	5.3.3	5-4	**Would the Department define *program and Benefit Package*?** The term "program" refers to a collection of activities authorized by the New York State legislature to provide services to citizens of the State. The boundaries of a program may be arbitrarily determined by the Department. The collection of activities through which the Department provides access to fee-for-service under Title XIX of the Social Security Act is a program, the collection of activities through which the Department provides access to health care in a capitated environment is a program, the access to services provided by the Office of Mental Health is a program even though some of the services are funded under Title XIX. The term "benefit package" refers to the list (or package) of services covered (or authorized) by a program.
122	5.3.4 last paragraph	5-5	**Are the items captured within Appendix J required functionality or desirable features?** The RFP Cross-Reference column indicates which items in Appendix J are required functionality.
123	6.2.1.2	6-4	**"The contractor shall provide an interface to the New York backbone network (NYT) to provide user access to the Replacement Medicaid System and the Medicaid data warehouse."** **What type of interface is required to connect to the NYT? What protocol is being used? What network hardware will be required to install the NYT interface?** The NYT will be a high speed fiber optic InterLATA backbone network utilizing frame relay and ATM switching with network access points (NAP) in each of the seven (7) LATA(s) with New York State. Vendors must identify exactly what type of local access will be provisioned at each customer site, the required bandwidth for each site, and the type of interface that is required at the NYT network access point. The NYT will provide the necessary interface cards to access the NYT in order to deliver data traffic across the backbone. When providing this information, vendors should take into consideration that the frame relay switches within each NAP will be connected to a local carrier's IntraLATA frame relay network via network to network interfaces. Frame relay traffic within a LATA will be delivered over this bandwidth and will not require individual interfaces for each connection. Dedicated circuits within a LATA will also be aggregated by the local exchange carrier and delivered via higher speed facilities into the NYT. While the design for the provisioning of dial-up traffic has not been finalized, it is anticipated that each NAP will also accommodate dial-up traffic either by direct dial to the NAP or by a dial-frame offering within each LATA.

124	6.2.1.7	6-8	**This section does not specifically require connectivity to other related LANs or New York State systems. Is the intent that these workstations be connected exclusively to the Contractor's LAN?** Yes; the focus of this section is on Department management of the implementation process. However, the Department would like to be able to maintain some linkage to the State mainframe and the Department LAN through a gateway or other technique.
125	6.2.1.7 Paragraph 2	6-8	**Please elaborate on the "consultant staff" engaged by the Department; specifically, what firms or individuals, for what purpose, and during which phases of the contract?** The Department will provide the JAD facilitator and reserves the right to use a contractor for this function. The Department is also considering the use of an quality assurance contractor.
126	6.2	6-16	**Section 6.2.2.3.5, Milestone bullet, requires installation of all LAN hardware and software, and required linkage to the State mainframe and existing LAN. What are those linkages exactly?** The critical milestone is the installation of the contractor's implementation site, including the contractor's LAN. The Department will work with the contractor during the Project Planning Task to define the linkages to the State's mainframe and the Department's LAN.
127	6.2.4.1.3	6-21	**We assume that the extent of the Department's review and approval authority is to ensure that the technical design is consistent with the user needs refined during the JAD sessions. Is this assumption accurate?** The Department's review and approval authority is not so limited. While the Department will not unreasonably withhold approval, the Department retains the right to review and approve every aspect of the design, development, and implementation of the Replacement Medicaid System.
128	6.2.4.2.4	6-22	**Section 6.2.4.2.4, first bullet, refers to the use of something called "Jackson diagrams" in the Technical Design Document to graphically depict the logic pathways of modules interworkings. Can the Department describe more fully, what Jackson diagrams are or provide a reference to a document that will provide a more comprehensive description of this technique?** Jackson diagrams are a common industry methodology for depicting logical relationships of modules. Full descriptions are available in various industry publications. The contractor is not required to use a specific methodology but the contractor is required to use some technique which can provide a graphical description of logic pathways.
129	6.2.4.3	6-23	**Mentioned in this description is the term 'components'. Does the word "component" mean the same as "function", as described in Section 6.2 on page 6-2?** To ensure consistent use of terms the following definitions apply: The terms "functional area" and "component" refer to major business segments as defined in the list in Section 7.1.4, but including the Medicaid data warehouse. A functional area comprises all automated and manual components of the business segment. A component is the automated portion of the functional area. The term "function" refers a group of processes (manual and/or automated) which meet a business objective. A function may refer to an entire functional area or it may be an element of a functional area (e.g., Utilization Threshold and Post and Clear are functions of the Service Utilization Management functional area).
130	6.2.7.2.11	6-32	**We ask that the Department define as minor changes individually requiring no more than two hours of effort to construct and unit test, and collectively not exceeding one percent of the forecast construction effort.** The original RFP language meets the Department's requirements.

131	7.12.15	7-24	**When the EMEVS was first developed, the Department received all of the reports on microfiche as well as on paper. Under the DEPS contract, these reports were maintained on report image files with on-line access.** **These reports exist from the beginning of the contract. It is important that this information be retained. The contractor shall migrate these reports to the new system.** **What software is used to create and view these files? Will this software be turned over to the successor Contractor?** It is extremely important that these reports be retained and that the Replacement Medicaid System have conceptually equivalent information. DEPS will provide data tapes of the appropriate information. The software currently used by DEPS to produce the reports is proprietary. Therefore the successor contractor will be responsible for providing the necessary functionality to allow access to the data in the current report formats.
132	7.2.2 Bullet 1	7-32	**Are "other New York State medical assistance and public health programs" identified as unique program codes in the current system?** No.
133	7.2.6.8	7-37	**This section makes reference to the contractor's responsibility to provide on-line access to the Client Eligibility Data Repository through PC-based workstations, some of which would be located in local district offices. If the Department has a requirement for the Contractor to procure any workstations to allow for remote interface with any component of the replacement Medicaid System, please provide detail specifications, including the number and location of workstations, processing speeds, internal memory requirements, modem speeds, etc.** The contractor may rely on the use of existing terminals.
134	7.2.6.4	7-37	**Will the contractor or the State make necessary changes to WMS for updating daily versus weekly?** The State.
135	7.2.5.3	7-37	**Will the contractor or the State be responsible for WMS maintenance?** WMS maintenance is a State responsibility.
136	7.5.1	7-66 7-67	**Are any of the existing EMEVS transactions compliant to any NCPDP, ANSI, and/or UN/EDIFACT transaction standards? If so, please specify the transaction and the standard and version utilized.** The ProDUR and pharmacy claim submission transactions in EMEVS are NCPDP 3.2 standard.
137	7.5.3.2.12 7.5.3.2.13	7-71	**Is it correct to assume that the first citation is specific to interactive claims receipt and adjudication and the latter citation is specific to batch claims receipt and acknowledgment?** Yes.
138	7.5.4.4	7-74	**Does the response time requirement refer to host time only or does it also include network time?** Host time only.
139	7.5.6.5	7-75	**Section 7.5.6.5 describes PC software and interface specifications. What are the detailed specifications for the software required?** The detailed specifications will be determined in JAD sessions. The requirement is to permit access by providers to appropriate data.

140	7.6.6.3	7-88	**What locations will be serviced by the courier? Will this include the pickup and delivery of checks to the contractor's NYC office, and other stops in other cities?** This requirement only provides for courier services between the contractor's Albany location and the Department locations in Albany.
141	7.6.6.24	7-90	**Claim Manual Pricing** **Does this requirement refer strictly to the types of claims that are currently manually priced by the FA or will the contractor be required to perform additional manual pricing on other types of claims? If so, please specify the other types and volumes by month.** This requirement refers strictly to the types of claims that are currently manually priced by the FA.
142	7.9.1	7-115	**"New York State also has contracts with three (3) vendors to handle specialized TPR collection activity. This activity includes Medicare for inpatient hospital and home health services, CHAMPUS, and medical support from absent parents."** **Does the State expect the contractor to contract with the present vendor to handle TPR collections? Will there be specialized TPR activity and does the State expect the contractor to contract with the present vendors to handle this activity? Are there any other TPR activities which will become a part of the Contractor's duties? Please define.** The Department and the local districts will continue to maintain primary responsibility for TPR activities.
143	7.9.6.10	7-121	**This section requests claims to be edited for trauma, accident and casualty related services, and to produce a monthly report and questionnaire of such claims.** **Is the Contractor's responsibility limited to mailing out the questionnaire to recipients or providers as appropriate, or is the Contractor required to provide resources to receive and evaluate completed questionnaires? If so, what are the specific activities required, and what are the projected volumes of questionnaires by month?** The specific requirements will be defined during JAD
144	7.10.3.2.2	7-124	**7.10.3.2.2 describes processing requirements with regards to providing bulletin boards or internet data exchange. Please clarify application requirements,** The detailed specifications will be determined in JAD sessions.
145	7.12.1 Paragraph 2 bullet 4	7-135	**Is the contractor expected to resolve any disputes that are in arrears at the time the contract is awarded? If so, how many years back will these disputes go?** Dispute resolution will remain a Department responsibility
146	7.14.3.3.6	7-144	**What are the maximum number and frequency of "user-defined" client reports that will be requested?** The Department expects that the contractor will offer a solution in which the users can generate reports based on defined criteria in a manner that does not require expenditure of contractor human resources. The criteria will be finalized during JAD.
147	7.14.3.3.4	7-144	**Does this refer to the top 50 or top 100 drugs and/or therapeutic categories?** The reference is to therapeutic categories which are used for drug interaction algorithms. These therapeutic categories utilize all drugs as defined by their formulary codes and their proprietary therapeutic assignations.

148	8.2.1 8.2.2.1	8-3 8-5	**Are the Medicaid DW data elements those referenced in the Managed Care DW, the QA&A DW, and the data elements listed in Appendix H, or, will the required data elements be determined in the requirements definition phase (JAD)?** The list of data elements provided in Appendix H and in Appendix C represent some of the data elements for the Medicaid data warehouse. The complete list of required data elements will be defined in JAD. Please note that the Managed Care data warehouse will be independent of the Medicaid data warehouse and will not be the responsibility of the Replacement Medicaid System contractor.
149	(9.3.5) 9.3.5	(9-27) 9-26	**Is this number specific to eligibility verification transactions, i.e., date-specific query of a recipient's eligibility to which is responded all data regarding eligibility for that date and the coordination of benefits information applicable for that date (provider restriction, benefit usage, managed care designation)?** **OR** **Is this number estimated to represent all of the transactions, eligibility inquiry and response, claims status inquiry and response, check amount and date inquiry and response, enrollment inquiry and response, prior approval request and response?** The number is estimated to represent all EMEVS-type transactions, which includes eligibility verification inquiries as well as Utilization Threshold, Post and Clear, ProDUR and all other transactions defined for the EMEVS replacement components.
150	11.2	11-5	**Since the Contractor is to complete Turnover activities if either of the two one-year extensions is not exercised, it appears that the six one-month extensions are for the purpose of completing the Turnover. Please verify this understanding.** The six one-month extensions are available for Department use for a variety of contingency purposes, including completing Turnover.
151	11.7.5	11-21	**Will the State accept a performance bond in lieu of a letter of credit?** No.
152	11.7.8.2	11-23	**Please clarify whether "product" provided by subcontractors (hardware and software) is Contractor Product or Third Party Product.** "Product" provided by subcontractors is "Contractor Product".
153	(11.9.3.3) 11.9.2.3	(11-31) 11-31	**This section addresses the reimbursable of postage. Will there be other reimbursable items, for example, claim forms and provider manuals? If not, could you please provide volumes and frequency of updates for these items?** Postage is the only reimbursable item. Volumes for claim forms and manuals are available in the documentation library in the monthly operating reports for the period January 1997 through November 1997.
154	11.10.1.2.2	11-39 11-40	**Since the contractor may be held financially responsible for contractor-caused erroneous payments, it will have an incentive to ensure those amounts are recovered. Would the State please revise this section to give the contractor the opportunity to recover erroneous payments which the State has not recovered before deducting the amounts from contractor payments?** The Department will work with the contractor to allow the contractor to recover erroneous payments. The Department will deduct the amounts from contractor payments for any unrecovered payments 60 calendar days old. Subject to Department approval, the contractor will be permitted to seek recovery of payments over 60 calendar days old.

155	(11.10.1.1.2) 11.10.1.1.2	(11-39) 11-38	**The liquidated damages for delays in meeting the Department-approved development schedule include any penalties imposed on the State by HCFA, for reductions in the maximum enhanced Federal Financial Participation (FFP). Depending on whether FFP reductions include program payments as well as administrative components, the liquidated damages could total millions of dollars per month. Would the Department please clarify the nature of these damages, and provide an estimate of the potential dollar value?**
156	(11.10.1.1.2) 11.10.1.1.2	(11-39) 11-38	**Please indicate whether the phrase "Enhanced FFP" includes only the cost of services provided by MMIS contractors, or does it include the amount of FFP that is paid in support of State staff and related costs associated with administration of the Medicaid program. Does it also include Medical services costs provided to Medicaid recipients that are reimbursed to the state by the Federal Government? Please provide a dollar estimate of the potential damages associated with this RFP section.** Section 11.10.1.1 provides for consequential damages for failure to achieve Federal certification as of start of operations. By definition, FFP is paid by HCFA only for the Federal share of administrative costs and does not include program costs (program costs are covered under FMAP, and are not in jeopardy if the system is not certified). If the system is not certified as of start of full operations, the contractor may be liable for the difference between the 75 percent that would have been paid by HCFA and the 50 percent actually paid for costs authorized under Section 1903(a) for the period between start of operations and date of certification. Section 11.10.1.3 provides for consequential damages for failure to meet any of three specified operational start dates. The potential liability to the contractor are the costs incurred by the Department to continue operations under current systems.
157	11.11.2	11-49	**Since not all events beyond the control of the contractor can be identified in a force majeure clause, would the State please delete the word "catastrophic" in the second to the last line of this section?** The original RFP language meets the Department's requirements.
158	(11.11.6) 11.11.6	(11-51) 11-50	**The RFP allows for destruction of provider claim submissions after a readable micro media version has been produced. The current contractor currently has about 27,000 boxes of paper claims and attachments stored in its facility. In addition, the Contractor has about 11,000 cubic feet of outside storage space and another 14,000 cubic feet at its 800 N. Pearl Street facility to house provider-submitted magnetic media containing billing claims. Will the contractor be required to take-over this inventory of older claims, and to provide storage space and staff to handle retrieval from these boxes?** **Should the contractor's proposal include the resources necessary to convert these documents to a micro media format in lieu of retaining the original paper documents?** Yes, the contractor will be required to take-over this inventory of older claims and provide storage space and staff to handle retrieval from these boxes. The Department desires that these documents be converted to micro media format and the paper documents be destroyed.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 23, 1998

Question number	RFP Reference	Page	Question and Response
159	6.2.10	6-39	**Section 6.2.10 states "the Medicaid data warehouse will be developed concurrently with the EMEVS redesign portion of the Replacement Medicaid system implementation and before implementation of the remainder of the Replacement Medicaid System components". There is an implied requirement for the contractor to develop an interim data warehouse with current Medicaid systems data and a replacement data warehouse with the Replacement Medicaid systems data. Is this the Department's intention?** The Department no longer requires the interim data warehouse.
160	8.2	8-2	**"The Department intends to preserve the financial, data-gathering, and training investments made in these data warehouse initiatives." Does this in any way imply the technical platforms that must be employed, e.g., DEC Alpha/Oracle and Sun/Sybase? Also, the Department intends to retain the Sun/Sybase OMC DW. What is the disposition plan of the DEC Alpha?** The hardware used for the QA&A data warehouse will be redeployed within the State.
161	8.2.2.1 8.3	8-4 8-6	**Will the DEC Alpha 8400 Server with its one terabyte of EMC symmetric storage, and the DEC Alpha 2100 Server with its 130 GB of disk space be available for the contractor to upgrade (if necessary) and use to house the Medicaid Data Warehouse described in Section 8. Will it be available free of charge for the lifespan of the contract? What is the date it will become available for the contractor use?** No. The contractor is expected to design, acquire, and install the platform for the Medicaid data warehouse.
162	8.2.2.1	8-5	**Section 8.2.2.1 lists QA&A investment in their data warehouse. Are the Business Assessment and Strategy document and the logical data model available for review by the offeror?** The Business Assessment and Strategy document and logical data model are available in the procurement library.
163	8.3	8-6	**What does the Department mean by "starting point for development of the Medicaid data warehouse"? Does this requirement mean that the Department is requiring use of the DEC Alpha 8400 and Oracle as the platform for the Medicaid DW or the OMM Data Marts? Or, does the Department mean to imply that data requirements will start with the data contained in the QA&A data warehouse? Or, does this requirement imply that the initial data load of the new Medicaid DW will come from the QA&A data warehouse? Will the QA&A data warehouse be replaced by the Medicaid DW or will it become the OMM Data Mart depicted in Exhibit 8.1 on page 8-7? Can the Department please clarify?** The Department no longer requires the interim data warehouse.
164	8.3	8-6	**This section indicates that "the Department requires the contractor to use this as the interim data warehouse and as a starting point for development of the Medicaid data warehouse". What does this mean? Please clarify the intended use of the current DEC/Oracle platform during Implementation and Operations.** The Department no longer requires the interim data warehouse.
165	8.3	8-6	**What does the Department mean by "interim data warehouse"? Will the offeror be required to run the QA&A data warehouse? If so, on what day do operations transfer to the offeror?** The Department no longer requires the interim data warehouse.

166	8.3 Paragraph 2	8-6	**The RFP states that "Because of the availability of the QA&A Oracle database and its platform, the Department requires the contractor to use this as the interim data warehouse and starting point for the development of the Medicaid data warehouse."** **Please clarify the intention of the interim data warehouse. Will the contractor be required to maintain the interim data warehouse during the development and implementation of the new Medicaid data warehouse?**
167	8.3	8-6	**The second paragraph of section 8.3 states that the "Department requires the contractor to use (the Oracle database and its platform) as the interim data warehouse". Is it the Department's intention to transfer control of this system to the Contractor, and should Bidder's proposals include allocations for the resource needed to operate this system? If so, what would be the implementation date for such an operations activity?** The Department no longer requires the interim data warehouse.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 23, 1998

Question Number	RFP Reference	Page	Question and Response
168	General		**Must all the services requested in the RFP be provided by a single vendor, or will the Department of Health consider carving out major elements to be handled by different vendors?** **For example, pharmacy management services separate from eligibility verification.** The Department will enter a contract with a single prime contractor which may subcontract with specialty contractors.
169	3.2.2.1	3-6 3-7	**The HIPAA requirement for certificates of creditable coverage went into effect last summer. Does EMEVS have to have the capability of generating these letters as required by law (each time someone is terminated and on request up to 18 months after termination)?** EMEVS is not being used to generate certificates of creditable coverage. These are produced by HSASC and NYSDOH.
170	(3.3.4) 3.3.3	(3-18) 3-18	**This section references the Systems Implementation Manager identified in Section 3.3.1. Should this instead refer to the Systems Implementation Manager for the Replacement Medicaid System (RMS) identified in Section 3.3.2?** The reference in the RFP was incorrect. However, the RFP as amended (amendment 2) contains the correct reference.
171	3.4.2	(3-23) 3-22	**Can the Department please explain the difference in the second and third bullets in this section? The second bullet requires a mandatory feature for prepayment aggregate monitoring tools, and the third bullet seems to ask for an optional prepayment fraud detection module. Can the Department please clarify the requirement for each component?** The Department will rely on the contractor's expertise to identify and bring to the Department tools and techniques for fraud and abuse detection and prevention.
172	4.3.1	(4-4) 4-3	**What amount of EMEVS traffic goes into the VRU that cannot be handled in the VRU, and the requestor either presses "0" and is diverted to another location or is told to hang up and is given another number to call?** There is no operator intervention, no calls are diverted to other locations and providers are not told to hang up and call another number. Unless technical problems with the telephone carrier occur, all calls receive an EMEVS response.
173	(4.4.1.2.7) Eliminated	(4-8)	**What score (or level) would the State apply to the comprehensiveness and quality of the current system and application documentation?** This reference was to the EMEVS Takeover and Operations, since this is not in the revised RFP (Amendment 2) it is no longer applicable. However, the procurement library is available for offeror perusal.
174	(4.4.1.2.8) Eliminated	(4-9)	**Section 4.4.1.2.8 is listed twice so we assume the second occurrence should be 4.4.1.2.9.** This reference was to the EMEVS Takeover and Operations, since this is not in the revised RFP (Amendment 2) it is no longer applicable.
175	(4.4.1.2.4) Eliminated	(4-8)	**Can the currently used 800 telephone numbers used for VeriFone call-ins be ported from the current EMEVS contractor to the successor contractor?** This reference was to the EMEVS Takeover and Operations, since this is not in the revised RFP (Amendment 2) it is no longer applicable. However, yes, the current 800 telephone numbers will be available for use by the successor contractor.

176	6.2.3.1.1	6-18	**This section implies that the State is considering providing only one JAD facilitator for this project. Given the required project schedule, it may be necessary to conduct multiple JAD sessions simultaneously during the JAD Task. Based on this, we suggest that more than one Facilitator be provided. In addition, based on previous experience, we have found that Facilitators with a background and understanding of health care and specifically MMIS processing, would be much more effective in conducting these sessions. Is the State expecting to provide only a single facilitator or will additional facilitators be provided as required to meet the needs of the project schedule? Does the State expect to provide facilitators with significant experience and knowledge of the Medicaid application?** This is a Department responsibility which the Department will meet in a timely and quality manner.
177	6.2.10	6-39 to 6-47	**The five-stage implementation process described in this section does not seem to correlate with the State's desired implementation schedule described in Section 8 of the RFP.** **I. The project schedule defines a two stage data warehouse/DSS implementation with the first stage (implemented on 2/28/2000) including the base warehouse and DSS tools and the second stage including the EIS and other specialized analysis tools (implemented on 11/1/2000). This section seems to describe a single stage implementation with all functionality being implemented concurrently. Is this section intended to define the required tasks and schedule for implementation of the data warehouse? Is it correct that Stage 1 of the DSS implementation will include the base data warehouse and DSS (including training of the LEVEL I users) and that Stage 2 will include the implementation of the remaining DSS/EIS tools and training of the LEVEL II and III users?** **II. This section references the RMS as the source of the data for the data warehouse. Given that the base data warehouse is to be implemented on 2/28/2000, and that, at that time, the majority of the RMS will not be implemented, it will be necessary to use the existing MMIS as the source for claims and other significant MMIS data. This will require the contractor to perform a dual mapping and load process (i.e. create a mapping and load process using the existing MMIS and a revised process for the RMS). This will significantly increase the cost of the data warehouse implementation and require additional work for both contractor and State staff. Is it the intention of the State to conduct a dual mapping of the source data files to the data warehouse?** The RFP clearly states that the Medicaid data warehouse must be implemented on February 28, 2000. There is no "second stage". The entire Medicaid data warehouse, including the DSS/EIS tools must be implemented on February 28, 2000. The Replacement Medicaid System components that constitute the EMEVS replacement will be operational on November 1, 1999 and will be a source of data for the Medicaid data warehouse. The Medicaid data warehouse will continue to receive data from the existing New York State MMIS until replaced by the remaining components of the Replacement Medicaid System.
178	6.2.10	6-39	**This section indicates that the "data warehouse shall capture all of the data elements in the current Medicaid Systems". Most transaction processing systems like the MMIS and EMEVS contain a significant number of data fields that are retained only to support the processing of the transaction processing system and are not useful for data analysis functions. In fact, a review if current data warehousing publications indicate that typically only about 25-30 percent of the data fields in most transaction processing systems are actually useful for data analysis purposes. Does the State actually intend to capture all MMIS data elements, or will there be an opportunity to eliminate data elements that are not necessary to meet the requirements of the DSS/EIS?** The Department expects to include every Replacement Medicaid System data element that is necessary for analytical purposes in the Medicaid data warehouse.

179	6.2.10.1.3	6-42	**This section indicates that the Contractor is to develop a technical architecture for the data warehouse/DSS (including hardware, software, etc.) during Stage 1, Task 3 of the DSS project.** **I. Is the Contractor to include a hardware/software solution as part of it's proposal for this RFP?** **II. If a hardware/software solution is to be included in the proposal, does the State's selection of the contractor's proposal indicate approval of the proposed solution? If not, and changes are required to the proposed hardware/software solution, how will increases or decreases in cost related to the changes be handled?** **III. If a hardware/software solution is not to be included in the proposal, how is the contractor to describe its solution to the DSS requirements? The selection of the hardware/software solution will define, to a great extent, the capabilities and features provided to meet the Department's requirements.** The contractor is expected to propose the platform, including hardware, system software, database, access tools, and presentation tools. The proposed solution must meet the Department's requirements set forth in the RFP as modified by JAD and Medicaid data warehouse design and Department approved design deliverables.
180	6.2.10.5.3	6-47	**"The contractor shall develop materials and shall provide training to all designated user staff."** **Is the State or the vendor required to provide a training environment for the end-users of the data warehouse/DSS/EIS during implementation?** **Is the State or the vendor required to provide the hardware (training server and RDBMS), application software, PC-work stations, and office furniture for the training environment?** **How many State end-users require training?** **Does the State require a fully-functional training lab for end-users of the data warehouse/DSS/EIS. A fully-functional training lab is highly recommended.** **If the State requires a fully-functional training lab for the data warehouse/DSS/EIS during operations, how many PC-workstations are required to support the training lab?** The contractor is expected to provide the training environment for end-users of the Medicaid data warehouse, including the hardware, software, workstations, training facility. There will be a maximum of 595 total Medicaid users. The Department will consider a recommendation for a training lab maintained at the contractor's Albany facility throughout the contract for on-going training.

181	6.3.2.1	6-52	**The RFP states, "In addition to the key personnel the contractor shall employ not less than seventy-five (75) full-time on-site programmer/analyst staff...". Pricing schedule F-2 indicates that these 75 Evolution staff are to be deployed during contract year 2.** **The traditional role of Evolution people has been to support the operation of the MMIS during the Operations Phase, and the current RFP confirms this. We are therefore confused as to the role of this staff during contract year 2, since there is no MMIS component of the RMS in operational status during this time period.** **Did the Department really intend to include these 75 Evolution people in pricing schedule F-2? If so, what specific work is intended for these 75 people during contract year 2?** The 75 Evolution staff in pricing schedule F.2 is correct. During Contract Year 2 the EMEVS replacement components of the Replacement Medicaid System, including the Client Eligibility Data Repository, the Utilization Threshold and Post and Clear functions of Service Utilization Management (as a minimum), and the Eligibility Verification, Prospective DUR, and Electronic Claims Capture elements of Electronic Commerce (as a minimum), and the Medicaid Data Warehouse will be implemented and operational.
182	7.2.3.1.1	7-33	**Please identify "related systems."** Section 7.2.3.1.1 should read "Daily client eligibility data from the WMS". Revised page is attached.
183	7.3.1	7-38	**In Section 7.3.1 it states that the contractor will take over provider enrollment which is now handled by NYS. What are the call volumes for this today? How many calls by hour are received per day, how long are they and is this function handled through a call center, an automated system such as VRU, or both?** Approximately 700 telephone calls are received weekly. These calls are handled by a telephone operator. This telephone line is currently operated between the hours of 8:30 am to 5:00 pm, Monday through Friday. There are no electronic systems used to complete this process. Approximately 12,000 applications for enrollment are received per year for all categories of service.
184	7.3.6.35	7-54	**"Develop and make available at no charge to providers, software including future updates, for providers to submit EMC Data via PC, Electronic Transfer, Disk, Tape."** **Which form types must this software support?** All transaction types subject to HIPAA EDI standards must be supported. Details will be finalized during JAD.
185	7.5.3.2.12	7-71	**"POS hardware and software shall support on-line real-time adjudication of pharmacy and HCFA-1500 claims ..."** **Is it the Department's intention for the claims adjudication function to include all editing through final adjudication, including all historical editing which could, as per current practice, extend back as far as six years? In order to arrive at a more cost effective solution, would the Department accept on-line editing which would access near-term history files of approximately ninety days, with the final history editing and full adjudication taking place as part of an offline batch process?** The Department expects the contractor to develop innovative solutions to meet the Department's objectives.

186	7.5.3.2.13	7-71	**"Accept electronic submission of all claim types from providers, of the appropriate claim type and format for the submitting provider, through direct links to the Replacement Medicaid System."** **What is meant by the term "direct links"?** **Does this mean dedicated telephone lines to the contractor's data center for any provider that wants one?** **If the contractor is required to provide these lines, please specify the number.** Direct links refers to direct communication with the contractor, which may include point-of-service network, PC dial-in, Internet, RJE, or host-to-host. The only dedicated lines are for providers who elect host-to-host and the dedicated line is at the provider expense. All other lines can be by common carrier. The contractor is expected to provide enough lines to support the volume.
187	7.5.6.1	7-74	**What are the statistics for the existing EMEVS voice traffic today? Those statistics should include the number of calls, the length of the calls, the number of calls that abandon and the number of busies received in the network?** Call number statistics associated will all telecommunication traffic is presented in the EMEVS Monthly Compliance reports and are available in the procurement library. The average voice call transaction (ARU) is 75.4 seconds. The ARU call average is 114 seconds with an average of 1.5 transactions per call. Statistics are not available for abandon of busy calls.
188	7.5.6.4	7-75	**"Supply to requesting provider, POS devices and the necessary PC software to perform eligibility verifications through use of a terminal keypad or interface with the provider's computer to enter necessary information. Software shall be provided at no charge; hardware shall be supplied at no more than fair market price to providers."** **Is this software for PC's currently available and will it be turned over to the successor bidder?** The software to support the TRANZ 330s is available and will be provided to the successor contractor.
189	7.6.3.2.11	7-81	**"Accept claims via hard-copy, electronic or any other media from providers, billing services, Medicare carriers, and intermediaries."** **Does this mean that the contractor must accept <u>any type of claim</u> via hard copy or do the same rules apply as now - i.e., version 4 claims can not be submitted via hard copy.** While the details will be finalized during JAD, the contractor must be prepared to accept any claim from any provider in any media. The Department may elect to continue certain policies, such as restricting version 4 claims to electronic media, but the contractor and the Replacement Medicaid System must have the flexibility to respond if the Department changes the policy.
190	7.7.1 paragraph 5	7-92	**How will the fiscal agent receive notification that Title XIX payments made outside the MMIS have occurred? What type of documentation will the fiscal agent be expected to keep in relation to the payments that continue to be made outside the MMIS? Will these payments be considered and recorded in the Replacement Medicaid System as "lump sum" payments since there will be no related history?** The Replacement Medicaid System Contractor will be notified of payments made outside the MMIS by the Department's finance office. The notification methodology and documentation retained by the fiscal agent will be determined during JAD, when the Department and the Contractor will finalize such details.

191	7.9.2	7-115	**Is it the Department's intention for the Contractor to provide staff to accomplish Third Party Resources functions? If so, please provide detailed task lists for this function, the volume of cases currently handled, and the number of State staff currently engaged in this function.** The contractor will be expected to assume one TPR function currently performed by the Department and another one that is being performed by a current contractor. The first function is to automatically pursue recoveries from Medicare or health insurance carriers when retroactive coverage is added to the database and that coverage would pay for claims already paid in full by Medicaid. There are currently seven state staff involved in this process. The second function is to operate a system that would verify that the amount of Insurance/Medicare or lack thereof on the Medicaid claim is correct. This is known as "Payment Integrity." There is no data available at this time to measure the size of this operation.
192	7.9.6.3	7-120	**"Receive and maintain complete on-line insurance information on all clients. The following information must be captured and maintained for each insurance coverage available to the client: ..."** **From what source will the contractor receive this information, and will there be any cost to the Contractor?** Most TPR information is gathered by local districts and entered to the Replacement Medicaid System via WMS. Other information will be gathered by the Department in the course of TPR activities and entered on-line by Department staff. If the contractor receives information from other sources, the responsibilities for update of the information will be finalized during JAD.
193	7.11.3.1.1	7-129	**Please provide State-specific data elements that presently have to be captured and give examples by type of anticipated new elements.** To be finalized during JAD.
194	7.11.3.3.6	7-131	**Please provide a comprehensive list of all reports that are currently produced.** Listings and sample report layouts for all MMIS and EMEVS reports are available in the Procurement Library.
195	7.11.4.2	7-132	**Process encounter claims and provide results on the provider bulletin board or web site.** **What is meant by "results"? How often must these results be posted?** The Department anticipates that the Replacement Medicaid System will have some pre-editing capabilities to determine if encounters submitted electronically are acceptable for processing. The contractor is required to report to the health plans whether encounters (and how many) are accepted for processing and how many must be resubmitted. The health plans have a right to receive feedback on the results of that preprocessing.
196	7.12.3.3.14	7-137	**Would the Department please give an example of State-specified information? Would these also be quarterly reports that are generated at the same time each quarter?** This requirement constitutes reporting on drug products based on user-supplied criteria. Specifics will be finalized during JAD.
197	7.12.3.3.24	7-138	**Would the summary reports to assist in the preparation of the HCFA-64 be generated on a quarterly basis?** To be finalized during JAD.

198	7.12.6.13	7-140	**What data is available to create these accounts receivable, and how accurate is the data? Will the contractor be expected to perform dispute resolution responsibilities back to 1991? Does the Department expect dollars and units by NDC level? If this is an accounts receivable, will the Department need to be able to adjust units and apply dollars, therefore needing more fields than dollars and units?** The contractor will create the accounts receivable using the invoices created and payments received. The contractor will not be expected to perform dispute resolution responsibilities. The Department does expect dollars and units by NDC level. The fields needed for the accounts receivable will be finalized in JAD.
199	7.12.6.10	7-140	**Please clearly define the role the contractor will play in the dispute resolution process.** Dispute resolution will remain a Department responsibility. However, the Department will rely on the contractor for information to support the dispute resolution process.
200	7.14.3.1.3	7-143	**Will the Department ensure that encounter records from managed care providers contain the appropriate NCPDP format for accessing pharmacy data?** Managed care encounter data exists in current NYS MMIS SUR claim compatible format that models fee-for-service data elements descriptions and field size. If necessary, crosswalk can be supplied by NYS.
201	8.2.1	8-3	**Will the Department provide the business plan, conceptual data model and physical data model for the Managed Care DW to offerors?** Yes. This document has been added to the Procurement Library.
202	8.2.1	8-3	**Has the Department selected the Decision Support System tools for the Managed Care DW? If not, what tools are being considered for implementation?** The contractor is not bound by the tools selected for the Managed Care data warehouse. The Department is relying on the offerors to propose technology for the Medicaid data warehouse that will meet the Department's needs.
203	8.2.2.1	8-5	**Has the Department selected the Decision Support System tools for the QA&A DW? If not, what tools are being considered for implementation?** The contractor is not bound by the tools selected for the QA&A data warehouse. The Department is relying on the offerors to propose technology for the Medicaid data warehouse that will meet the Department's needs.
204	8.2.2.1	8-5	**Does the 280 million rows of data in the QA&A database represent 9 months of data (3 quarters) or 2 years of data?** The 280 million rows of data is the size expectation for two years of data.
205	8.2.3	8-6	**Is the Medicaid Fraud Control Unit the user of IBM's Fraud and Abuse Management System (FAMS)? Will the Medicaid DW provide data to FAMS?** Yes, if required by the Department.

206	8.3	8-7	**Are the two data marts - one for QA&A and one for the Bureau of Program and Data Analysis - the same as the OMM Data Marts depicted in Exhibit 8.1 on page 8-7? If so, are they to be developed by the contractor or are they the same as the QA&A decision support tools planned for implementation by the fall of 1998 (reference page 8-5) and the Bureau of Program and Data Analysis system described in section 8.2.2.2 on page 8-5? Please clarify.** The two data marts QA&A and the one for the Bureau of Program and Data Analysis are the same as the OMM data marts depicted in Exhibit 8.1 and they are to be developed by the contractor. The Medicaid data warehouse and the two data marts will replace the QA&A data warehouse and will replace or supplement existing BPDA reporting capabilities.
207	8.3	8-7	**How will the Metadata developed by the contractor be used by the MFCU and OMC data warehouses?** It is the Department's intent that the offeror work with OMC and MFCU as well as the Department in the development of the Metadata in order to develop a consistent Metadata of Medicaid data. The Meta data will provide all users of Medicaid data a consistent definition of the data.
208	8.3.2	8-11	**"Key attributes of the architecture must include the following...Portability across multiple computer platforms...no device-specific code...proprietary extensions avoided." This will not allow performance to be platform/DBMS optimized. Is this true?** The Department cannot respond to the question directly regarding platform/DMBS optimization. It is important to recognize, however, that the Medicaid data warehouse will become the property of the State and, as specified in Section 11.5.1, the ownership shall "include any software and hardware required to fully operate the Replacement Medicaid System that is not commercially available to the State of New York..." In order to migrate the Medicaid data warehouse to a successor contractor, the architecture must not be platform dependent.
209	8.3.4	8-14	**The RFP requires that data be cleansed and verified before loading in to the DW. Analysis is enhanced by having data "standardized" as well. For instance, coded values can change meaning over time (e.g., the local procedure code for immunization types or category of service codes). With a 60-month DW, this is probable. When standardizing data, some claim data fields will need to be mapped to standard values for more meaningful analysis. Does the Department expect data to be standardized as well be cleansed and verified?** Yes. The Department anticipates that many of the data will be standardized.
210	8.3.6	8-15	**Does the requirement for a single end user password and password change facility imply synchronization across multiple existing platforms?** Security procedures need only be synchronized within the platform under the control of the Replacement Medicaid System contractor. Security for the Medicaid data warehouse does not have to be synchronized with the Managed Care data warehouse or the MFCU data warehouse. The contractor may elect to synchronize security procedures between the Medicaid data warehouse and the other components of the Replacement Medicaid System.
211	8.3.5	8-15	**Does the Department feel that Raid 5 is sufficient to meet the mirroring requirement?** The Department will consider any recommendations that meet the Department's needs and requirements.
212	8.3.5	8-15	**Is the purpose of disk mirroring high system availability?** The purpose of mirroring the detail data layer is to facilitate disaster and error recovery.

213	8.3.6	8-15	**What is envisioned by the requirement that data exchanged between users of DW servers and NYT servers are encrypted? Does this apply to sensitive identifying columns like SSN, or all data? What level of encryption is required?** The Department expects the contractor to develop high-quality data and information security procedures, including use of firewalls, data encryption, passwords, and workstation ID numbers. Medicaid data must be protected from accidental disclosure or fraudulent acquisition, such as by hacking. To the extent that access to the Medicaid data warehouse and the Replacement Medicaid System is via NYT, the contractor will be required to conform to NYT protocols and security requirements.
214	8.4.1	8-16	**Does the Department intend to store denied claims in the Medicaid DW? Does the Department intend to store pended claims in the DW?** The Department will include denied claims in the Medicaid data warehouse but not pended claims.
215	8.4.1	8-16	**What does the Department mean by "accept, clean and sort all data elements"? Is this to mean each data field in each system (MMIS and WMS) or all required data elements as determined in the DW design?** The Department means all required data elements as determined in the design of the Medicaid data warehouse.
216	8.4.2	8-17	**The RFP states a requirement that "The data must be organized by payment cycle date and date of service. Does the Department expect two complete copies of the data organized this way or will an indexing strategy suffice?** The Department expects to have the capability to analyze data by date of payment or by date of service. The Department will rely on the contractor's expertise to identify cost-effective ways to meet the requirements.
217	8.4.3	8-18	**What is the Department's intent for retrieval of archived data? Will the requested retrieval be by cycle date? How long will the contractor have to retrieve data? Overnight? How should retrieved data be accessible? To the entire suite of analytic tools? Please clarify.** The Department recognizes that retaining data indefinitely would represent a significant storage cost so the Department has defined the data that requires immediate access. Data which does not require immediate access will be stored in an archival mode, but which can be retrieved on a schedule to be developed by the contractor and the Department. Archived data that is retrieved shall be loaded to the Medicaid data warehouse and be available to all analytic tools.
218	8.4.4	8-18	**Can the Department estimate how many additional data fields may be required in the DW? Could you specify the data additions in terms of a percentage of original data?** The purpose of this requirement is to permit the Department to add data elements to the Medicaid data warehouse where the need for the data is currently unknown, but will be identified in the future.
219	8.4.4	8-18	**After the RMS has been implemented and the Medicaid DW has been updated with the new data elements, will the Department consider "new" data elements as "out-of-scope" and approve additional funding for implementation of the new data elements (given approval of the data element change document required by the RFP)?** The reason that the Department has specified flexibility in the architecture is to minimize the cost of adding data elements in the future.

220	8.5.1	8-20	**Can the Department qualify or establish a maximum number of predefined queries and predefined reports that the contractor must deliver?**
221	8.5.2.3	8-22	**Can the Department quantify or establish a maximum number of predefined reports that the contractor must deliver? Are these the same reports required as a component of Section 8.5.1?** The requirement is to maintain a library for predefined queries and reports. The term "predefined" for queries and reports means that the queries and reports be pre-existing and available to users to execute with little or no change. It does not necessarily mean that the queries and reports must be defined before the Medicaid data warehouse is operational. The number of predefined queries and reports that must be available when the Medicaid data warehouse becomes operational will be determined during the implementation.
222	8.5.4	8-23	**This section does not include any data mining requirements as mentioned in Section 8.1 (second bullet).** **Does the State require data mining capabilities? If so, what capabilities are required?** **Does the State require in-place data mining capabilities, (i.e. executing data mining functions directly against the data warehouse on the DSS server)? Please describe the State's vision for a data mining application and how the information will be used.** Section 8.3 states, "The contractor shall develop a Medicaid data warehouse containing data mining, decision support, and executive information that improves the analytical quality of, and access to, Medicaid data."
223	8.5.5.2	8-24	**Can the Department elaborate on the requirement to migrate MAR to the Medicaid DW? Is it intended that MAR reports be accessible from the DW in the early phases of the project (when the DW is created from the current MMIS) and that eventually all MAR reports will be generated from the DW, resulting in eliminating MAR from the RMS? Is it intended that the MAR summary files that are required for analysis be downloaded from the MMIS or be created by the Medicaid DW? Please clarify.** It is the Department's desire to utilize the Medicaid data warehouse for the type of analysis and information management that has been traditionally addressed by the Management and Administrative Reporting Subsystem of an MMIS. However, since the Medicaid data warehouse solution is not yet known and since a significant number of individuals and entities are dependent on existing information, the Department determined that the Replacement Medicaid System contractor shall take over and operate the existing MAR subsystem and operate it until a logical plan for migration can be developed and executed.
224	8.5.5.2	8-25	**If it is the Department's intent to replace MARS fully with the Medicaid DW, is the same requirement expected for SUR processing?** That is the ultimate goal of the Department.
225	8.5.5.3	8-25	**Does the Department expect the Contractor to design and develop reports for the five bullet points (access to care, appropriateness of care, continuity of care, etc.), or does the Medicaid DW have to have the flexibility to allow that kind of analysis to be easily developed by end users?**
226	8.5.6.2	8-27	**Does the Department expect the Contractor to design and develop reports for the six bullet points (provider practice patterns, variations in charged and paid amounts, admission rates, etc.), or does the Medicaid DW have to have the flexibility to allow that kind of analysis to be easily developed by end users?** The Medicaid data warehouse must provide the capability to provide easy and timely access to this type of information and permit the analysis to be presented in forms useful to the end users in a timely manner.

227	8.5.6.2	8-27	**Does the requirement to compare to normative data intend that both internal normative data and external (to NY Medicaid) normative comparisons are both desired or required?** Both are required.
228	8.6.2	8-28	**What is the difference between background and batch query execution?** Background queries are those that can be run in the background permitting the workstation to be fully available to the user for other applications. Batch queries are queued and processed in batch mode.
229	8.6.2	8-28	**"Batch queries submitted before midnight should be completed by 8:00 a.m." It is conceivable that a series of large, complicated queries submitted before midnight would not be complete by 8:00 a.m. Is that acceptable?** The Department will be reasonable. The Department expects the contractor to develop innovative solutions to meet the Department's objectives.
230	8.6.2	8-28	**Is it acceptable to propose a DBMS that does not provide a "progress meter" capability?** No.
231	(9.2.6.1) 9.2.5.1	(9-6) 9-5 to 9-6	**RFP Section 9.2.6.1 specifies that the proposal present its section on Replacement Systems Capabilities "in the same order as presented in Section 7 of this RFP," which itemizes 16 functional areas. However, 9.2.6.1 also says that the descriptions shall identify (1) the components to be used, (2) the source system of each, (3) the major areas of proposed modifications or enhancements to each, and (4) anticipated problems and solutions; whereas Section 7 breaks each functional area down into (1) business objectives, (2) system requirements (inputs, processing requirements, outputs, and interfaces), (3) performance standards, (4) state responsibilities, and (5) contractor responsibilities. These organizational structures are distinctly different, and it's not clear which structure, if any, is preferred by the state. Please clarify.** Section 7 identifies the Replacement Medicaid System requirements, while section 9.2.6.1 describes how the proposed solution will meet the requirements defined in Section 7.
232	(9.2.7.3) 9.2.6.3	9-13	**We assume the reference to "Section 7" in RFP Section 9.2.7.3, *Approach of Operation of Functional Areas*, refers to Subsections 7.1.1 - 7.1.2.4.1. Is this correct?** It refers to all of Section 7.
233	(9.2.7.3) 9.2.6.3	9-13	**RFP Section 9.2.7.3 calls for the proposal to describe its approach to operations for those same 16 functional areas from Section 7, but with yet another structure to be applied to the discussion of each functional area. The structure also calls for discussion of quality assurance plans, which appear to be addressed completely separately in 9.2.10.1. Please clarify.** Since Section 9.2.7.3 requires the offeror to describe its approach to operations and fiscal agent responsibilities (including non-automated functions), the discussion requires a different structure than that needed to describe the functionality of an automated system.

234	9.3.3	(9-26) 9-25 to 9-26	**DW fixed price quote requirement cannot anticipate the yet-to-be-determined inputs of the JAD process and their obvious potential impact on costs. Can the DOH define portions of the data warehouse project to be quoted fixed price? How can the vendor control run-away design/requirements changes?** Section 6.2.1.12 of the RFP states, "The Department recognizes that, with the passage of time between proposal submission and completion of JAD and with the dynamics of the program, changes may occur in the scope of the Replacement Medicaid System as presented in this RFP. Such changes may include additions, modifications, or deletions of requirements. It shall be a joint responsibility of the contractor and the Department to maintain requirements traceability and change control tracking documentation to help in assessment of whether a modification to the contract is necessary."
235	11.5.1	11-10 11-11	**The second paragraph indicates that certain hardware is covered by the system ownership provision while the second to the last bullet on page 11-11 is consistent with typical MMIS ownership provisions and federal regulations which do not include equipment. Please clarify whether it is the intent of the State to own some or all of the hardware.** Section 11.5.1 is clear that New York State ownership of the Replacement Medicaid System includes "any software **and hardware required to fully operate** the Replacement Medicaid System that is not commercially available to the State of New York" [emphasis added]
236	11.10.2.3.4	11-46	**The damages associated with network downtime of $1,000 per minute are sufficient to bankrupt a contractor in a rather short time. Would the Department agree to a maximum annual penalty associated with this performance standard? In a similar manner, would the Department agree to an annual maximum for all liquidated damages across the entire contract?** The network is the backbone of the eligibility verification system. Excessive network downtime will cause hardship to both the provider and client community. In addition, there is a potential to lose federal reimbursement. The Department must be assured that the telecommunication network will be operational 24 hours a day 7 days a week with minimal interruption. Therefore, the Department will not agree to a maximum annual penalty associated with performance standards and will not agree to an annual maximum for all liquidated damages across the entire contract.
237	11.10.2.4.2	11-47	**"The staffing levels for any type of position is less than the percentage of the level for that position specified in Section 11.9.3.5 for a period of more than thirty (30) days."** **In order to provide sufficient time for the contractor to attract and hire highly qualified staff, would the Department agree to substitute a period of sixty (60) days in lieu of the referenced thirty day period?** No, it is the Department's opinion that thirty calendar days is appropriate. The Department requires the Evolution group be a stable, well trained unit and high turnover or vacancies negatively impact the effectiveness of this unit. As stated in Section 11.10.2.4.3, before assessing any damages the Contract Administrator will take "...into consideration the role of a key person, the impact on implementation or operations, and any mitigating circumstances presented by the Contractor."

238	7.3.4.5 Appendix E	E-2	**We have reviewed the RFP requirements for Provider Relations telephone support as referenced, and we have several observations that seem relevant:** **I. The scope of work is considerably broader than the services currently offered by the incumbent Fiscal Agent.** **I. The requirement to allow no more than 10% of calls to receive a busy signal is significantly tighter than the 25% standard that the incumbent MMIS contractor is required to meet.** **I. Because most of the calls from providers are complex in nature, and require careful instructions from Provider Relations phone representatives, the opportunities for automated responses are limited.** **I. The requirement to implement an automated call tracking and resolution function will certainly provide improved information for monitoring contractor responsiveness to the provider community. However, the best systems available entail at least some level of manual effort and therefore would extend the time needed to fully handle each phone call.** **Given these facts, we are concerned that the total cost to the Department of providing telephone support services will increase dramatically during the next contract term. Will the Department consider a more flexible set of performance standards to govern the performance of these functions?** No.
239	Appendix H	H-1	**Appendix H "contains some of the data elements for the Medicaid data warehouse." Included are DB2 tables of EMEVS data elements. We do not find reference to the use of the EMEVS data elements in Section 8. Pertaining to EMEVS, what level of detail and functionality must be carried on the Data warehouse? Volumes for Eligibility Verification Transactions listed in Section 9.3.5 are 140,000,000 a year. If the Department is requiring a record of each of these transactions in the data warehouse, storage requirements will be significantly increased. Does the Department intend for these transaction records to be included?** **Is the EMEVS design subject to JAD discussions?** The Department will require that EMEVS transactions be included in the Medicaid data warehouse (please note that some of the EMEVS data elements are included in Appendix H). The details will be finalized during the Medicaid data warehouse design.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
April 30, 1998

Question Number	RFP Reference	Page	Question and Response
240	General		**Please identify the amount of money paid to CSC and Deluxe Electronic Payment Systems in 1997 in each of the following categories:** **I. Compensating for ongoing contractual services (excluding any payment for pass through expenses)** **II. Reimbursement for pass-through expenses** **III. Payments for extracontractual services (extra payments for extra service not identified in contract, e.g., payment for unanticipated system changes)** **Also please identify any liquidated damages or penalties assessed either contractor.** Spreadsheet for 1997 payments and liquidated damages is enclosed.
241	General		**What guidelines can the Department of Health provide regarding conflicts of interest inherent in some potential bidders? In a number of cases potential bidders may be owned by or otherwise affiliated with Medicaid providers or other organizations directly or indirectly receiving Medicaid payment. It would appear not to be in the best interests of the Department to contract with an organization who would be issuing payments to itself, monitoring the quality of care it delivered, and reviewing itself for potential fraud, abuse, unnecessary services, or billing errors.** **Several states have addresses this situation by forbidding companies in the "payment stream" from providing Medicaid contractor services. For example, at least three states have forbidden drug manufacturers, wholesalers, chain pharmacies or their subsidiaries and affiliates from serving as the state's Medicaid drug administrator. Another state canceled a utilization review contract when the UR firm was acquired by a hospital chain.** **Those in the "payment stream" having a high potential for a conflict of interest would include providers themselves (pharmacies, hospitals, physicians, etc.), manufacturers of drugs or other devices, organizations of providers (Hospital Association, Nursing Home Association), PPOs (comprised of hospitals or physicians, HMO's and other similar organizations (Integrated Delivery Systems, MCOs).** **Many organizations in the above categories have divisions or subsidiaries providing services being contracted for under this procurement.** **What is the Department's position on permitting "payment stream" organizations such as the above to be included in a contract, whether as a prime or sub-contractor, under this procurement?** In general, it will not be an inherent conflict of interest for the contractor and/or subcontractors to perform the responsibilities detailed in the RFP and to perform its other business interests. The RFP and the resultant contract contain some safeguards against potential conflicts of interest, including performance standards and deliverables. It is incumbent upon the offeror to adequately address potential conflicts of interest in its proposal (see Section 9.2.1), demonstrating that its approach will ensure potential conflicts do not arise. The Department may ask questions of the offeror about this potential conflict of interest and may require that additional safeguards be added to the contract.

242	General		**Will the Department certify that all systems for which the Contractor is to develop interfaces will meet the terms of the State's Year 2000 certification requirements? Examples of these interface systems would include WMS, Client Notice System, Growing Up Healthy subsystem, Ambulatory Prenatal care Program, and others.**
243	1.2.1	1-5 1-6	**Are WMS and the other systems listed Year 2000 compliant or will they be made Year 2000 compliant before the selected contractor incorporates them into the Client Eligibility Data Repository?** Since most of these systems are not under the Department's control, the Department can make no such guarantee. The systems, and therefore the data, are in the process of being made year 2000 compliant. Actual due dates will vary by system.
244	General	Offerors Conference	**Reference to on site staff requirements. Some areas of the RFP mentions on site in Albany, which is pretty clear, and other areas mention simply on site. The question is does on site necessarily mean in Albany in every case, or could some of these be on site at the processing center? Specifically referenced is 75 on site programmers in Section 6.3.2.1.** Section 3.1.1 requires the contractor to establish a site within thirty (30) miles of the New York State Capitol Building in Albany and states, "All work specified in this RFP...is required to be performed in this facility." All references throughout the RFP to "on-site" refer to this Albany-area location. The specific reference to "on-site" evolution staff in Section 6.3.2.1 means on-site in the Albany area. Similarly, the reference to on-site data warehouse user support staff means on-site in the Albany area.
245	1.1.3 Paragraphs 2 and 3	1-2 1-3	**On page 1-2, the RFP states DEPS will continue to operate EMEVS through 4-30-99. On page 1-3, it states the contractor will takeover EMEVS operations on 3-1-99. Please clarify this discrepancy.** This reference was to the EMEVS Takeover and Operations which is not in the revised RFP (Amendment 2).
246	1.1.3	1-3	**The specified EMEVS takeover of operations date is 3/1/99. Considering the proposed start of work date of 9/8/98, there will be approximately 24 weeks to accomplish a seamless, low risk EMEVS takeover. This includes new network solution (4.3.1), transferring all EMEVS applications and operating systems software, complete staffing requirements (4.4.1.2.2), all telephone and voice response requirements all necessary computer hardware requirements and completed facilities preparation (4.4.1.2.4), disaster recovery plan and back-up capabilities, and network cutover.** **Section 4.1.1 states that the contractor approach to takeover must "insure no negative impact is experienced by EMEVS stakeholders....", and that "the Department intends to give responding offerors flexibility in meeting the requirements of the Transition Phase of the projects."** **In light of this, why is the Department holding back the final two months of available EMEVS contract extensions?** **In order to provide a seamless transition and maximize service to the provider community, would the Department consider executing the final 2 one month extensions of the current DEPS EMEVS contract rather than require a March 1, 1999 cutover?** This reference was to the EMEVS Takeover and Operations which is not in the revised RFP (Amendment 2).

247	2.2.6 Bullet 6 2.2.7.4 2.2.9.1 9.2.1 Bullet 1	2-8 2-11 2-13 9-2	**Some of these sections indicate that the State will be willing to negotiate terms and conditions of the contract while others indicate the contrary. In order to ensure that all parties are comfortable with the contract, please clarify at what stage of the procurement the State will negotiate contract terms and conditions.** The Department will not negotiate terms and conditions.
248	3.1.1	3-1	**Does the facility as used herein mean space now occupied by the existing MMIS or the entire building?** The facilities being used to meet the requirements of the existing New York State MMIS and related contractual obligations including leased space, hardware, software, and staff, may not be used concurrently in support of the implementation or operations of the Replacement Medicaid System.
249	3.1.2 3.1.3 3.1.4 3.1.5 6.2.1.7	3-1 to 3-4 6-8	**These sections call for "workstations" to be provided for various classifications of state staff. We can not find any further detailed specifications for these workstations. We need to know the detailed specifications for these workstations in order to provide them. For example, what class of CPU and speed is required, how much RAM is to be installed, how much hard drive space is required, what I/O devices (floppy drives, CD drives, modems, etc.) are required, what operating system will be used, and what application software (office suite) will be required? Will all workstations be identical, or will there be differing requirements based on intended usage?** It is the Department's intent for the workstations to be consistent with current technology at the time they are installed. If the workstations were installed today, the minimum Department hardware requirements would be: 233 MHz processor with 32 megabytes of ROM; a 4 to 5 gigabyte internal hard drive; 12X CD ROM drive; 3" floppy disk drive; 100 megabyte Zip drive (all drives internal); 17" monitor with high speed bus; full-function 101 key keyboard; full function mouse; and a network card. The installed software would include MS Windows 95 (or Windows NT), MS Office 97, Virus Scan, and Lotus Notes. Offerors should consider this guidance for pricing workstations.
250	3.1.3	3-3	**The second paragraph on this page asks for "electronic communication with the local social service districts". Please specify the nature of these electronic connections. How many of these connections are required?** OSC expects that the requested connectivity to the OSC LAN will provide the necessary access to local districts via NYT and the Internet.
251	3.2.2.1	3-6 3-7	**HIPAA allows entities to transmit and receive data in non-standard formats if they use a clearinghouse. Will the State accept this solution?** The Department will consider innovative suggestions from the offerors provided they are consistent with HIPAA and other Federal requirements.
252	3.2.2.1	3-6 3-7	**The NPI rule may require states to enumerate providers, but we are not yet certain. Is this function considered to be included in the scope of work of the RFP under the general rubric of complying with HIPAA EDI requirements?** Yes. Section 3.2.2 states, "The New York State Replacement Medicaid System must be in compliance with the national standards as prescribed by the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 and any other Federal requirements that are effective as of the date of the offeror's proposal."

253	3.2.2.1 5.3.5	3-6 3-7 5-5	**The NCVHS held the first public hearing regarding claims attachments in February 1998. There are no existing national standards. The transcribed testimony and council discussion posted on the NCVHS Web site indicate that the process of defining a claims attachment standard could easily move into the Year 2000. Because of the general delays in the HIPAA Notice of Proposed Regulation (NPRM) process, HCFA has published that the implementation of the regulations will be 24 months after the final regulation is published. Because the potential of a final regulation for a claim attachment is in the Year 2000 and there are few indicators as to how the hearings, definitions, and recommendations will evolve, companies face an enormous risk in determining how to quantify the business effort and associated costs of implementation of claims attachments. Unknowns and their associated risks are reflected in proposers' costs. Will the State consider removing the requirement for claims attachments from the RFP?** No. This is required by law. Offerors should assume that the attachment requirement will be similar in structure and syntax to the ANSI requirement for the billing standards. **During the bidder's conference the intimation was that offeror's bids were required to accommodate HIPAA rules in effect at the time the bid was submitted. Will the State amend the RFP to incorporate this "in effect at the time of submission" thinking?** Section 3.2.2 states, "The New York State Replacement Medicaid System must be in compliance with the national standards as prescribed by the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 and any other Federal requirements that are effective as of the date of the offeror's proposal."
254	3.2.2.1	3-6	**"It is expected that HCFA will adopt the standards for most transaction sets and related code sets (data elements) by February 1998. HIPAA required that Medicaid agencies be prepared to accept the electronic standards within two(2) years (by February 2000)."** **Since the referenced standards have not yet been released, would the Department expect that the related implementation schedules would be adjusted to accommodate the release date (i.e., the standards would not be required to be implemented until two years after the actual release date(s))?** Although the standards have not been formally established by the Secretary, most of the standards are known and implementation guides for many of the standards have been published. The Department expects the Replacement Medicaid System to be fully compliant with HIPAA standards on scheduled implementation.
255	3.2.2.4	3-8	**Does the Department have a preference for whether the Medicaid Statistical Information(MSIS) files are generated from the RMS or the Medicaid DW?** No.
256	3.2.7	3-15	**The RFP makes reference to the need to establish access to the Replacement Medicaid System by local districts throughout the state. Is there a requirement for the contractor to provide remote terminals in each of these locations?** The contractor may rely on the use of existing terminals.
257	3.4.1 bullet 1	3-22	**What is the purpose of the Monthly Financial Report?** The Monthly Financial Report supports the Department's contract management activities.

258	3.4.2	(3-22) 3-21	**Does the Department want the "advanced fraud detection tool" to work in concert with the IBM Fraud and Abuse Management System which was installed recently?** Yes.
259	3.4.2	3-23	**In the last paragraph, the Department asks for development of a fraud detection and prevention program. Does the State anticipate that the Contractor establish a staffed unit of fraud detection personnel to support and enhance the efforts of the SUR, provider audit, MFCU, and Comptroller's units? If so, what is the anticipated staff level that the Department expects?** This requirement is part of New York State's effort to be responsive to the HIPAA requirement for all entities fighting health care fraud to work more cooperatively. The establishment of a fiscal agent unit to work with the Department's SUR and QA&A units and with MFCU to provide a coordinated response to the problems of fraud and abuse is as new to the Department as it is to the offerors. Thus, the Department has not established an expected staffing level and anticipates that the offerors will propose an appropriate staffing level.
260	4.1	4-1	**Second paragraph, second sentence: "The Medicaid systems to be replaced by the Replacement Medicaid System are.... Several State-operated systems, some of which are components of the Welfare Management System (WMS) and some of which are standalone systems; all of the State-operated systems are currently operated by the Human Services Application Service Center (HSASC)."** **Please provide a complete list of all the State-Operated systems that are to be replaced by the Replacement Medicaid System. Please include a description of the functions these systems perform, the computing platform(s) used, and system-level documentation.** The current Medicaid systems are described in detail in Sections 7.1.1 through 7.1.3. These systems will be replaced by the Replacement Medicaid System. The WMS and its subsystems are described in Section 1.2.1. The details of the interface with WMS will be finalized in JAD.
261	4.3.1	4-6	**First paragraph: "The current EMEVS contractor will be required to upgrade the network to improve data communication speeds and reduce data problems. There will be no change in the EMEVS software, and the network upgrade will be a stop-gap measure until the Replacement Medicaid System contractor can begin operations with the EMEVS Redesign."** **Are the Replacement Medicaid System bidders expected to include the upgraded EMEVS network in the Replacement Medicaid System network design? Please provide schematics and information regarding the network upgrade that DEPS will install as part of their contract extension, so that bidders can write their proposals to match the configuration that will be turned over.** The Replacement Medicaid System contractor is expected to provide a network that meets the requirements specified in Sections 7 and 8 of the RFP. The Department will not require the Replacement Medicaid System contractor to duplicate the network upgrade installed by DEPS.
262	4.4.2.4.3	4-14	**What is the frequency of provider issues and problems? Please provide last year's data and specify the metrics that the State now uses for performance measurement.** The information sought is included in the procurement library which is available for offeror perusal.

263	(4.4.2.4.2) Eliminated (4.4.2.4.3) Eliminated	(4-14)	**What standards are currently being met by the incumbent?**
264	(4.4.2.4.2) Eliminated	(4-14)	**This section states that the Contractor will handle various types of EMEVS transactions "at least as expeditiously as DEPS". Please provide specific response time requirements for each of the stated transactions, along with the specific measurement approaches which the contractor must use to measure compliance.** This reference was to the EMEVS Takeover and Operations which is not in the revised RFP (Amendment 2). However, the statistics associated with transaction and Voice call volumes are presented in the EMEVS Monthly Compliance reports. This report is available in the procurement library. The communication network must provide timely responses to provider inquiries. The level of responsiveness will be measured by a Provider Response Measurement System, a quantitative analysis system provided by the successor contractor. This system will measure the speed of the response from the time the transaction leaves the provider until the response is returned back to the provider. The following minimum standards must be met for all CALLS (not transactions) within a calendar month: ARU - 90% of all calls must be responded to in less than or equal to 238 seconds POS - 90% of all calls must be responded to in less than or equal to 18 seconds PC - 90% of all calls must be responded to in less than or equal to 38 seconds These times are based on when the InterVoice equipment receives the call from the provider until the call is terminated.
265	5.3.3	5-4	**Please provide a list of the Non-Title XIX programs that must be accommodated and the detailed requirements for these programs.** The Department expects that the Replacement Medicaid System will be highly flexible to accommodate both current needs and future changes. Section 5.3.3 describes some of the system architecture elements required to accommodate multiple programs, some of which may be added in the future.
266	6.2.1.1	6-3	**Given that the Offerors will likely bid some proprietary systems in response to the Medicaid DW requirement, does the Department accept that the look and feel of the on-line screens in the Replacement Medicaid System and the Medicaid DW may be different?** Yes
267	6.2.10.3	6-46	**At the point in time that the RMS is fully implemented and the interface to the Medicaid DW is transitioned from the MMIS to the RMS, will the Department expect each of the new data elements defined for inclusion in the Medicaid DW be "back populated" in the rolling 60-month database or will the Department want the new data elements only from that point-in-time forward?** To be finalized in the Medicaid data warehouse design. The Department will work with the contractor to minimize the number of data elements that must be "back populated".

268	7	7-1 to 7-160	**Based on our Independent review of the current MMIS application code, we have identified a number of functional requirements that are represented in the existing application logic, but do not seem to appear in the details of the State's RFP. The NYS-MMIS main edit table contains approximately 1000 edits. These edits span more than 31 invoice types and 4 regional classifications, resulting in more than 2.5 million unique edit combinations. In addition to the main edit table, there are several smaller edit tables embedded in individual program and a great many programs contain logic which bypasses individual edits so as to reflect state policy initiatives. In addition to the bypasses, many programs contain logic which is applied to specific providers or groupings of providers based upon Department agreements with, or accommodations made, for those Providers.** **Is it the State's intention to include these functional requirements in the Replacement Medicaid System, and should bidders include in their fixed price proposals the resources needed to incorporate these functions?** The Department stated its intent in Section 7.1.4 of the RFP: "In general, it is the intent of the Department that the Replacement Medicaid System must, at a minimum, meet or exceed all of the functionality of the current MMIS and EMEVS, as described in the previous sections. It is the intent of the Department to move forward, not backward, in capability." The contractor shall be responsible for providing a transfer base and modifying that transfer base to meet the requirements of the New York State Replacement Medicaid System. The Department anticipates that any transfer base, regardless of source, will meet many but not all of these requirements.
269	7.1.1.3 Paragraph 3	7-4 to 7-5	**How is it determined which checks and remittance advices go to what locations around the State? How are the updates and revisions to this list received, and what is the time frame for completing the updates? What is the average number of checks and remittance advices per checkwrite that must be sorted and delivered to other locations?** A provider can arrange to pick up checks and remittances by submitting a request in writing to the fiscal agent. Detail is provided in the "Provider Relations Technical Support Unit Procedures" and a overview of the mailing of checks and remittances is available in the Computer Services Manual, both available in the procurement library. There are currently no contractual time frame requirements for completing the changes required for a provider to be added to or deleted from the check pickup process. For cycle 077 (checks dated April 13, 1998 for release on April 29, 1998), 2,782 providers have made arrangements for their checks and remittances to be picked up (1,168 in Albany, 1,411 in New York City, with 203 that will be mailed).
270	7.1.1.3	7-5	**"... The Check is collated with the remittance statement and either mailed to the provider or prepared for pickup at one of several Contractor pickup locations around the state."** **Where are the locations of the Contractor pickups?** Checks can be picked up at the fiscal agent's facilities located at 800 North Pearl Street, Albany and 37 East 28th Street, New York City.
271	7.1.3.1	7-25 7-26	**Does SDX eligibility post to the Interim Recipient Eligibility File (IREF) before posting to the MMIS? Is the IREF a component of the WMS? Is the WMS responsible for identifying overlapping and/or duplication of eligibility?** **SDX eligibility is available from SSA daily. What is the frequency of update in New York? Who is the Network Data Mover for New York?** SDX updating occurs in WMS and the responsibility will remain with the WMS. SDX eligibility posts to IREF prior to posting to MMIS. IREF is not a component of WMS. Overlapping and/or duplication of eleigibility is identified in IREF. SDX is updated daily by HSASC.

272	7.2.3.2.18	7-35	**Has New York already implemented QI1 and QI2 programs in the WMS? Is the application process different for QI1 and QI2s? How will New York issue checks to the QI2 eligible? With what frequency will New York issue checks?** The Department notified local Departments of Social Services to begin taking applications for the Medicare Premium Payment Program. The application process is the same for QI-1s and QI-2s. Checks will be issued once annually for the reimbursement to QI-2s. **Does New York automatically buy in to Part A and/or Part B for those eligibles who are entitled to Medicare?** There is an automatic buy-in of Medicare Part B for individuals who are in receipt of Supplemental Security Income and are 65 years of age or older. There is no automatic process for Part A buy-in.
273	7.2.3.4.2	7-36	**Do "health plans" and "other entities" transmit to WMS, to IREF, or directly to MMIS/EMEVS?** Currently, all eligibility is captured in WMS and its subsystems. It is transmitted to MMIS/EMEVS in part directly and in part via IREF. In the Replacement Medicaid System and as a result of the WMS redesign, the plan will be for the IREF to cease to exist. The system will interface directly with WMS or its successor. Currently most Managed Care enrollment is accomplished by the local districts through WMS. There is an option for health plans to enter enrollment transactions into EMEVS, but the transactions are processed through WMS. Please note that Sections 7 and 8 specifies the desired state, not the current state.
274	7.2.3.4.1	7-36	**Section 7.2.3.4.1, This sentence notes a requirement for a 2-way interface to the WMS. Please specify the exact meaning of a 2-way interface?** A 2-way interface refers to the flow of data both from the WMS to the Replacement Medicaid System, as well as the flow of data from the Replacement Medicaid System to the WMS. For example, while the majority of the data is transmitted from the WMS to the Replacement Medicaid System, there are some TPR specific data fields which are transmitted from the Replacement Medicaid System to the WMS as described on page 7-114.
275	7.2.5.2	7-37	**Is the contractor's access to WMS limited to inquiry only?** Yes.

276	7.3.6.13	7-52	**"Support the capture of rate information either directly or through interfaces with existing rate-setting systems"** **From what sources will the rate information be received? In what format(s)? What will the volumes and frequency of the updates be? Please define the specific activities involved in this function.** Medicaid rates are received from the Department of Health, Division of Health Care Financing; Office of Mental Health; Office of Mental Retardation and Developmental Disabilities; Office of Alcoholism and Substance Abuse Services; and from Local Departments of Social Services (LDSSs). Current transmittal media include Lotus files, SUN system files, and IBM mainframe cartridges, as well as paper input. The contractor will be responsible for accepting these sources in their current forms and entering the data to the Replacement Medicaid System. Alternatively, the contractor may provide the technical support to rate setting agencies to support direct, on-line entry of rate changes. The approach for each rate setting agency will be finalized in JAD. Department of Health mass rate changes occur up to twice per year. A single change may involve ten thousand (10,000) individual rate line transactions due to the need to "map" Medicaid rates to specific provider service locations. A provider may have between one (1) and seventeen (17) service locations.
277	7.4.6.29	7-65	**Resolution Manuals** **The contractor is required to "update and deliver resolution manuals."** **To what type of resolution does this statement refer?** **To whom do these manuals need to be delivered?** **Please define the activities the contractor will need to perform these updates. What is the volume of updates per month? How many pages will be updated per month?** Claims or other transactions in a pend status due to failing a daily, weekly, or combination edits must be resolved. A resolution manual provides the rules for resolution of these transactions. The resolution manuals will be delivered to appropriate contractor staff and appropriate Department staff as determined during JAD. It is anticipated that once the manual is initially developed update activity will be low.
278	7.5.1 7.5.3.2.6	7-66 7-67 7-70	**Does the State own the EMEVS terminals deployed in provider sites today?** **If so, what devices are presently deployed? Please specify manufacturer and model(s).** **If so, how many devices are deployed?** **If so, what are the replacement/repair rates presently experienced by the incumbent?** The State currently owns 13,282 VeriFone Tranz-330 terminals. Medicaid providers currently own 3,402 VeriFone Tranz-330 terminals. Over the past 4 months the incumbent contractor has repaired/replaced 363 terminals.

279	7.5.3.1.3	7-68	**Is it a correct assumption that the reference to "voice" in this citation means an individual?** **Are there limitations as to which State and/or contract personnel can provide this service? If so, please describe the limitation.** **Are all of the functions listed in this citation available today?** **What is the most recent annual volume, totally and by access mode?** **How may host-to-host connections are in place today?** **What are the State's criteria for approving host-to-host connectivity?** The reference to "voice" in this Section means Audio Response Unit (ARU) eligibility transactions. (ARU is defined in Appendix B) The ARU service is the responsibility of the successor contractor. ARU information can be found in the EMEVS Provider Manual provided in the procurement library. Volumes can be found in the procurement library. There are currently 13 CPU to CPU links. The criteria for approving host-to-host connectivity should be established by the successor contractor.
280	7.5.3.2.12 7.5.3.2.20	7-71	**Is it correct to assume that this is an unintentional repetition of a requirement? If not, please explain how these citations differ.** It is an unintentional repetition of a requirement.
281	7.5.3.2.18	7-71	**Is it correct to assume that the requirement describes the State's intended response to electronic claims transmitted in batch mode?** Yes.
282	7.5.3.4.3	7-73	**What Medicare carriers and intermediaries transmit crossover data to New York today? Please specify the type of data transmitted (Part A, Part B, DME).** Although there is no automatic crossover of data at this time, negotiations are being conducted to begin automatic crossover of inpatient claims. **How often is New York Medicaid Eligibility data made available to carriers and intermediaries today?** Medicaid files are sent to selected insurance carriers on a quarterly basis for commercial health insurance matches. The Department does not routinely share Medicaid data with Medicare intermediaries or Medicare carriers. **Is the existing frequency adequate or does the State need other options?** The existing frequency is adequate. **What health care payers other than Medicare carriers and intermediaries transmit or exchange data with New York Medicaid today?** The Department of Health currently matches Medicaid eligibility files with membership files of the following health insurance carriers; Empire BC/BS, BC/BS of Utica/Watertown, BS of Northeastern NY, BC/BS of Central NY, BC of Northeastern NY, HIP of Greater NY, United Healthcare (formerly Metropolitan Life), BC/BS of Rochester, United Health (formerly Travelers), U.S. Life, BC/BS of Western NY and GHI.

283	7.5.6.9	7-75	**Is the confirmation number communicated to the providers to be used as a guarantee of eligibility? Is this number used during claims processing?** Yes to both.
284	7.5.6.4	7-75	**Hardware and software solutions that are specific to one transaction, in this case eligibility, and to one payer, will be made obsolete by HIPAA regulations. Will the State consider deleting this requirement?** No. There will still be a need for this type of transaction under HIPAA standard requirements.
285	7.6.6.3	7-88	**"Deliver to the Department and pick up at the Department, contractor mail, reports, and other deliveries once in the morning and once in the afternoon each business day, and at the request of the Department."** **Will the contractor be responsible for courier service currently provided by the NYS DOH, OGS or Youth Services?** This requirement only provides for courier services between the contractor's Albany location and the Department locations in Albany.
286	7.6.6.28	7-90	**MCO stop-loss claims** **Is the contractor required to perform the stop-loss documentation review and payment decision as well as the automated processing of the base stop-loss claims?** **If that is the case, is medical expertise required to perform the function? What volume can be expected? What specific steps will be required to complete the review?** Typically stop-loss thresholds are established by dollar amounts which can be automated. The contractor will not be required to make related medical decisions.
287	7.7.1 paragraph 4	7-92	**How are payments to the "Public Goods Pool" made? Through inter-agency transfers? Does this mean that a percentage of each provider payment made for inpatient hospital, outpatient, ambulatory surgery centers, and hospital-based pharmacy services is made and denoted on a separate "register"?** Actual payments to the "Public Goods Pool" are made within the Department. The contractor's responsibility is to generate reports, based on qualifying claims and Department supplied percentages, and to identify the amount to be paid.
288	7.7.3.2.1	7-96	**How many paper checks are generated with each payment cycle? How many EFT transactions are generated with each payment cycle? Does the Department plan to mandate EFT? If so, when?** For calendar year 1997, the system generated an average of 18,938 checks and 25,835 remittances per cycle. The Department does not currently provide EFT payments. The Department does not plan to mandate EFT.
289	7.7.3.2.4	7-96	**What is the current frequency of extra payment cycles?** There have been no extra payment cycles to date under the contract with the current fiscal agent.
290	7.7.3.2.5	7-96	**How many hard-copy remittance advice statements are produced each payment cycle? How many electronic media are produced each cycle?** For cycle 077 (checks dated April 13, 1998 for release on April 29, 1998), the system generated 19,252 checks and 24,612 remittances. Of these, 457 tape suppliers received 6,359 remittances on magnetic media.

291	7.9.3.4.2 7.9.3.4.3	7-118	**How many state and federal agencies and private insurers are currently used for TPR data matching? Do these requirements mean that the MMIS must be able to perform data matching with any agency/insurer, regardless of data format?** The current matching includes 11 insurance carriers, the Department of Motor Vehicles, and the Federal Social Security administration. In addition, there are plans to amend existing agreements with the National Insurance Crime Bureau and Medicare Fiscal Intermediaries (5 in total as currently configured). There is also a contract pending that will have a contractor perform matches with an additional 27 insurance carriers and HMOs. Where the returns from third party collections justify the cost of match, the Replacement Medicaid System must support that match. With the implementation of EDI standards under the Health Insurance Portability and Accountability Act, the need to maintain matching with a large number of data format should not be an issue.
292	7.9.6.10	7-121	**This contractor responsibility, related to third-party resource processing requires the contractor to produce a monthly report and questionnaire of claims for trauma, accident, and casualty-related services. Please provide more information on this questionnaire: is the Department or the contractor responsible for developing this questionnaire? Will Department staff or contractor staff review/process the completed questionnaire?** The questionnaire will be a standard format which will be designed by the contractor and Department staff during JAD. The criteria for triggering the production of the questionnaire will also be finalized in JAD. Because the Department, the local districts, and TPR contractors are responsible for third party recoveries, the Replacement Medicaid System contractor's responsibility will be to generate the reports and deliver them to the specified participants and to generate the questionnaires and send them to the appropriate parties (clients, providers, attorneys, etc.).
293	7.10.3.2.2	7-124	**7.10.3.2.2 describes processing requirements with regards to providing bulletin boards or internet data exchange. Please clarify application requirements.** The Department is interested in improving the capabilities of the Child/Teen Health Plan to positively impact the health of children in New York State. One way of increasing such capabilities is to provide a means for an open and free exchange of information and ideas between providers, local districts, and the Department. Full details of the application will be finalized during JAD.
294	7.11.3	7-128 7-129	**If the system is to process provider network affiliations and encounter data, all the MCOs must interface with the Medicaid system. Accurate, current provider information and meaningful encounter data are dependent on the quality and timeliness of the MCOs providing the information. If the MCOs contract at the local district level, what provisions exist to ensure cooperation, reliability, and accuracy, so that the contractor can comply with the provider information and encounter data requirements? For example, does a specific requirement exist for the MCOs to ensure timely transmission of PCP and encounter data?** The Department will work closely with the contractor during JAD to finalize such details.

295	7.11.3 Paragraph 1 7.11.3.4	7-128 7-131	**The first paragraph of System Requirements indicates that WMS will be used to accept enrollment data from counties and will transmit enrollment information to the Department.** **The Interfaces section suggests enrollment information will also be transmitted from the enrollment broker and directly from the health plans.** **Please provide current and future specific information on enrollments captured by WMS vs. those captured by the Enrollment broker.** Upstate enrollments are via WMS, NYC enrollments are expected to be via enrollment broker. **Will all enrollment data come via the WMS? If not, which system overrides the other?** Refer to question 273 and above answer. **What is the role of the health plans in capturing enrollment information? Is it correct that health plans will not directly enroll or disenroll clients?** Counties that have agreed to the Partnership Plan will not be permitted enrollment by the plans. The Department will work closely with the contractor during JAD to finalize such details.
296	7.11.3 Bullet 4 7.11.3.2.9 7.11.6.10	7-129 7-130 7-134	**Stop/Loss is a listed subcomponent of the Managed Care Systems Enhancement Project, and a Stop/Loss threshold is also referenced in Contractor Responsibilities on page 90. Under Processing Requirements on page 87, the system is required to maintain edit logic to recognize once a managed care benefit threshold has been reached and pay subsequent claims on a fee-for-service basis. Is the processing requirement described above the same as the Stop/Loss threshold?** **Does the Stop/Loss threshold require that the system independently recognize a person that has exhausted a benefit and change the claimant's status to fee-for-service for that benefit? With managed care clients, what would be the basis for the system's history of benefit use? Encounter data? MCO shadow claims? Which benefits will have benefit thresholds? Will all the MCOs have the same thresholds?** **Who has the obligation to notify and explain the benefit change to the client who is moving from managed care to fee-for-service for part of his benefits?** The Department expects the Replacement Medicaid System to have the capability to recognize when a Managed Care enrollee has met a stop/loss threshold (on the basis of dollars or benefits) and to pay subsequent claims on a full or partial fee-for-service basis. The Department will work closely with the contractor during JAD to finalize the details of this requirement.
297	7.11.3.2.10	7-130	**What is the methodology to be used in determining prorated premiums?** **Will premiums be prorated on a daily basis or mid-month basis?** To be finalized during JAD.

298	7.11.3.3.4	7-131	**States provide HCFA with annual EPSDT reports, Enrollment reports, quarterly status reports, and modified HCFA 64 reports. Would you provide a comprehensive list of the federally-required managed care reports to be provided by the Replacement Medicaid System?** A comprehensive list of reports produced by the MMIS is available in the procurement library. Reports that are not produced by the MMIS are not in the Procurement Library.
299	7.12.1 Paragraphs 1 & 2	7-134 7-135	**Is the State of New York currently sending a state manufacturer agreement to the participants of the program, or is this a contractor responsibility?** Yes. Currently the state operates the drug rebate program. Manufacturer agreements would continue to be sent by the State. **Do the HCFA releases that contain the update information on new and terminated labelers go directly to the contractor, or to the State to be forwarded to the contractor?** The HCFA tape referenced would initially come directly to the State for manipulation. Subsequently it would be forwarded to the contractor for rebate invoicing, etc. Detailed procedures, however, will be finalized during JAD.
300	7.12.3.2.6	7-136	**Please define the tracking of correspondence related to rebate activity and explain how it relates to the creation and mailing of the invoices.** It is the Department's intention for the successful contractor to assume invoice responsibility for drug rebates. One inherent function would be to log in, reconcile and maintain hardcopy and electronic records relating to manufacturer correspondence. The relationship between invoices and correspondence is one of reconciliation between amounts billed and the agreed to payments.
301	7.12.3.2.8	7-136	**Does the Department follow the HCFA guideline/recommendation that if the exchange of information fails to resolve the dispute, and the disputed amount is under $10,000 per labeler code and under the $1,000 per product code of labeler's code at the nine digit NDC level, the State may cease the resolution process? If not, what are the thresholds currently in use?** Dispute resolution will remain a Department responsibility and such decisions will be made by the Department.
302	7.12.3.3.19	7-137	**Would the Department please define in detail the required data elements and the desired medium for these reports furnished? By "all drugs" does the Department mean each separate nine digit NDC, or would there be a grouping, such as by the first seven digits of the NDC?** The reports should be by the nine digit NDC (package size should be ignored). The elements shall be the standard OBRA '90 rebate elements necessary to run a successful program. The desired medium would be by primarily electronic and then secondarily hardcopy.
303	7.12.3.3.21	7-137	**As you are aware, some manufacturer's have more than one labeler code. Are we correct in assuming the Department expects the contractor to link all of the labeler codes under a manufacturer to produce this report?** Yes. For invoice as well as reporting, labeler code level should be maintained. For reporting and filing, it would be important to have the labeler codes grouped by manufacturer.
304	7.12.3.3.10	7-137	**What are the guidelines for collection letters, and how often are these mailed?** The State will specify the actual wording of the collection letter which will be sent out by the contractor on a quarterly basis.

305	7.12.6.6	7-140	**Does the current system contain information from the onset of the program forward? If not, how many years of drug rebate data is available at this time? If the contractor were to move forward with a new MMIS, would they be expected to transition all of this data into the new system? Would the prior period adjustments only be applicable for the years of data maintained by the contractor?** The Contractor must populate the Replacement Medicaid System with sufficient data to be able to track receivables from 1991 forward and to begin generating invoices as of the start of operations. Prior period adjustments would only apply to years for which the contractor has data.
306	7.12.6.7	7-140	**Does the Department have a preference of electronic format? Are both a bulletin board and disk acceptable means for electronic format?** The Department has no preference for specific electronic formats. However the rules of confidentiality must be adhered to.
307	7.16.1 7.16.4.1 7.16.6.10	7-154 7-155 7-158	**"The environment includes a test (mirror) version of on-line and batch programs and system files that are identical to the production environment."** **7.16.4.1 "Execute cycles in accordance with established schedules"** **7.16.6.10 "Perform claims processing in a simulated production environment."** **Does the State want a completely separate test system mirrored after the production system? Does this requirement include establishing separate production files such as reference files, history files, etc., or will the contractor be allowed to reference production files from the test system?** The Department requires a completely separate test system mirrored after the production system. A separate test system allows the Department to modify the reference file to meet a test scenario without impacting the production file. Additionally, the Department will need to test functionality of the reference file which could adversely impact the production file. The test system will have a mirror of the reference files/tables, a subset of the history, client, and provider files/tables. It is important that the test system truly mirror the production system, but it is equally important that use of the test system not contaminate production files.
308	8.2.2.1	8-5	**What is the length of the adjudicated claims record?** The adjudicated claims record (ADJVAR) is a variable record. The largest record is 1,197 bytes (inpatient) and the smallest is 777 bytes (pharmacy). ADJVAR is then converted to a 1,000 byte record (ADJCLAIM) for all claim types and is sent weekly to HSASC.
309	8.2.3	8-6	**Will the Medicaid DW provide data to the FWA system developed by the Los Alamos National Laboratory?** Yes.
310 311	8.3.1.2	8-9	**What are the numbers of authorized and concurrent users functional department?** **What are the number authorized and concurrent end-users for each software application to the data warehouse/EIS/DSS?** Exhibit 8.3 of the RFP identifies 888 authorized users and 595 concurrent users. The breakdown by functional department, location, or application has not yet been determined.

312	8.3.1.2	8-9	**Will the Department provide an estimate of the number of users who will access the Medicaid DW in comparison to the number of users who will access the OMM Data Marts and the Office of Managed Care DW? For example, of the 84 Level I And Level II Managed Care users, how many will access the OMC DW and how many will access the Medicaid DW directly? How many will access both?** Exhibit 8.2 identifies the number of users accessing the Medicaid data warehouse directly.
313	8.5.4	8-23	**Given the volume of data in the data warehouse, SAS would be the preferred statistical software that will meet the defined requirements and provide the levels of performance that the Department desires. The large volume of data, and number of users, also require SAS server-resident (UNIX) applications. By incorporating SAS server-resident applications, most statistical calculations can occur on the UNIX server thereby reducing network traffic and improving overall system performance.** **Based on the requirements on 8.5.4, the following SAS modules would be required to provide the levels of service required:** **<u>Client resident (Workstation) Modules</u>** — **<u>Server-resident Modules</u>** **SAS/ECO version 6.12 for Windows** — **SAS/BASE server for UNIX** **SAS/STAT version 6.12 for Windows** — **SAS/STAT server for UNIX** **SAS/ETS version 6.12 for Windows** — **SAS/Access for RDBMS for UNIX** **SAS/Connect for UNIX** **If the server-resident UNIX products are not included, the target data would need to be extracted and downloaded to a PC for analysis, which would result in degraded performance.** **Does the State agree with the analysis and thereby require these SAS software modules, or equivalent server based products?** **Does the State desire the capability to directly access the data warehouse using the selected statistical software?** **Does the State desire the capability to execute processor-intensive statistical functions on the DSS server?** The Department expects the contractor to develop innovative solutions to meet the Department's objectives.
314	9 6.2.1.2 6.2.1.3	9-1 to (9-28) 9-27 6-4 6-5	**RFP Section 9, "Proposal Submission Requirements," contains instructions for organizing and writing proposals submitted in response to the RFP. However, there does not appear to be a clear instruction for describing the hardware, platform, and system software that will support MMIS operations. The hardware and platform are, of course, a very major consideration in system operations.** **Does the Department expect to see a response in bidder proposals to hardware, platform, and system software? If so, in which section of the proposal should the response appear?** **Our suggestion would be to place the hardware description in 9.2.6, "Approach to Replacement of the Medicaid Systems," to make this section a comprehensive description of the new Medicaid system.** The hardware/platform description is an integral part of the Replacement Medicaid System capabilities (Section 9.2.5.1 as amended) and of the Approach to the Medicaid Data Warehouse (Section 9.2.7 as amended).

315	9	9-1 to (9-28) 9-27	**Some sections of the RFP are not addressed in Section 9 Proposal Submission Requirements. Please clarify if and where/how these sections should be addressed:** **I. Sections 3.1-3.3** **II. Section 4.5 and its subsections [Sections 4.2 and 4.3 of the amended RFP]** **III. Section 4.6 [Section 4.4 of the amended RFP]** **IV. Section 5** **V. The rest of Section 6 (Section 6.2.1.9 is addressed)** VI. **The rest of Section 7 (Sections 7.5.7.8 and 7.14 are mentioned in Section 4.5 as requiring answers). Do Sections 7.1.2.4.2-7.1.4 have to be responded to or are they for information purposes?** Section 9 specifies what must be included in the offeror's proposal. The proposal will be evaluated on the basis of that presentation. Sections 3 through 8 present the system requirements for the Replacement Medicaid System, the responsibilities of the fiscal agent contractor, and the performance standards that must be met. Some of the requirements in Sections 3 through 8 are requirements with which the contractor must comply and require no discussion or elaboration in a proposal. For other requirements, the Department expects the offeror to elaborate on how they will meet requirements so that the Department can evaluate which offeror to select.
316	9.2.1	9-2	**In Section 9.2.1 Transmittal Letter it is stated that "The Transmittal Letter shall include the following:** **"A statement that the offeror accepts the terms an conditions as stated in the RFP and, in particular, the standard terms and conditions specified in Appendix A."** **If an offeror determines, through review of the RFP Terms and Conditions, that it is generally and conceptually in agreement, but that some provisions require further discussion and clarification with the State to insure full understanding of the State's intent, how does the State prefer that the offeror address this in its proposal?** **Additionally, if an offeror does request further discussion and clarification, will the offeror automatically be deemed non-compliant and be eliminated from contention?** The Department has stated that the terms and conditions of the RFP are not open to negotiation. If an offeror needs clarification on terms and conditions, this question and answer process is the appropriate forum. Section 9.2.1 states, "Offerors may not place any conditions, reservations, limitation, or substitutions in their proposal with regard to the contract language, nor may offerors include any statements intended to alter the order of precedence as defined in Section 11.1.1.3 of this RFP." Thus, the time to obtain clarification is now, not in the proposal.

317	9.2.2 Appendix I	9-3 I-3	**The second paragraph of Section 9.2.2 states: "The technical Proposal shall contain a cross reference from each subsection of Sections 6, 7 and 8 of this RFP and related RFP addenda to the appropriate section and subsection of the Technical Proposal."** **This would result in a cross reference ordered by RFP section, that might look as follows, for example:** **RFP Section — Proposal Section** **6 Scope of Work — 1.1.1.1** **6.1 Introduction — 1.2.3.4** **6.2 Implementation Phase — 1.2.3.4.5** **Item 12 on page I-3 asks: "Is there a cross-reference from each section, and subsection of the offeror's Technical Proposal back to the appropriate subsection of sections 5, 6, 7 and 8 of the RFP and addenda?"** **Fulfilling this requirement would result in a cross-reference ordered by proposal section, for example:** **Proposal Section — RFP Section** **1 — 6** **1.2 — 5.1.2.3** **1.2.1 — 8.4.3.2.1** **The two examples cited above show one-to-one relationships only. In actual practice there would be multiple cross-references in each direction.** **Are the RFP sections to be cross-referenced 6, 7 and 8, or 5, 6, 7, and 8?** **Which order does the Department want the cross-reference in?** The purpose of the cross-reference between the RFP and the offeror's proposal is to facilitate the evaluation and to assist the evaluators to find the appropriate areas of the proposal in order to maximize the offeror's score. The minimum cross reference is stated in Section 9.9.2, which requires cross-references between the proposal and RFP Sections 6, 7, and 8. If these sections are included in the cross-reference, the proposal will pass mandatory requirements. It is incumbent on the offerors to prepare their proposals in a manner that will maximize their technical scores. To do so, offerors are encouraged to be innovative. For example, offerors may recognize that evaluators know the contents of the RFP but not the proposal and may want to prepare a cross-reference from the RFP to the proposal. Offerors may elect to reference the proposal sections back to the RFP. Offerors may also elect to include more RFP sections, such as Section 3 in their cross-reference.

318	9.2.2	9-3	**RFP Section 9.2.2 states that there must be an "RFP Cross-Reference" relating sections of the proposal to "each subsection of Sections 6, 7, and 8 of the RFP," whereas the Appendix I checklist of mandatory requirements states that the cross-reference must be to "the appropriate subsection of Section 5, 6 and 8 of the RFP." Which is correct?** The second section of the Technical Proposal shall contain a Table of Contents of the Technical Proposal. It shall also contain a cross reference from each subsection of RFP Sections 6, 7, and 8 to the appropriate section of the Technical Proposal. The "approach" sections of the Technical Proposal shall also have a cross-reference from appropriate subsections of RFP Sections 6, 7, and 8 to the appropriate subsections of the proposal section. The relevant proposal subsections are: Approach to Replacement of the Medicaid Systems Approach to Operations of the Replacement Medicaid System Approach to the Medicaid Data Warehouse Approach to Implementation of Optional Components Approach to Quality Management and Customer Service
319	(9.2.6) 9.2.5	(9-5) 9-4	**We assume the reference to "Section 7" in RFP Section 9.2.6, Approach to Replacement of Medicaid Systems, refers to Subsections 7.2 - 7.17. Is this correct?** Yes.
320	(9.2.6) 9.2.5	9-5	**RFP Section 9.2.6 indicates that the description of the proposed replacement system be organized around two major areas: (1) system capabilities, and (2) approach to design, development, implementation, and transition. While later subsections of 9.2.6 clearly address capabilities, implementation, and transition, however, its less clear where design and development are to be addresses. Please clarify.** Section 9.2.6.2 states, "This section of the Technical Proposal shall describe the offeror's approach to some of the key issues that will impact the success of the Replacement Medicaid System **construction** and implementation effort." [emphasis added]. This section further states, "Discuss the proposed methodology for accomplishing the Implementation Phase activities" The **Implementation Phase** consists of all of the tasks defined in Sections 6.2.2 through 6.2.9.

321	(9.2.9.1) 9.2.8.1	9-17	**What type of data will be required on the hot list and who will identify the "hot list" providers subject to comparison?**
322	(9.2.9.1) 9.2.8.1	9-17	**This section refers to profiling based on mathematical and statistical analysis of historical and current data. Current data is stated as the most recent 6 months of history, what is the definition of historical data?**
323	(9.2.9.1) 9.2.8.1	9-17	**Will the contractor expect updates for the fraudulent scheme profiles to come from MFCU?**
324	(9.2.9.1) 9.2.8.1	9-17	**How often will the fraudulent scheme profiles be updated?**
325	(9.2.9.1) 9.2.8.1	9-17	**What type of data is contained on the MFCU files?**
326	(9.2.9.1) 9.2.8.1	9-17	**What type of data is expected to be collected from the Private Insurance files?**
327	(9.2.9.2) 9.2.8.2	(9-18) 9-17	**What is the time frame for client's recent history?**
328	(9.2.9.2) 9.2.8.2	(9-18) 9-17	**Other than Medicaid providers, how many other "Selected Providers" would there be and would they all be local or would some providers be located out of state?**
329	(9.2.9.3) 9.2.8.3	9-19	**This enhancement requires direct access to the Client Repository from local offices and state staff. Will the Contractor be required to supply and install additional terminal devices or PC's or is the intent to provide electronic linkages to the existing local systems? If the latter, how will the prospective bidder obtain detailed information about these existing systems upon which to base their technical approach and cost?** All three components identified in Section 9.2.9 are optional because the Department is unable to provide enough specification to permit offerors to adequately price the solution. Offerors are encouraged to recommend solutions and provide an estimated price.
330	(9.2.10.1) 9.2.9.1	(9-20) 9-19	**RFP Section 9.2.10.1 says the offeror must outline its quality management plan "as defined in sections 3.4 ... and 6.2.1.9". However, the organizational structures contained in those sections match neither each other nor the points of discussion laid out in 9.2.10.1. Also, are subsections of 3.4 considered to be pertinent here? RFP Section 3.4.5, in particular, is referenced separately later under 9.2.10.1 (Customer Service). Please clarify.** Section 9 specifies what must be included in the offeror's proposal. The proposal will be evaluated on the basis of that presentation. Sections 3 through 8 present the system requirements for the Replacement Medicaid System, the responsibilities of the fiscal agent contractor, and the performance standards that must be met. Some of the requirements in Sections 3 through 8 are requirements with which the contractor must comply and require no discussion or elaboration in a proposal. For other requirements, the Department expects the offeror to elaborate on how they will meet requirements so that the Department can evaluate the proposals.

331	10.3.1	10-3	**As stated on page 10-1 of the amended RFP, the technical/price ration for evaluation purposes is 70 percent technical/30 percent price. However, with the elimination of the requirement to takeover and operate the current EMEVS, the total available technical points was reduced from 9,500 to 8,000 points. The total available points for price remains at 3,000 points.** **Please note that the total available points, as announced in the amended RFP, produces a ration of 73 percent technical to 27 percent price.**
332	10.3.4	10-4 to 10-5	**With the total available technical points reduced to 8,000 points, we believe the portion of the scoring formula "y=(n/z) * 7,000, where:" should read "y=(n/z) * *8,000*..." Please clarify.** During the "Scoring of Technical Proposals" step of the evaluation, technical scores will be awarded based on a 8,000 total available points and will be distributed by category in accordance with Section 10.3.1. During the "Final Scoring and Ranking" step all technical scores will be normalized to 7,000 points in accordance with the formula illustrated in Section 10.3.4. Thus, an offeror who scores 8,000 points in the "Scoring of Technical Proposals" step will be awarded 7,000 in the "Final Scoring and Ranking" step. The technical/price ratio in the evaluation will remain at 70/30.
333	11.3.2.3	11-8	**In order to expedite the dispute resolution process, would the State please modify this section to include a time frame for issuance of the decision similar to what is in Section 11.3.2.2?** No.
334	11.7.5	11-21	**Would the State be willing to limit the vendors' liability to the amount specified in Section 11.7.5 of the RFP?** No.
335	11.7.5	11-21	**Regarding Section 11 Terms and Conditions, our understanding of limitation of liability is that it is capped to $10,000,000 per 11.7.5, Letter of Credit which states that "The Contractor shall procure... a ten million dollar ($10,000,000) letter of credit to secure the Department against default under this Contract by the Contractor." Is this an accurate interpretation?** No. The Letter of Credit specified in Section 11.7.5 is a means to protect the State of New York from default by the contractor. It is not intended as a limitation of liability.
336	(11.9.3.3) 11.9.2.3	11-31	**The current MMIS Fiscal Agent processes postage, manuals, forms, etc., as cost reimbursement items.** **If the items that were formerly reimbursables under the old contracts are now to be embedded in the fixed price, please provide activity volumes and frequency for all items.** Monthly volumes for claim forms and manuals distributed for the period January 1997 - November 1997 are available in the procurement library. Summary postage costs are also available in the library. **The cost for these items may be substantial and will be beyond the control of the contractor. In order to arrive at the most cost effective solution for these items, would the Department consider designating these items as a cost reimbursable?** No. Postage will be the only reimbursable item.

337 enclosure	Appendix C		**Please make originals of all claim forms used in the NY Medicaid available to offerors.** Enclosed are originals of the forms and envelopes which are available in the procurement library.
338	Appendix L	L-14 to L-18 Forms F.1 - F.5	**The number of "Annual Days" to be used in the calculation of technical staff pricing is specified as 225 days (with the exception of 165 days for Data warehouse user support on schedules F.1 and F.2). The forms note that "The daily rate is a fully loaded rate and includes all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs. Please provide the rationale for using 225 days for the base for the pricing calculations.** As set forth in Section 11.9.2.5 of the RFP (as amended), "...the Contractor shall be reimbursed at the daily rate specified in Pricing Schedule F for each individual provided times the number of days for which the individual is used on New York State evolution projects". The 225 days used for pricing account for training and administrative time which are a part of the annual administrative fee.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
May 11, 1998

Released as number	RFP Reference	Page	Question and Response
339	General		**Can the Department specify how many detailed encounter records and adjudicated claims are processed each year?** Total claims and encounter records processed by the current fiscal agent, as reported in the weekly summary control report, are available in the procurement library (See "Summary of Payments to CSC and Claims Processing").
340	General		**For our evaluation of the workload of the current systems running at CSC, we would like to request the following SMF record data in tape format for MMIS, MARs and Surs:** **Record — Description** **6 — Print** **21 — Tape Mounts** **30 — CPU** **70-79 — I/O** **We would like to have one years worth of data to cover all peak periods, but request at a minimum 30 days worth.** This information will be provided to the requesting offeror and is available to all offerors upon request.
341	Bidders Conference statements regarding the availability of EMEVS software		**If we understood the Department correctly, there are several hundred proprietary modules in the EMEVS systems that fall within two categories: modules developed by DEPS which are scheduled to be replaced with public domain software by the summer of 1998, and modules licensed by DEPS from FDR and its successor - these modules are not scheduled for replacement and would have to be licensed from FDR and its successor. Our questions are as follows:** **1) When will the DEPS software and the public domain replacement modules be made available to bidders under the Freedom of Information Law Statutes - can this software be made available in the summer of 1998 prior to the award of the contract?** The DEPS software and public domain replacement modules can be made available to the Replacement Medicaid contractor only after the Office of the State Comptroller approves the contract between the Replacement Medicaid System contractor, and the Contractor executes and delivers to FDR/TMSI a form "Acknowledgment and Agreement", which binds the Contractor to the confidentiality obligations and all other terms, conditions and provisions of the License Agreement, and then, only for the operation of EMEVS.

341 continued			**I. For the second category:** **a) Will the Department identify the specific modules and the functionality of those modules?** There are over 500 proprietary modules per the software license agreement. Although this information is confidential and may not be divulged at this time, it will be made available to the successful offeror after contract award. **b) Will these modules be available to the successful bidder free of charge?** These modules will be made available to the successful offeror, free of charge, after contract award subject to the terms and conditions of the software license agreement. A copy of the software license agreement has been added to the procurement library. **c) Will the Department provide the name and contact point of the firm from which the software would be licensed?** The firm from which the software would be licensed is as follows: Mr. Dennis Wildsmith Transaction Management Services, Inc. 2121 North 117 Avenue IMS-34 Omaha, NE 68184-3600 **d) Would the Department specify the expectation of bidders in pricing this software in the bids?** As stated in the answer to item #2)b) above, these modules will be made available to the successful offeror, free of charge, after contract award subject to the terms and conditions of the software license agreement. A copy of the software license agreement has been added to the procurement library.
342	1.1.3	1-2	**Second bullet in Section 1.1.3 states "The EMEVS contract with Deluxe Electronic Payment Systems (DEPS) will be extended for one (1) year (through October 31, 1999). During this time period DEPS will continue to operate the EMEVS, will upgrade the telecommunications network to ensure that it does not fail before replacement, will ensure that it is Year 2000-compliant, and will make other changes at the direction of the Department."** **The scripts that are used with the Intervoice Voice Response Units (VRU) are not Year 2000 compliant. The Intervoice VRU hardware is also not Year 2000 compliant. Will DEPS upgrade the scripts and replace the Intervoice VRU equipment as part of the telecommunications network upgrade? If so, will the new equipment and scripts be turned over to the Replacement Medicaid System contractor.** Should the Department move forward with the upgrade of the EMEVS telecommunication network, the new network equipment and the associated scripts will be Year 2000 compliant. Both the scripts and the network hardware will be turned over to the successor contractor.

343	1.1.3	1-2	**Second bullet in Section 1.1.3 states "The EMEVS contract with Deluxe Electronic Payment Systems (DEPS) will be extended for one (1) year (through October 31, 1999). During this time period DEPS will continue to operate the EMEVS, will upgrade the telecommunications network to ensure that it does not fail before replacement, will ensure that it is Year 2000-compliant, and will make other changes at the direction of the Department."** **The scripts that are used with the VeriFone Tranz 330 POS terminals are not Year 2000 compliant. Will DEPS upgrade the scripts and or replace the Tranz 330 POS terminals as part of the telecommunications network upgrade? If so, will the new equipment and scripts be turned over to the Replacement Medicaid System contractor. Alternatively, are bidders required to include the replacement of the VeriFone Tranz 330 POS terminals, or upgrading their script, in this fixed price bid?** At this time there is no plan to replace the VeriFone Tranz 330 POS terminal. The scripts used with these terminals will be Year 2000 compliant.
344	1.2.1	1-6	On page 1-6, you state that "all of the logic in these systems must be incorporated into the Client Eligibility Repository". Is the logic referred to the data-related business rules, or all application logic (both data and process)?
345	1.2.1	1-5 1-6	**On page 1-6, you state that "all of the logic in these systems must be incorporated into the Client Eligibility Data Repository". We believe your intent is not to replace these systems but use the data from them. Is it correct to assume that the word logic really implies data?** No, the word "logic" means logic, not data. The Department's intent is to duplicate the logic of many of the listed WMS subsystems and ancillary processes in the Replacement Medicaid System. WMS will be going through a redesign and development process. It is the Department's intent to be able to retain the processing logic of those WMS subsystems which are exclusive to Medicaid processing, including: Restriction/Exception Processing (lock-in), Principal Provider Processing (nursing home residents), TPR, Prepaid Capitation Processing, and Pay-in Processing.
346	1.2.2 Bullet 1	1-7	**This section refers to "remote job entry (RJE) for selected providers." What are the criteria that define the selected providers? Is this a category of service that is forecast for growth? How many providers now use the RJE service option?** An approved RJE provider is a large volume provider or service bureau accessing EMEVS for eligibility verification and must be enrolled in the Medicaid program. Service bureaus must have the approval from the providers they represent. There are currently ten RJE providers. At this time, we do not expect significant growth in this area.
347	3.1.2 6.2.1.7	3-1 6-8	**These sections call for laser printers to be provided for State staff. In section 3.1.2 the introductory paragraph call for 5 printers, but only three are mentioned in the bullets. How many printers are required in total? What are the specifications required for the "high speed" printers? What are the specifications for the remaining printers?** The requirement is for five (5) high-speed laser printers with current technology at the time they are installed. If the printers were installed today, the minimum Department requirements would include: 17 pages per minute speed; 600 dpi resolution; 4 megabyte buffer memory; Adobe PostScript enabled; 45 scaleable fonts with True Type features. **In section 6.2.1.7, the introduction calls for three printers, but the bullets only mention 2. What is the total required, and how many are to be "high speed"? What are the specifications for all of these?** The requirement is for three (3) high-speed laser printers (refer to above specifications).

348	3.1.3 3.1.4 3.1.5	3-3 3-4	**These sections call for workstations for various State staff, but do not call for any printers. Will there be any print services required for these workstations?** Yes. The requirement is for eight (8) high-speed laser printers with current technology at the time they are installed; four (4) printers for the Office of the State Comptroller staff and four (4) for the Division of Quality Assurance and Audit staff. If the printers were installed today, the minimum Department requirements would include: 17 pages per minute speed; 600 dpi resolution; 4 megabyte buffer memory; Adobe PostScript enabled; 45 scaleable fonts with True Type features.
349	**3.2.3.1**	**3-9**	**In this section, the first paragraph ends with a sentence "as security standards are revised ... the contractor must meet the revised standards." Since this appears to be an indefinite scope of work, should offerors assume that such work will be done using evolution team resources?** No. The complete sentence states that "As security standards are revised, as discussed in Section 3.2.2.3, the contractor must meet the revised standards." Section 3.2.2.3 references the anticipated standards established under the Health Insurance Portability and Accountability Act. The Department does not consider this to be an indefinite scope of work; rather it is potentially a one-time anticipated change to ensure that the Replacement Medicaid System is compliant with HIPAA standards. The Department expects the contractor to be familiar with and to use state-of-the-art security standards. The Department also expects the contractor to be familiar with the probable standards to be identified by the HHS Secretary in accordance with HIPAA. Therefore, the Department is anticipating that the contractor will not need to make any changes to be compliant with this RFP requirement.
350	3.2.7 bullet 4	3-16	**Would the Department define the parameters of qualification for "computer-to-computer communications for qualified providers" service so offerors may size and design accordingly? Alternatively, would the Department provide a list of qualified providers with descriptions of their connectivity?** Computer-to-computer users must be an enrolled Medicaid provider or State approved service bureau and capable of communicating using SNA protocols.
351	3.4.2	(3-23) 3-22	**Please provide clarification of a portion of Section 3.4.2 of the NY Replacement Medicaid System RFP. Are the functions listed in 3.4.2, bullets 2 and 3 mandatory requirements, or are they considered optional under Section 9.2.8?** Bullets 2 and 3 are mandatory requirements and are not dependent on the development of the optional Front-End Electronic Fraud, Waste, and Abuse Prevention Module.
352	(4.5.1) 4.3	(4-15) 4-3	**The successor contractor will be required to upgrade the network to improve data communication speed and reduce data problems. There will be no change in the EMEVS software, and the network upgrade will be a stop-gap measure until the Replacement Medicaid System contractor can begin operations with the EMEVS Redesign. Are the POS and other field equipment included in the network upgrade, or just the communications lines and back-end equipment?** At this time there is no plan to replace the VeriFone Tranz 330 POS terminals. The terminals will not be a part of the network upgrade.

353 354	4.3.1 4.3.2	(4-4) 4-3	**Will New York State be the Customer of Record for telecommunications services? Tariffs prohibit Contractors from reselling these services.** **Section 4.3.2 describes both data communications and Intervoice services. Please clarify the responsibilities of the contractor with respect to providing telecommunication services.** The reference in the second question appears to be in error (should the reference be Section 4.3.1?). The Replacement Medicaid System contractor will be responsible to ensure that telecommunications connections exist so that the providers are able to access the replacement EMEVS components and that State and local district personnel can access the Replacement Medicaid System subject to Department-approved security procedures. Since this is a contractor responsibility, the Department anticipates that the contractor will be the Customer of Record, acting as an agent for the State.
355	6.2.3.2.6	6-19	**This RFP section requires the contractor to perform a comprehensive assessment of business process of the New York State Medicaid. The effort associated with such an assessment is extremely difficult to estimate without a much more detailed description of the specific processes to be evaluated, and the expected deliverables arising from such a project. In order to provide for a more consistent response, would the Department provide the detail of this activity that will allow for an accurate resource commitment? Alternately, would the Department stipulate a fixed level of contractor resource, for example, one person-year of consulting support?** The replacement of the New York State Medicaid systems is an opportunity for the Department to re-evaluate how it does business. The business processes currently used by the Department are antiquated, inefficient, and bound by the limitations of the existing Medicaid systems. The contractor is expected to provide the expertise to assist the Department in redesigning the business processes to take advantage of new technologies in order to make those processes more efficient. During the Implementation Phase, business process assessment and design will be limited to those business functions directly affected by the Replacement Medicaid System (claims processing, provider enrollment, rate data capture, etc.). Other business processes will be assessed on an on-going basis as specified in Section 3.4.3 of the RFP.
356	6.3.2 bullet 1	6-50	**Would the Department delete the phrase "and re-certification" requirements? This constitutes an undefined scope of work at a future date and subjects the contractor to considerable financial penalty.** The RFP language meets the Department's requirements. The Re-certification requirement is from Section 1903(r)(4)(A) of the Social Security Act which states, "The Secretary shall review all approved systems not less often than once every three years, and shall reapprove or disapprove any such systems". In cases where HCFA imposes a significant new requirement on MMIS systems and makes reapproval contingent on that requirement, the contractor will meet the requirement either through evolution or through a contract amendment. Therefore, the contractor will be responsible for re-certification.

357	7.1.2.4.2 Paragraphs 1 & 2	7-18	**Please describe the meaning of "day-specific eligibility." Does this mean that eligibility may be for a partial month, or does this mean that eligibility can be posted on a daily basis? Is there a required notification period of 10 days before eligibility may be closed?** Day specific eligibility means that eligibility can end on any day of the month. EMEVS does not provide notification in advance of a client losing eligibility**.** **How are the 24 months of eligibility history notated in the EMEVS? In the MMIS?** The EMEVS contractor runs a quarterly report and deletes all information on clients who have not had eligibility for the past 25 months. The eligibility dates are in date sequence (latest first). Up to 99 occurrences of dates can be on file. The MMIS maintains a recipient eligibility record on file back to the first day of eligibility, unless a period of 6 consecutive years of ineligibility occurs, in which case the entire record is purged.
358	7.1.2.6	7-21	**What is the size of the record transmitted by the TRANZ-330 terminal?** The size of the record transmitted by the Tranz 330 POS terminal is 256 characters.
359	7.2.3.1.6	7-33	**Is MABEL a component of the WMS? How are the Federal Poverty Levels applied to the Eligibility Determination Decision? Are the FPLs hard-coded or table-driven?** Yes MABEL is a component of WMS. FPLs are applied based on the characteristics of the clients budget. Eligibility would be determined using either the MA level or one of the poverty levels. FPLs are table-driven.
360	7.3.1	7-41	**"The Contractor shall prepare and publish monthly bulletins that are sent to providers to advise them of changes in the program or procedures."** **Does this refer to the current Medicaid update? What are the volumes involved?** Yes. The current volume is 65,000 a month. **The cost for these items may be substantial and will be beyond the control of the contractor. In order to arrive at the most cost effective solution for these items, would the Department consider designating these items as a cost reimbursable?** No.
361	7.3.1	7-41	**The contractor is responsible for the development and maintenance of the provider manual and bulletins.** **Will the Department supply the contractor with edited and formatted copies of provider bulletins and mailings or will the contractor be responsible for editing and layout design?** The contractor will draft some text at the request of the Department, typically where the content relates to the Replacement Medicaid System or fiscal agent responsibilities. The Department will provide final approved text. The contractor will be responsible for layout design and production.

362	7.3.3.2.2	7-43	**"The Department intends to migrate the provider file so that a provider enrolled to perform multiple categories of service would have one (1) ID number. This transition should be made as the national provider file and national provider identifier are implemented."** **What does this mean? Providers are currently enrolled under multiple categories of service and have one provider ID.** There are providers enrolled in the NYS MMIS under multiple provider Ids because not all of their categories of service are compatible. The NPI will require only one provider ID per provider regardless of the number and types of services provided. The contractor will be required to migrate the file to be compliant with the definitions for the National Provider Identifier (in accordance with the specifications presented at http://www.hcfa.gov/stats/npi/overview.htm).
363	7.3.4.12	7-49	**Mail provider manual revisions and provider bulletins within eight (8) business days of approval by the Department, or sooner, as requested. Will the contractor be required to actually produce these bulletins?** Yes**.** **What are the volumes of provider bulletins to be mailed?** The bulletins will be issued monthly to all active providers (currently 65,000).
364	7.3.4.16	7-50	**"Update all manuals, including provider manuals, internal procedure manual, and operating procedures manuals, to include information sent to providers in the provider bulletins and to reflect changes made during the quarter."** **Are we to assume the internal procedures manual and the operating procedures manuals are one and the same?** Yes.
365	7.3.6.2	7-51	**Provider Enrollment** **In order to calculate staffing requirements the offeror needs to know volumes of enrollment requests/applications received by the enrollment unit(s) and volumes of request for enrollment changes.** New York State receives approximately twelve thousand (12,000) provider enrollment applications per year and approximately seven hundred (700) phone calls per week.
366	7.5.1	7-66 7-67	**Does the incumbent provide any transaction translation?** **If so, for which transactions?** **If not, does the incumbent purchase transaction translation service from any Valued Added Network (VAN)?** **If so, which VAN(s) provide translation services and for which transaction(s)?** All transactions except for pharmacy prospective drug utilization review/electronic claim capture are proprietary in nature and thus do not use translation. This does not preclude the need to comply with HIPAA standards for appropriate transmissions when the standards are required. The incumbent does not purchase translation service from any VAN.
367	7.5.1	7-66 7-67	**For each present EMEVS transaction, how many transaction transmission versions are currently supported by the incumbent?** There is one EMEVS transaction format in use. The format is used for PC to host and host to host transmissions.

368	7.5	7-66	**Please explain role of NYT.** This question has been addressed in two previous answers as follows: **Question 2:** The NYT Request for Proposals and related information can be located on the Office for Technology web site at *http://www.irm.state.ny.us/nyt/nyt.htm* **Question 123:** The NYT will be a high speed fiber optic InterLATA backbone network utilizing frame relay and ATM switching with network access points (NAP) in each of the seven (7) LATA(s) with New York State. Vendors must identify exactly what type of local access will be provisioned at each customer site, the required bandwidth for each site, and the type of interface that is required at the NYT network access point. The NYT will provide the necessary interface cards to access the NYT in order to deliver data traffic across the backbone. When providing this information, vendors should take into consideration that the frame relay switches within each NAP will be connected to a local carrier's IntraLATA frame relay network via network to network interfaces. Frame relay traffic within a LATA will be delivered over this bandwidth and will not require individual interfaces for each connection. Dedicated circuits within a LATA will also be aggregated by the local exchange carrier and delivered via higher speed facilities into the NYT. While the design for the provisioning of dial-up traffic has not been finalized, it is anticipated that each NAP will also accommodate dial-up traffic either by direct dial to the NAP or by a dial-frame offering within each LATA.
369	7.5.3.2.1	7-69	**Is it correct to assume that the existing EMEVS requires a separate inquiry for each of the responses described in this citation?** No. The responses described in this citation are currently provided in a single inquiry, except for last checkwrite amount and date, and number of amount of pended claims which are not provided by the current EMEVS.
370	7.5.3.2.2	7-69	**Information that is transmitted to a PC or POS device can be readily displayed in word format rather than in numeric or alphabetic code. Information that is transmitted to an individual via a voice response system is usually limited to the amount of data that can be readily recorded and maintained. For example, all insurance programs/companies could be recorded and played back in place of a code. Recording and maintenance of the recording of all provider names and/or recipient names could be cost prohibitive and actually delay timeliness of information. Is it correct to assume that the voice response system will not be expected to provide the individual names of recipients? Is it correct to assume that the voice response system will provide individual provider names only when there exists a restriction to that particular provider?** The voice response system is not expected to provide the names of recipients or providers. The Department will consider recommendations that provide a high quality cost-effective eligibility verification system.
371	7.5.3.2.5	7-70	**How many personnel are employed by the incumbent for this responsibility today?** The incumbent current employs two (2) people for this responsibility.
372	7.5.3.2.16	7-71	**Because New York Medicaid eligibility is day-specific and because the EMEVS query must be date-specific, is it a correct assumption that this function is limited to the single day claim generated on or for the date of the new day claim?** The Department expects the contractor to develop innovative solutions to meet the Department's objectives.

373	7.5.3.2.15	7-71	**Is this a proprietary or an ANSI standard today? Is the ANSI 998 Acknowledgment Transaction Standard acceptable?** This transmission presently uses a proprietary format. The ANSI 998 format will be considered.
374	7.5.4.1	7-73	**Is it correct to assume that downtime for preventative maintenance that is regularly scheduled, publicized, and pre-approved by the State is an acceptable exception to this requirement?** No. System downtime for preventative maintenance is not an acceptable exception to this requirement. There must be system redundancy. As stated in the RFP, the system must be available 7 days a week 24 hours a day.
375	7.5.4.2	7-73	**Please provide a listing of the State's holidays and identify those holidays when operator assistance must be made available.** Department approved holiday's requiring operator assistance from 8:30 a.m. to 5:30 p.m. Eastern time are: New Years Day Martin Luther King's Birthday Memorial Day Fourth of July Labor Day Thanksgiving Christmas
376	7.5.6.5	7-75	**Section 7.5.6.5 describes PC software and interface specifications. Please clarify**. The Replacement Medicaid System contractor will be required to provide software to providers which will enable them to submit EVS transactions, Utilization Threshold transactions, Post and Clear transactions, other Service Utilization Management transactions, ProDUR transactions, and Electronic Claim Capture (ECC). The contractor will also be required to provide software that will enable providers to submit claims in an electronic "batch" format. The software must be provided free of charge to the providers and must permit them to access information or submit transactions as defined in detail in JAD. If a component of the needed software, such as an Internet browser, is commercially available, the contractor is not required to provide that component to the provider free of charge.
377	7.6.1 7.6.4.16	7-77 7-87	**The last sentence states that "Claims...will be assigned a status of deny, pend, or approved." What does the RFP mean by *pend* for an on-line claim?** The same meaning as a pend for a paper claim. All claims which successfully enter a claims processing cycle with either pay, pend or deny in that cycle. This is true for paper, mag submitted, or on-line claims. A claim may be "pended" for a number of reasons: awaiting possible file update, claim correction form issuance, manual review by contractor, manual review by state staff, etc.
378	7.6.6.7	7-89	**"Archive hard-copy claims, accompanying documentation, and ECC transmittal documents."** **How many years of provider submitted media (original paper, diskettes, tapes) must the contractor retain in archive?** Original paper claims must be retained for three (3) years, at which time they can be converted to quality, readable micromedia, which must be retained another three (3) years. Diskettes, tapes and ECC transmittal documents must be retained for six(6) years. Refer to Section 11.11.6 for additonal retention requirments.

379	7.7.3.2.17	7-98	**What is the average number of 1099s generated each year? Is the fiscal agent responsible for the generation of B notices and back-up withholding? If so, how often are B notices currently generated, and what is their volume?** There were 33,833 1099's mailed out for calendar year 1997. The Department currently sends a "B" notice to providers for verification of the Employer Identification Number. The incumbent does not send out backup notices. The Replacement Medicaid System contractor responsibilities are identified in Section 7.7.6.14.
380	7.7.3.3.14	7-99	**Is it the Department's intention to hold claims which have been approved for payment for any reason other than the current two-week check issuance lag?** Yes. It is also the Department's intent to hold claims approved for payment in an automated pend status rather than holding issued checks (see Section 7.7.3.2.15). **Is it required of bidders to propose a full-fledged accounts payable subsystem to accomplish delayed payments of adjudicated claims?** Yes. The contractor will be required to provide reports by the various categories indicated in Section 7.7.3.2.1.5 of adjudicated claims otherwise payable but held for payment and to release for payment some or all of the payable claims upon direction from the Department. Therefore, a system to provide this processing and reporting capability is required.
381	7.8.6.2 7.8.6.3 7.8.6.9 7.8.6.11	7-111 7-112	**It is understood that the contractor will be responsible for receiving (via telephone/fax) and determining the approval/denial of prior approval/prior authorization requests of various types. What are the estimated volumes of these requests? What are the specific activities the contractor must perform in order to approve or deny these transactions? Is there a requirement to utilize the services of professional medical personnel, such as RN's to perform this function?** The Bureau of Medical Review and Evaluation (BMRE) will continue to receive and process the over 600,000 prior approval requests annually. The contractor's responsibility will be to provide automation support to replace the existing Prior Approval File system (see Section 7.1.3.4) operated by the State and to replace the Dispensing Validation System currently in EMEVS (see Section 7.1.2.4.3). The Department expects the Replacement Medicaid System to provide more efficient automated support to BMRE's prior authorization/prior approval activities, including on-line approval processing and electronic PA request submittals.
382	7.8.6.15	7-112	**"Produce, print, and distribute to providers, free of charge, PA forms and procedures manuals."** **What are the type and volume of PA forms and procedures manuals (pages), and the frequency of distribution?** **The cost for these items may be substantial and will be beyond the control of the contractor. In order to arrive at the most cost effective solution for these items, would the Department consider designating these items as a cost reimbursable?** Prior approval forms for dental, physician, durable medical equipment and transportation are to be produced, printed and distributed. The total number of prior approval forms is estimated to be approximately 1.5 million per year. Postage will be the only reimbursable cost.

383	7.11.1 Paragraph 2	7-126	**Please provide specifics on the current and anticipated geographic distribution of the MCOs across the districts plus information on the phased county-by-county roll-out, including phase dates, counties included in each phase, and anticipated MCOs in each district.** Enclosed is a copy of the most recent enrollment report by county, indicating which MCOs are currently serving each county. Also enclosed is the most recent phase-in schedule. It should be noted that this phase-in schedule is subject to change, contingent on the availability of MCO capacity in each county. In order to begin mandatory enrollment of Medicaid clients into managed care, a county must be able to provide a choice of at least two plans, and those plans must have sufficient capacity to serve the anticipated eligible population. In some instances counties scheduled for an early phase have been unable to begin implementation due to a lack of plan choice or capacity. **The role of the enrollment broker is not discussed in the overview, but the broker is mentioned in subsequent sections. What is the involvement of the enrollment broker in the managed care program implementation?** The contract between the designated enrollment broker, Maximus, Inc. and the Department calls for the contractor to provide a range of services including: education, outreach and enrollment for Medicaid clients entering managed care in the five boroughs of New York City, including processing enrollment actions, and working with NYC Human Resources Administration on actions that require local district involvement such as exemptions, newborn enrollments and changes to client information. The contractor will also provide a Help-line for the entire state, including providing provider participation in specific plans to facilitate choice of plans for those clients who want to keep their current provider and providing assistance with enrollments and disenrollments.
384	7.11.3.2.15	7-131	**Please define the volume and types of current manual payments and confirm that electronic retrospective payment of the adjustments complies with this requirement.** There are no manual payments in the Managed Care system. Revised page enclosed. The Department will consider any innovative solution that meets our needs.
385	7.11.6.4 7.11.6.5	7-134	**These sections require the contractor to generate monthly lists of plan specific PCPs, specialists, facilities, and ancillary providers for clients to use in choosing a PCP.** **Are these lists currently generated? What is the current and expected format? What medium is currently used to distribute the information?** **What are the specific expectations and requirements for the future distribution of the monthly lists?** **For ultimate client use, who is to receive the reports and in what medium?** These reports which are not currently generated will be used by the Local Departments of Social Services. The specific expectations and requirements and medium will be determined in JAD.
386	7.12.3.3.9	7-137	**Are the follow-up letters to confirm that the manufacturer has actually received the invoice, or for another purpose? Are these letters generated once per quarter or more frequently?** Invoices are initially sent “return receipt requested” mail. Invoice follow-up letters are used to initiate steps for dispute resolution. These letters are generated quarterly.
387	7.12.3.3.7	7-137	**What are the components of a detail drug claims listing report?** To be finalized during JAD.

388	7.12.4.3	7-138	**"Collect ninety percent (90%) of the dollar amount of rebates invoiced by the end of the fiscal quarter following the period for which the rebate was issued". This performance standard is not dependent on the CONTRACTOR performing, but the drug manufacturer/labelers paying their invoice on time. If they do not pay on time the contractor could be assessed damages under Section 11.10 Performance Standards and Damages Provisions. Is it the State's intent to hold the Contractor liable for lack of action of the drug manufacturers?**
389	7.12.4.3	7-138	**In order to meet the 90% collection rate, it would seem that the Contractor's only leverage over manufacturers will be to initiate court proceedings in cases of non-payment. Since these proceedings are quite lengthy, the time to collect will be even longer. Are there other measures that the Contractor can take to enforce timely payment? What is the average time between invoice and collection data currently experienced by the Department?** The Department expects the contractor to exercise due diligence in tracking and collecting receivables under the Drug Rebate program. The Department will not be holding the contractor liable for lack of action by drug labelers, but the Department will hold the contractor liable for lack of due diligence in performance. Please note that dispute resolution will remain a Department responsibility. The contractor shall provide a report to identify each labeler which does not meet the threshold.
390	7.12.5.4	7-139	**Will the State perform the dispute resolution process in its entirety? What does the Department consider the formalized dispute resolution process, and how does this relate to the contractor?** Yes the State will perform the dispute resolution process in its entirety. The contractor will produce a report listing the drug manufacturers/labels disputing the invoice.
391	8.2.2.1	8-5	**Is the QA&A investment, which includes "a collection of required data elements" the same as either of the data element lists referenced in Appendix C, page C-5, Section C.3 - Medicaid Data Warehouse Data Elements?** Yes, the collection of required data elements is the same as data element lists referenced in Appendix C, page C-6, Section C-3 (see also Appendix H). The list of required data elements will be finalized in JAD.
392	8.3.4 11.10.2.3.2	8-14 11-44	**Section 8.3.4 states "The Medicaid data warehouse shall be available for on-line access twenty-four hours per day, Monday thru Friday. The Medicaid data warehouse must also be available Saturday and Sunday, except for scheduled maintenance and refresh times. The Medicaid data warehouse is considered not available when the LAN cannot access the data warehouse during these times.** **Sections 11.10.2.3.2 conflicts with Section 8.3.4 concerning on-line access time. Please clarify.** Sections 8.3.4 and 11.10.2.3.2 are indeed inconsistent. Section 11.10.2.3.2 is changed to be consistent with Section 8.3.4 . Revised page enclosed.
393	8.4.2	8-17	**Section 8.4.2 states the BPDA analyst requires "incurred claims" other than adjudicated claims. What is meant by "incurred claims"?** The reference to "incurred claims" was in error. Revised page enclosed.

394	8.5.5.2	8-25	**"The Medicaid data warehouse shall also provide the functionality to produce SURS recipient monthly exception processing Claim detail, Claim detail special reporting and on-line reports."** **This appears to be inconsistent with 7.13 "The Department has ... determined that the SUR components of potential transfer bases will not meet the needs of the users of the SURS component. Therefore, the Department requires the contractor to take over and operate the existing SURS". Please clarify.** The Department wants to ensure continuity of MAR and SUR Reporting, which is why there is the requirement to takeover and operate the existing MAR and SUR components. The Department's intent is to migrate MAR Reporting, and to the extent possible SUR Reporting, to the Medicaid data warehouse. For these reasons, the Medicaid data warehouse has to have the ability to replicate such SUR reporting as monthly exception processing claim detail, claim detail special reporting, and on-line reports.
395	11.1.4	11-3	It appears that the name of the law containing "Section 794" was omitted. What is the name? The second and third bullets in Section 11.1.4 should be combined as follows: "Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, and its implementing regulation, 45 CFR Part 84." Revised page enclosed.
396	11.7.6	11-22	**We would like clarification of a specific provision of the RFP for the Medicaid Management Information System (MMIS). The issue relates to Section 11.7.6 of the RFP which provides that the contractor agrees to indemnify and hold harmless the State from any and all claims resulting from acts or omissions of the contractor. In RFP awards, it has been the State's practice to use existing contract language that has already been approved by the state control agencies and universally accepted by the vendor community. In the area in question, many state vendor contracts limit the liability of the contract to either the overall value of the contract or the value of the letter of credit or bond required by the contract (in this case $10 million). Is there any limit on the contractor's liability in the MMIS procurement. It appears somewhat unclear whether a "cap" on contractor liability is present in the RFP. Could you please clarify the intent of the Department to limit the liability of a contractor under this agreement?** No limit on contractor's liability has been established with respect to this indemnity provision. A "cap" on contractor liability has not been explicitly stated nor implied in any provision of the RFP. It is not the Department's intent to limit contractor liability.
397	Appendix C.2	C-3	**EMEVS source code is not listed as being available in the library. In order to determine the scope of a takeover or redesign it is essential that a bidder have detailed knowledge of the present system. Where can EMEVS source code be obtained?** The DEPS software and public domain replacement modules can be made available to the Replacement Medicaid contractor only after the Office of the State Comptroller approves the contract between the Replacement Medicaid System contractor, and the Contractor executes and delivers to FDR/TMSI a form "Acknowledgment and Agreement", which binds the Contractor to the confidentiality obligations and all other terms, conditions and provisions of the License Agreement, and then, only for the operation of EMEVS.

REPLACEMENT MEDICAID SYSTEM RFP - QUESTIONS AND ANSWERS
May 14, 1998

Question Number	RFP Reference	Page	Question and Response
398	2.3.7 Paragraph 2 Number 4	2-18	**Would the State please clarify what the State requires from the contractor in regard to the workforce breakdown discussed in this requirement?** The Department does not require offerors to submit a staffing plan as part of their proposals; however the Contractor selected will be required to submit a staffing plan which shows the total number of staff working on the contract broken down into various categories including but not limited to gender and ethnic background. The form used will be a matrix and will be supplied by the Department.
399	3.1.3	3-3	**"The contractor shall provide ... multi-function workstations with access to the Medicaid systems (current MMIS/EMEVS and the Replacement Medicaid System, including the Medicaid data warehouse); WMS inquiry for both upstate and New York City; TIP production development for both upstate and New York City; electronic communication with the local social services districts, other State agencies, a data line connection with the OSC LAN and the Department's LAN, and Medicaid providers; and a copier and facsimile machine."** **This information is needed to design the LAN and WAN for the Replacement Medicaid System.** **Please provide a description of the network connections and protocols that are currently being supported by the following systems:** **1. Current MMIS/EMEVS** **2. Upstate and New York City WMS** **3. Upstate and New York City TIPS production** **4. Local social service districts** **5. Other State agencies** **6. OSC LAN** **7. The Department's LAN** **8. Medicaid providers** The following information reflects the current systems as accessed by the Office of the State Comptroller. The Department expects the contractor to develop innovative solutions to meet the Department's objectives. **1. Current MMIS/EMEVS** EMEVS is accessed through either a workstation provided by DEPS or through an IBM 3270 terminal. The workstation is a dial-up SNA, leased line, Hayes Auto Sync modem (9.6 bps), 3270 Emulation program and 3770 for RJE capability (sending and receiving reports). MMIS is accessed through a 3270 terminal.

399 continued			**2. Upstate and New York City WMS and 3. Upstate and New York City TIPS production** Category 5, RS232 connection to an Async Terminal Server (ATS) through a Unisys 6000 controller; connected via Ethernet TCP/IP lines to a local equivalent Racal Data Com/hub; through a switch/router which outputs to a private NYT Fiber Optic line (T3 bandwidth) to 40 North Pearl; connected to a switch/router to a Unisys Communication front end controller to the Unisys mainframe. The terminals connected to these lines serve as inquiry or selected updates to TIP databases either on-line or in batch environment. The multifunction terminals connected to the ATS must be able to do Production inquiry, Production update, training to other databases and program development functions. **4. Local social service districts** Ethernet network connections with TCP/IP and IPX protocols. **5. Other State agencies** Preferred connections are Ethernet network connections with TCP/IP protocol. In cases where SNA is required, DataLink switching with SNA encapsulated is preferred. **6. OSC LAN** Ethernet LAN with connection to the OSC network via a T-1. **7. The Department's LAN** Fiber Optic Ethernet LAN connections with TCP/IP and IPX protocols and a combination of Novel 3.12, 4.0 and Windows NT 4.0 file servers. Networking supports connections to IBM mainframes, Notes servers and various UNIX servers; also supports wide area network connections to remote offices using frame relay. The Metropolitan area connections are supported with ATM provided by NYT MAN. **8. Medicaid providers** OSC currently accesses Medicaid providers through the Internet via the OSC LAN.
400	3.4.2	3-22	**This RFP section calls for establishment of a fraud detection and prevention program, which we assume will be staffed by contractor personnel. Please confirm that our assumption is correct. In order to provide consistency among the various bidders' proposals, would the Department stipulate the required staffing levels as they have for Evolution personnel? Alternatively, would the Department accept a fixed price per hour for several levels of personnel, allowing the Department to define resource levels at a later date, based on competitively-procured hourly rates?** Section 3.4.2 of the RFP calls for development of a fraud detection and prevention program that functions as a component of the claims processing life cycle. The activities that are identified in this section can be part of the routine fiscal agent responsibilities as a part of the administrative fee. This function is part of New York State's coordinated effort to detect or prevent fraud and abuse in accordance with provisions of HIPAA. This is a new effort and the Department will rely on the contractor to provide innovative solutions.
401	3.4.2	3-23	**Does this section refer to the Edit 1141 prepayment review program through the Criteria-based Pends Resolution Systems, which is currently under the Administrative direction of Quality Assurance and Audit?** No. Edit 1141 is a prepayment review process. The edit itself functions as a mechanism for pending claims for specific pre-targeted providers. The criteria based pends resolution system is simply a mechanism for processing claims quickly and efficiently. This section of the RFP addresses a much larger and more sophisticated approach to conducting, fraud, waste and abuse detection across the board, without the need to pre-target providers.
402	(4.4.1.2.6) Eliminated	(4-8)	**Is the current EMEVS Year 2000 compliant? If not, when will it be Year 2000 compliant?** This reference was to the EMEVS Takeover and Operations. Since this is not in the revised RFP (Amendment 2) it is no longer applicable. However, the existing EMEVS is not yet Year 2000 compliant. With the exception of the Intervoice and associated software, EMEVS is expected to be Year 2000 compliant by the end of 1998.

403	7.2.1	7-31	**Currently New York State relies on transmission of eligibility data from the Welfare Management System (WMS) to the EMEVS and MMIS contractors to update contractor files for eligibility verification (EMEVS) and claims processing (MMIS) functions. With the introduction of a client repository how will this process differ?** The eligibility determination process will remain within WMS. Eligibility data will be transferred to the client repository. The repository will become the recipient reference file for use by the Medicaid Systems contractor in completing eligibility verification and other EMEVS functionalities as well as for claims processing.

404	7.2.3.3.6 7.3.3.3.9 7.7.3.2.9 7.2.6.9 7.2.6.10 7.8.3.3.3 7.12.3.3.8 7.12.3.3.9 7.12.3.3.10 7.15.6.4	7-36 7-47 7-97 7-38 7-38 7-108 7-137 7-137 7-137 7-153	**All of these RFP sections require various markings. In order for the bidder to provide resources to perform these tasks, it is necessary to know the frequency and volumes of these mailings for each specific task. Would the Department please provide these statistics?** The statistics, where available, are identified below each item **Alternatively, would the Department consider treating the cost of production including printing, paper, and envelopes as a reimbursable item?** No. Postage will be the only reimbursable**.** **7.2.3.3.6 "Mailing labels and letters for changes in service packages or eligibility resulting from legislation, as requested by the Department."** This cannot be estimated as legislative changes may or may not occur. Most mailings are targeted to affected subpopulations within the total Medicaid population. **7.3.3.3.9 "Provider acceptance letters and notification of change letters."** An estimated volume for this task is 24,000 per year. This is currently systems generated. **7.7.3.2.9 "Maintain provider accounts receivable and deduct amounts from payments due to providers as directed by the Department. Generate overpayment notification letters or other informational letters relating to account activity."** This task will average about 100 letters per week. **7.2.6.9 "Produce mailing labels with various select-and-sort options, such as aid category, program type, date of birth, county, census track, and zip code."** Volumes are not available as this will be a new process. **7.2.6.10 "Generate and mail letters to clients as requested by the Department ."** Volumes are not available as this will be a new process. **7.8.3.3.3 "Letters for clients who are identified as receiving services at a rate which will exceed the limit before year's end or having reached the established service limit for the UT program."** Override Application response letters average 126,000 per month. Nearing Limit and At Limit letters average 115,000 per month combined. **7.12.3.3.8 "Invoice cover letters"** Drug rebate letters which are sent quarterly, average 800 per quarter. **7.12.3.3.9 "Invoice follow-up letters"** Approximately 500 per year. **7.12.3.3.10 "Collection letters"** Approximately 100 per year. **7.15.6.4 "Generate patient profiles and provider alert letters monthly using user-defined parameters."** Approximately 1,000 provider alert letters are sent out monthly in response to the Retrospective Drug Utilization Review.

<table>
<tr><td>405</td><td>7.3.6.32</td><td>7-54</td><td>Under “contractor responsibilities” it states to identify the need to establish reciprocal arrangements with other states to monitor care given to N.Y.S. Medicaid clients in out-of-state facilities, and to monitor the arrangements. It further states “to perform reciprocal care monitoring activities for other states requesting such arrangements as directed by the Department”.

Could the Department more clearly define the activities associated with the task? For example: Is the “care monitoring” a function that will require medical staff, such as an R.N. to perform?

This function is no longer required.</td></tr>
<tr><td>406</td><td>7.6.3.2.24
7.6.4.1
7.6.6.7</td><td>7-82
7-85
7-89</td><td>Retention Requirements. Please specify retention requirements and volumes for the following: microfilm/source/com, paper claims/CCF’s TOA, checks, TSN applications/provider agreements and electronic billing certifications?

Canceled checks are retained indefinitely.

<table>
<tr><th>Item</th><th>Retention</th><th>Volume</th></tr>
<tr><td>Paper claims</td><td>3 years</td><td></td></tr>
<tr><td>CCF’s</td><td>1 year</td><td></td></tr>
<tr><td>TOA</td><td>1 year</td><td></td></tr>
<tr><td>TSN applications/provider agreements/ electronic billing certifications</td><td>1 year</td><td></td></tr>
<tr><td></td><td>Total</td><td>27,000 - 30,000 boxes</td></tr>
<tr><td>Microfilm/source/com</td><td>6 years</td><td>85,000 rolls</td></tr>
<tr><td>Checks</td><td>indefinitely</td><td>4,000 - 4,500 check storage boxes</td></tr>
</table></td></tr>
<tr><td>407</td><td>7.6.6.2</td><td>7-88</td><td>“Prepare and control incoming and outgoing New York State Medicaid program mail, as directed by the Department, to ensure claims and other correspondence are picked up at and delivered to any site designated by the Department, in the most effective and efficient means available.”

Where are these designated sites? What is the volume of New York State Medicaid program mail from these sites? What is the frequency of deliveries?

Section 7.6.6.2 requires the contractor to maintain a mailroom at its Albany-area facility. In addition to receipt and distribution of mail, the contractor must provide courier service to the Department locations in Albany (see also question number 285). Current volumes (incoming and outgoing) are not available, but would include all US Postal Service and other delivery services (e.g., Federal Express, UPS, etc.) for claim submission, CCFs, MOAS/MUTI, claim forms, manuals, provider correspondence, etc. Deliveries once in the morning and once in the afternoon each business day, and at the request of the Department.</td></tr>
</table>

408	7.7.1 Exhibit 7.2	7-92 to 7-95	**Transition Requirements for Payments Currently Made Outside the MMIS** — **Amount Paid 7/96-6/97** **Care at Home case management: 100,000** **Residential Treatment Facility tuition payments: 7,200,000** **Prepaid Mental Health Plan (PMHP): 300,000,000** **Krieger v. Peralez - Reimbursement for covered services to eligible clients by enrolled providers for up to three (3) months prior to date of eligibility: 300,000** **Greenstein v. Dowling - reimbursement to eligible clients whose coverage was delayed due to agency error: 30,000** **NYC MAP Payments - Payments made on behalf of NYC and based on Greenstein v. Dowling; claims checked to ensure that they were not paid under any other decision: 90,000** **McMahon v. Dowling - Disabled Audit Children who were entitled to, but did not receive, extension of benefits; recipients are reimbursed for medical bills, pay-in; Part B premium 50,000** **NYC MAP Provider Payments - Made to NYC nursing homes because the principal provider file cannot be updated with dates of service over fifteen (15) months old: 1,500,000** **General Off-Line Payments - 500,000** **Reimbursement to Medicaid providers (DRGS)** **for services which cannot be made through the MMIS: 500,000** **Partial DRG payments (all other reasons)** **Part A Medicare deductibles** **Medicare coinsurance days** **Recipient eligibility problems** **Organ donors** **Other miscellaneous reasons** **Medicare Part A and Part B Insurance Premiums 400,000,000** **For each payment listed above, how many paper checks and/or EFTs are currently written for each transaction type per payment cycle?** The specific amount for each transaction type is not discernible. However, checks and/or EFTs for all programs listed total less than 5,000 per year, or less than 100 per week. Therefore, payment transaction implications are minimal.

409	7.7.4.6	7-100	**How many adjustment requests are received by the fiscal agent per month? If the appropriate information is not returned from the provider to finalize the adjustment request, what is the procedure for returning those funds? Are they returned to the provider or the Department?** Adjustments are processed through the system, against individual claims when a provider submits a standard claim with the Adjustment Indicator set. An adjustment claim processes like any other claim, subject to all claim processing edits. If an adjustment claim fails one of more edits, the provider is notified on the remittance as for any other claim; the adjustment is not made, and the original claim record remains on the history file. Successful adjustments are either charged to, or credited to, the provider during the actual processing cycle and are reflected in the provider's check for that cycle. If a negative adjustment is larger than the provider's payment for the cycle, the provider receives a zero payment for the cycle and the provider accounting system will deduct the balance from the provider's check in subsequent cycles until the full amount is recovered. No particular count for any time period would be meaningful or predictive because the reasons for filing adjusted claims are so varied.
410	7.9.4.3	7-119	**This performance standard requires the contractor to provide micromedia copies of claims within one business day of the request. Can the Department give some idea of how many of these requests the contractor can expect on an average day or week?** Up to 13,000 copies of claims, checks and remittances have been requested on a monthly basis.
411	7.10.3.2.4	7-124	**Please provide volumes per month of the referenced notices.** Based on information from state fiscal year 1997 (4/1/96 - 3/31/97): An average of 635,000 notices a month were provided, based on Periodicity requirements to participating C/THP eligible families. There were 61,361 new eligibles during the year. An average of 633,000 notices a month were provided to non-participating, eligible families.

412	7.11.3 Paragraph 2 bullets 1 to 6	7-128 7-129	**The Replacement Medicaid System must include functionality of the Managed Care Systems Enhancement Project's six components. Please expand upon the status of each of the six referenced initiatives. Are any of the subcomponents fully operational today?** The status of the six referenced initiatives is as follows: Services/Medical Assistance Interface (SERMA) It was determined that Managed Care was not the appropriate program for these children due to the numerous relocations. PCP file Not presently operational. The major remaining project is to build the capacity to handle dual enrollments (i.e., enrollment in a basic managed care plan and a SNP - AIDS or MH simultaneously). The system needs to be able to handle two or more eligibility records at the same time. Enrollment/disenrollment Not presently operational. The major issue is related to the enrollment broker which needs to have the same capabilities for enrolling and disenrolling individuals as the disability worker. Also a feedback loop (e.g. rosters) needs to be available to the broker. Stop/Loss Functions are operational, mostly on a manual basis Claims Processing Operational. Modifications are needed for the implementation of the AIDS and MH SNPs and will depend on resolution of PCP file issue. Reporting Operational with continued revisions to the MEDS requirements. These will include revisions to the system to implement HIPAA standards as well as fixing problem areas such as possible need to reconstruct categories of service from new place and type of service data elements. There is a need for upgrades to increase transmission speeds for encounter data coming in over the electronic gateway. There is a need to transfer the enrollment rosters and MEDS submission reports and registers to the DOH Health Provider.
412 continued			**Would the Department provide further definition of Services/Medical Assistance Interface (SERMA) and Stop/Loss?** SERMA Medicaid eligibility for foster care children in NYC is established from a Purchase of Service line on a Services case in WMS. Based on the Purchase of Service line a Medicaid individual record is established without an MA case being created. Stop/loss Managed Care Plans are reimbursed by Medicaid if they pay claims on behalf of a Medicaid client and exceed specific limits. These limits per calendar year currently are: $50,000 for hospital inpatient If a plan provides for more than 30 inpatient days for mental health or substance abuse, the plan can be re-imbursed for days in excess of 30 If a plan provides more than 60 visits for alcohol/substance abuse or more than 20 mental health visits
413	7.13	7-141	**The RFP states the Contractor shall "Maintain a sixty (60) month rolling On-Line SURS current history file."** **What is the intent of this file? What kind of user access is required of this file? What is the format of this file?** This file is intended to provide longitudinal reporting capability to the On-Line SURS batch reporting system. It is expected that this file will be accessed every other weekend. The format of the file will be similar to the existing On-Line SURS current history file, i.e., a monthly record for each eligible, except that this file will contain 60 monthly records.

414	8.4.2	8-17 to 8-18	**Under Detailed Medicaid Data Requirements, the maximum months of data is indicated for the data warehouse and data marts. To further help with database sizing, what are the estimated paid claims volume per month? Also, what is the estimated size and volume of the encounter data that may be housed in the data warehouse and data marts?** Paid claims average 12 to 15 million per month. During an eight (8) week period a total of 1,535,303 encounter transactions were processed. A weekly average of 191,912 encounter transactions were processed with a weekly high of 385,770 and a low of 6,871.