Request for Proposal (RFP)

Replacement Medicaid Management Information System (R-MMIS)

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Replacement Medicaid Management Information System (R-MMIS)
Fiscal Agent Services Project

FAU Number 1002031048

Schedule of Key Events

Initial Procurement Library Release (Process Flows of eMedNY System)		09/03/09
RFP Release Date		06/04/10
Offerors' Conference Date	10:30 AM	07/14/10
Written Questions Due Date		07/22/10
Response to Written Questions	On or about	08/12/10
Proposals Due Date	1 PM ET	10/29/10

DESIGNATED CONTACTS:

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies the following designated contacts to whom all communications attempting to influence this procurement must be made:

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Pursuant to State Finance Law § 139-j (3) (a), the Department of Health also identifies the following allowable contact for communications related to subject matter pertinent to this solicitation:

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For further information regarding these statutory provisions, see the Lobbying Statute summary in Section V.J Administrative Requirements Lobbying Statute of this solicitation.

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For further information regarding these statutory provisions, see the Lobbying Statute summary in Section IV.J Administrative Requirements Lobbying Statute of this solicitation.

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III	**REPLACMENT MMIS (R-MMIS) STATEMENT OF WORK**	Presents the project's statement of work, including: project planning phase requirements, implementation phase requirements, certification phase requirements, system and operational enhancement requirements, operations phase requirements, turnover phase requirements, technical systems architecture requirements, security privacy and confidentiality requirements, functional requirements, facilities requirements, business continuity and disaster recovery requirements, organization and staffing requirements, training requirements and contractor performance requirements.
IV	**PROPOSAL REQUIREMENTS**	States the general requirements covering format and content of the proposal submitted.
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I. PROCUREMENT OVERVIEW

A. INTRODUCTION

The New York State Department of Health (the Department) is soliciting proposals to procure a replacement Medicaid Management Information System (R-MMIS) and successor fiscal agent. The purpose of this procurement is to obtain the services of a responsive and responsible contractor to 1) implement a Federally-certifiable R-MMIS; 2) provide operational support for the R-MMIS; and, 3) provide fiscal agent services.

This procurement is being undertaken in accordance with New York State (NYS) Finance Law, Article XI to procure a replacement Medicaid Management Information System (R-MMIS) and successor fiscal agent under the NYS Social Services Law, Section 367-b. The Department is statutorily authorized under this section to "enter into agreements with fiscal intermediaries or fiscal agents for the design, development, implementation, operation, processing, auditing and making of payment, subject to audits being conducted by the state in accordance with the terms of such agreements.

The Department's primary objective is to implement a Federally certifiable R-MMIS that provides: 1) all functionality currently supported by eMedNY, New York State's Federally certified MMIS; 2) enhanced functionality for: Provider Servicing and, Pharmacy Benefit Management, as well as dental claims and prior approval processing; 3) support for the Health Insurance Portability and Accountability Act (HIPAA) version 5010 and NCPDP D.0 Electronic Data Interchange (EDI) standards; 4) support for the International Classification of Diseases ICD-10 Coding System; 5) a commercial-off-the-shelf (COTS) Financial Management System (FMS) solution; and, 6) an enterprise technical and application architecture sufficiently flexible to support system enhancements that meet the changing needs of New York State's Medicaid program, based on the Centers for Medicare and Medicaid Services (CMS) Medicaid Information Technology Architecture (MITA) standards.

The Department envisions multiple, overlapping phases to complete the project requirements set forth in this RFP. These phases include: Project Planning; Implementation; Certification; System and Operational Enhancements; Operations; and Turnover.

During the Project Planning Phase, the contractor must develop and put into practice a series of plans (e.g., project management, risk management, scope management, and configuration management plans) based on its proposed project management and systems development lifecycle (SDLC) methodologies. These plans must be designed and developed to support all project phases.

The Implementation Phase includes the tasks required to successfully implement an R-MMIS for the Department. These tasks include: project initiation, requirements validation, system design, system development, testing, organization change management, data conversion, operational readiness, implementation, and incumbent transition support. Methodologies, including the SDLC methodology employed during this phase, will form the foundation for the methodologies to be used in future phases of the project. The Implementation Phase has been

divided into three distinct functional phases intended to facilitate the development of an R-MMIS that will meet all the functional requirements described in this RFP while minimizing risks that might impact a successful, on-schedule implementation.

Functional Phase I will include the design, development and implementation (DDI) of a Federally-certifiable R-MMIS that meets all Federal and New York State (NYS) requirements specified in this RFP including all functionality currently supported by eMedNY, New York State's Federally certified MMIS; enhanced Provider and Pharmacy Benefit Management functionality; support for the Health Insurance Portability and Accountability Act (HIPAA) version 5010 and NCPDP D.0 Electronic Data Interchange (EDI) standards; and the implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding on the compliance date set by the Centers for Medicare and Medicaid Services (CMS). Upon completion of Functional Phase I, the contractor must support the Functional Phase I requirements, the Operations Phase and the System and Operational Enhancement Phase.

Functional Phase II will include the implementation of a commercial-off-the-shelf (COTS) Financial Management System.

Functional Phase III will include the DDI of capabilities to broaden the application of information technology and system interoperability for Medicaid systems necessary to support transition to successively higher levels of MITA maturity. New York's vision is to transition to a MITA maturity level of 3 for most business processes over the course of the R-MMIS contract period. In order to achieve this vision, the R-MMIS must provide an enterprise technical and application architecture capable of supporting MITA standards and the Department's efforts to achieve target MITA maturity levels.

The Certification Phase encompasses all tasks required to substantiate that the R-MMIS meets the CMS requirements for MMIS certification and obtain CMS certification. While this phase begins when the R-MMIS becomes operational, the certification review schedule is determined by CMS.

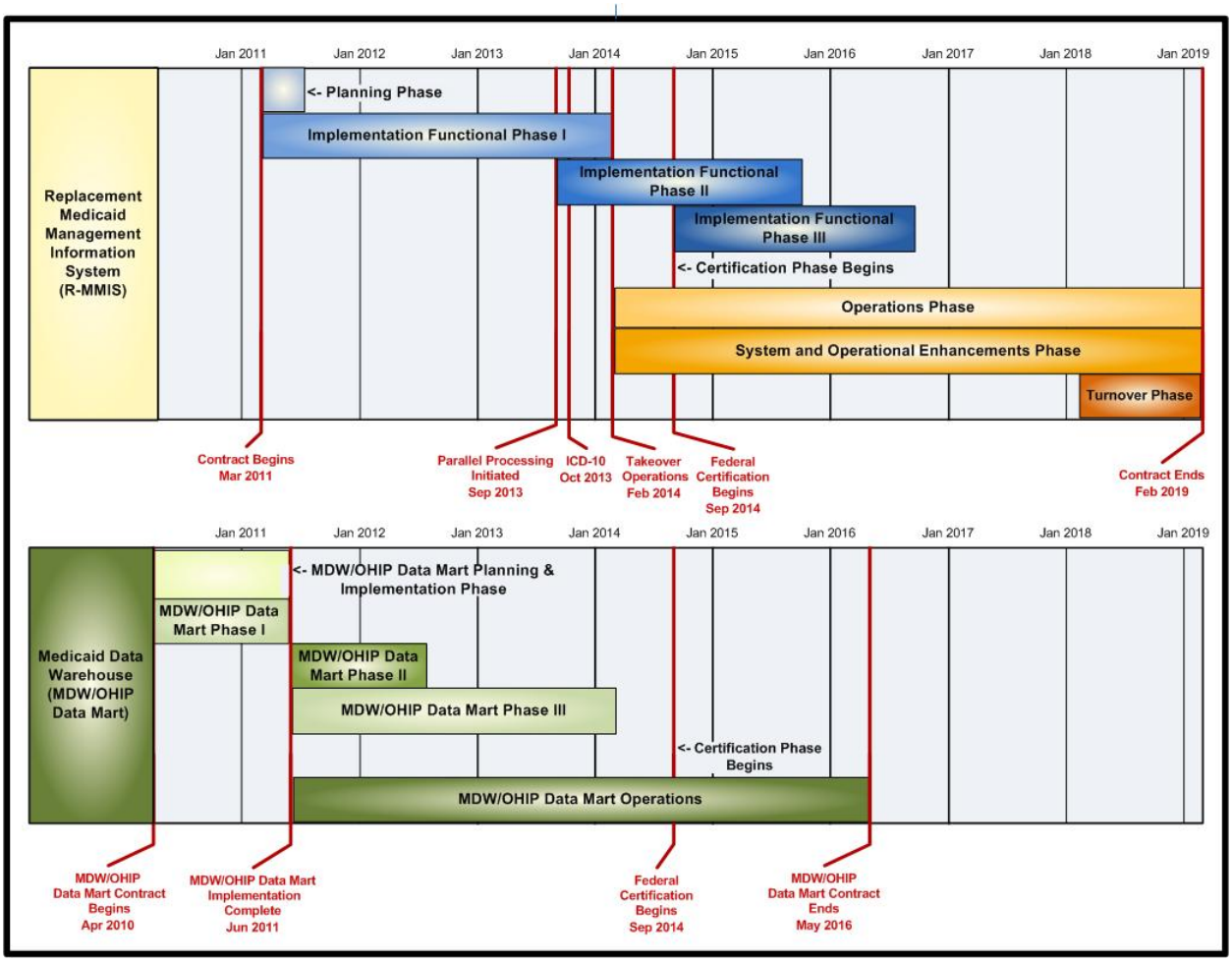
Upon implementation of the R-MMIS, both the System and Operational Enhancement and Operations Phases will commence. The System and Operational Enhancements Phase includes both maintenance and enhancement tasks that must be performed throughout the life of the contract to modify the R-MMIS in accordance with new State and Federal mandates, program policy changes, program growth and emerging technologies. The Operations Phase includes all tasks necessary to operate a complete and certifiable system and to ensure that transactions are processed, providers are paid, and reports are produced in an accurate and timely manner, in accordance with Federal and State policy.

The Turnover Phase represents a period of transition during which the R-MMIS and all related operational and technical support activities that have been maintained and operated by the contractor will be turned over to the Department or successor contractor(s).

The current contract supporting eMedNY and fiscal agent services ends in June 2012. The current contract for eMedNY Data Warehouse operations ends in June 2010. After analyzing the options for procuring contractor services to implement an R-MMIS, data warehouse and provide fiscal agent services, the Department elected to pursue two separate procurements for the replacement of the data warehouse and an R-MMIS with fiscal agent services employing a phased-in approach. The Department has completed the procurement of a Medicaid Data Warehouse (MDW)/OHIP Data Mart contractor.

This overall approach is illustrated in Exhibit I-1.

Exhibit I-1 R-MMIS Project Phases



B. DEPARTMENT OVERVIEW AND VISION FOR THE R-MMIS

The Department is the Single State Agency responsible for the administration of New York's Medicaid program. The Department administers the Medicaid program in conjunction with the fifty-eight (58) Local Departments of Social Services (LDSS) and other State agencies including the Office of Temporary and Disability Assistance (OTDA), Office of Children and Family Services (OCFS), Office of the Medicaid Inspector General (OMIG), Office of the Attorney General (OAG), Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcohol and Substance Abuse Services (OASAS).

Within the Department, the Office of Health Insurance Programs (OHIP) is directly responsible for administering a wide variety of public health insurance programs including Medicaid, Family Health Plus, Child Health Plus and the Elderly Pharmaceutical Insurance Coverage Program (EPIC). As part of its responsibility for the Medicaid program, OHIP has oversight responsibility for the operation of eMedNY and the Medicaid fiscal agent services. The Office of Long Term Care (OLTC) is responsible for the administration of the wide variety of waiver programs approved by CMS.

Key aspects of the Department's vision for New York's Medicaid program include providing for and protecting the health of New York's low-income and disabled citizens by supplying health insurance coverage and increasing health care access while improving quality, and controlling costs. The Department's vision is closely aligned with CMS and MITA goals and objectives. By implementing an R-MMIS, the Department seeks to support the continuous improvement of New York's ability to:

1. Provide members with access to quality health care;
2. Improve health care outcomes for members; and,
3. Ensure efficient, effective, and economical management of the NYS Medicaid program.

C. PROJECT BACKGROUND

In 1998 the Department conducted a competitive procurement for an R-MMIS with a Data Warehouse component. eMedNY was designed and developed in two phases. Phase I was implemented in November 2002 and Phase II was implemented statewide in March 2005. The current eMedNY Data Warehouse was implemented in 2002.

eMedNY and Data Warehouse systems implemented during that procurement met many of the objectives specified by the Department. The major accomplishments of that effort included:

1. Improved integration of the Medicaid Eligibility Verification System (MEVS) with the MMIS. In previous systems the MEVS was not completely integrated with the MMIS processes. eMedNY has resolved problems associated with separate systems;

2. Improved coordination of eligibility data between source systems and eMedNY. The previous system had difficulty maintaining the consistency of data definitions between the MMIS and the eligibility systems. eMedNY has improved the consistency of data definitions and reduced inconsistencies caused by data interface schedules;
3. Achieved compliance with all requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005;
4. Supported claim processing volumes required by the NYS Medicaid Program. eMedNY performs all claims edits and audits required by Department policy while processing the required volume of claims timely and accurately;
5. Implemented web-based interfaces that allow users to access eMedNY. This has improved access to data that was not available through previous client-server or mainframe interfaces;
6. Introduced the first data warehouse to the NYS Medicaid Program. The current eMedNY Data Warehouse has succeeded in providing access to MMIS data for hundreds of users in the Department, other State agencies and Local Departments of Social Services. The eMedNY Data Warehouse provides an integration point for data from the MMIS and external sources. It has become the central point for reference, research and analysis in supporting the management of the NYS Medicaid Program;
7. Established the eMedNY Data Warehouse as the "authoritative source for Medicaid data" for other analytical platforms, standardizing Medicaid data for the OHIP Data Mart, other State agency and local government data marts;
8. Improved provider and member fraud and abuse tracking using information from the eMedNY Data Warehouse; and,
9. Enhanced analysis of program and service delivery effectiveness based on information from the eMedNY Data Warehouse.

D. PROJECT GOALS AND OBJECTIVES

One of the Department's prime objectives for this procurement is to competitively acquire the services of a contractor to replace eMedNY and provide fiscal agent services. The R-MMIS must:

1. Provide all functionality in eMedNY, the Federally certified MMIS, and be positioned to achieve Federal certification;
2. Provide enhanced Provider, Pharmacy Benefit Management, and other functionality specified in this RFP;
3. Support HIPAA version 5010 and NCPDP D.0 EDI;
4. Support the International Classification of Diseases ICD-10 Coding System;
5. Implement a commercial-off-the-shelf (COTS) Financial Management System (FMS) solution; and,
6. Implement an enterprise technical and application architecture sufficiently flexible to support system enhancements that meet the changing needs of New York's Medicaid program, based on the CMS MITA standards.

A key Department goal is the implementation of an R-MMIS flexible enough to support the implementation of various program and clinical initiatives within the NYS Medicaid Program. These initiatives are placing increasing demands for rapid adaptation on eMedNY. As these and other changes are made to the NYS Medicaid program, it is necessary to have an R-MMIS with technical and application architecture capable of responding to the demands of a rapidly changing environment.

The Department is committed to improving the quality of data produced and disseminated by the R-MMIS. Ensuring that the data is useful to the widest possible audience increases the return on investment (ROI) of the system. In support of this commitment, the Department has established an enterprise data governance function. Contractor requirements necessary to support this function are detailed in this RFP.

The Department's vision for managing public health care encompasses the following goals and objectives:

Reduce Administrative Burden for the Provider	The Department is committed to making changes that will make it easier for health care providers to enroll, participate, and be reimbursed in its programs. The Department is taking steps to streamline the enrollment process through the adoption of standards, alignment with other programs, and automation of processes. A main objective in this area is to simplify the combination of program, policy and operational constraints to payment.
Eliminate Administrative Barriers to Enrollment and Expand Coverage	One of the key health care initiatives of the current administration is to expand health care coverage to all eligible New Yorkers. The Department has a goal to remove administrative barriers that delay and prevent some eligible citizens from receiving health care benefits. The objective is to identify and make changes to administrative processes that are used to determine eligibility and to support the implementation of Federal health care reform.
Accommodate Benefit Flexibility to Provide Member Services	The capability to accommodate new benefits, service rules, and edits into operations and systems quickly is a critical component to realizing the vision to effectively align program benefits with beneficiaries. Inherent in this endeavor is the need to share clinical information at the point-of-service to enable the identification of beneficiaries for new benefit programs and to better manage high need and high cost services. The introduction of COTS products is critical to developing the capability to implement software and procedural enhancements in a timely and cost effective manner.
Buy value – quality, cost effective care – for Medicaid beneficiaries	The Department envisions the development of patient centric health care delivery programs that will provide quality, cost effective health care. This will begin to be achieved as the Department moves to predictive modeling, patient centric utilization management, care and case management, the adoption of a medical home model, and increasing patient education and counseling.
Integrate Electronic Health Care Records into Benefit Management	The electronic exchange of health care information is the centerpiece for realizing a number of health care management improvements. The ability to share detail clinical information at the point-of-service is at the center of a new generation of health care programs that effectively match the right services with the right people at the right time.

Implement Medicaid Rate Reform – Pay for Performance	The Department has taken the initial steps in developing Pay for Performance initiatives which link compensation to the quality of outcomes, standardized quality measures or the extent to which specific goals are achieved. The Department understands that in order to continue to create and effectively evaluate Pay for Performance outcomes, more specific clinical data is needed. The Department envisions reforming Medicaid rates to: encourage care in the right setting; buy value and high quality, cost effective care; and, reinforce health planning and policy priorities.

E. OVERALL APPROACH TO THE CONTRACT

The proposed technical approach must follow MITA principles, standards, and architecture configurations. The resulting R-MMIS must meet the current needs of the NYS Medicaid program and be sufficiently flexible to meet future needs of the program, including compliance with MITA standards. As part of Functional Phase III, the successful offeror must implement a series of enhancements designed to attain successively higher MITA maturity levels.

Since the quality of the R-MMIS is of paramount importance to the Department, contractor selection will be based on the "Best Value" approach. Although price will be a factor, the overall value in terms of "quality, cost and efficiency" pursuant to Article XI of the New York State Finance Law will be the prime determinate.

Offerors should note that concurrent with the R-MMIS project, the Medicaid Data Warehouse (MDW) will be designed, developed and implemented under a separate contract. Close collaboration between the MDW contractor, R-MMIS contractor, Department staff and Department contractor staff will be critical to the success of both initiatives. As the primary source of the MDW data, the R-MMIS serves as the foundation for the wide range of analytical activities and compliance with Federal MMIS certification requirements being fulfilled by the MDW. The MDW will rely on data extracted from the R-MMIS to provide Program Management (e.g., Data Warehouse, Management and Administrative Reporting Subsystem (MARS) and Federal reporting); Program Integrity (e.g., Surveillance and Utilization Review Subsystem (SURS), Retrospective Drug Utilization Review (R-DUR)); and, Care Management (e.g., Early and Periodic Screening, Diagnosis and Treatment) functionality.

F. TERM OF THE CONTRACT

The Department intends to award a contract that will extend for eight years. The base period shall be eight years and shall include all implementation and operations tasks. The Department shall have the option to extend the contract for up to two one-year periods.

G. SCOPE OF WORK SUMMARY

The scope of work for the contractor is divided into six major phases: Project Planning; Implementation (including Functional Phase I, Functional Phase II, and Functional Phase III); Certification; System and Operational Enhancement; Operations, and Turnover.

Contract start date is targeted for March 2011 with implementation of the R-MMIS, initiation of Federal certification and takeover of operations in February 2014. The R-MMIS contractor will operate the R-MMIS and provide fiscal agent services under the term of the base contract until February 2019 with options for two one-year extensions beyond this date.

II. DESCRIPTION OF THE NEW YORK STATE MEDICAID PROGRAM AND CURRENT MEDICAID MANAGEMENT INFORMATION SYSTEM ENVIRONMENT

A. INTRODUCTION

New York's Medicaid program is one of the largest insurance programs in the nation providing health care coverage to over four (4) million New Yorkers with approximately 3.1 million members receiving their health care through enrollment in a managed care plan. NYS Medicaid's annual cost is expected to reach $51 billion in State Fiscal Year (SFY) 2010-11. eMedNY, New York's Medicaid Management Information System, processes payments for approximately one of every three health care dollars paid in the State. It is also the primary source of Medicaid data used for financial reporting, program analysis, auditing, and quality measurement.

Within the Department of Health, the Office of Health Insurance Programs (OHIP) is directly responsible for administering public health insurance programs. These responsibilities include the oversight of eMedNY, fiscal agent services and this procurement.

B. OFFICE OF HEALTH INSURANCE PROGRAMS (OHIP) AND REFORM AGENDA

OHIP administers a variety of public health insurance programs including Medicaid; Family Health Plus, a Medicaid expansion covering low-income workers; Child Health Plus, an expansion covering nearly 400,000 children through managed care programs with premiums based on family income; and, the Elderly Pharmaceutical Insurance Coverage Program (EPIC), providing prescription drug coverage to over 300,000 seniors who meet the program's income criteria.

OHIP is comprised of eight (8) major operational units, including the:

1. Division of Coverage and Enrollment;
2. Division of Provider Relations and Utilization Management;
3. Division of Systems;
4. Division of Managed Care;
5. Division of Quality and Evaluation;
6. Division of Financial Planning and Policy;
7. Division of Health Care Financing; and,
8. Administrative Services Group.

OHIP was established in January 2007 with the mission to expand coverage and access; to buy value with New York's health care dollars; and to advance system-wide reform. It centralized all of the major operations of Medicaid along with the operations of New York's other public health insurance programs.

While OHIP is responsible for the major operations of the Medicaid program, there are a variety of Federal, State and Local government agencies that have key responsibilities related to the program. OHIP and the Office of Long Term Care (OLTC) work in conjunction with other State agencies including the Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Alcoholism and Substance Abuse Services (OASAS), and the Office of Children and Family Services (OCFS) to ensure that the needs of the special populations that these agencies serve are addressed within the parameters of the NYS Medicaid program. OHIP works with the Office of Temporary and Disability Assistance (OTDA) and New York's Local Departments of Social Services to administer and fund the Medicaid Program.

Program integrity is the shared responsibility of OHIP, the Office of the Medicaid Inspector General (OMIG), Office of the State Comptroller (OSC), the Office of the Attorney General and the Centers for Medicaid and Medicare (CMS). The distribution of responsibilities across these organizations results in a diverse set of stakeholders with specific and distinct information needs that must be met by the R-MMIS.

OMIG is responsible for conducting investigations and investigative audits for all of the Medicaid programs involving State and/or Federal tax dollars. Their responsibilities make them key stakeholders in ensuring that the design, development and implementation of the R-MMIS meets the appropriate standards for program integrity. To reduce the burden of post-adjudication recovery, the OMIG and OHIP will focus on cost-avoidance through improvements in claims editing and detecting potential patterns of abuse during the adjudication process. For additional information on the OMIG's responsibilities, the OMIG Medicaid Work Plan is available on the OMIG website (http://www.omig.state.ny.us/).

NY Medicaid's Reform Agenda includes rationalizing reimbursement; expanding access to coverage; expanding access to care; pursuing improvements in quality and outcomes; improving care for enrollees with complex medical needs; making advancements in Long Term Care; assuring program integrity; and, strengthening information technology systems.

Since 2007, New York has made significant strides in achieving these reform objectives. It broadened coverage making it more accessible; increased investment in ambulatory care to reduce preventable inpatient hospital stays; and, strengthened the commitment to quality through primary care standards, retrospective review of services and selective contracting. As OHIP continues to implement policies that advance the reform agenda, the R-MMIS will play a critical role in supporting all stakeholders in the development and evaluation of reform initiatives.

C. NEW YORK STATE MEDICAID MANAGEMENT INFORMATION SYSTEM (eMedNY)

eMedNY is a complex system that encompasses a variety of components allowing it to process an average of 1.7 million transactions per day with application access for Department, other State Agency, Local Departments of Social Services staffs and providers. Among these transactions are institutional, professional, dental, pharmacy and transportation claims

transactions; service authorizations, prior approvals and prior authorizations; and eligibility inquiries. These components provide the following capabilities:

1. Transaction processing (real time and batch);
2. Web-based application for Department, other State Agency, and Local Departments of Social Services access;
3. Internet application for provider access;
4. External file transfer;
5. Report repository and delivery;
6. Imaging and document management;
7. Workflow Management;
8. Interactive Voice Response (IVR); and,
9. Point of Service (POS).

C.1 eMedNY CORE APPLICATION

The eMedNY core application is based on the integration of several software applications including the Core Affiliated Computer Services (ACS), Inc. Omnicaid and Prescription Drug Claim System (PDCS) systems. These systems were modified and extended to meet the requirements of the NYS Medicaid program. Over the course of the current contract, a variety of major initiatives have resulted in substantial modifications to the base software applications. This has increased the complexity of both maintenance and enhancement activities, resulting in higher costs and longer development times.

The eMedNY application architecture utilizes a modular approach that separates the application into eleven (11) subsystems. These subsystems include:

1. Claims Processing;
2. Client;
3. Electronic Commerce (eCommerce);
4. Financial;
5. Prior Authorization;
6. Provider;
7. Reference;
8. Third-Party Liability;
9. EPSDT (Early and Periodic Screening and Diagnostic Treatment);
10. MARS (Management and Administrative Reporting Subsystem); and,
11. SURS (Surveillance and Utilization Review Subsystem).

Each eMedNY subsystem is a collection of functional objects that encapsulates the Medicaid program functionality. These objects include the screens, reports, interfaces and services required by the subsystem. As a result of this “siloed” approach, eMedNY is limited in its ability to facilitate business processes that require functions contained in different subsystems.

The eMedNY subsystem data is maintained in relational databases. These relational models facilitate data sharing among applications and minimize data replication. In addition, a

variety of COTS and proprietary products are integrated to effectively and efficiently manage eMedNY operations. Detailed information on the eMedNY core application, database and technical architecture, including processing volumes, can be found in the Procurement Library.

C.2 CHALLENGES OF THE EMEDNY ENVIRONMENT

While eMedNY accurately processes claims and the Web Portal has been well received by the provider community, the Department has identified a series of challenges inherent in the current architecture that must be addressed by the R-MMIS contractor. While these are reflected throughout the requirements set forth in this RFP, challenges of particular note include:

1. The eMedNY application and technical architecture lack the flexibility to support the rapid changes in functional and technical requirements that are essential for today's Medicaid program and regulatory environment. Lengthy timelines to execute change orders do not provide an adequate level of responsiveness to business areas reliant on eMedNY;

2. The lack of flexibility severely limits the Department's ability to implement MITA Maturity Level 3 business capabilities in the near term;

3. The eMedNY application architecture has not taken advantage of Service Oriented Architecture (SOA) and commercial-off-the-shelf (COTS) solutions in many areas where significant benefits could be provided, including the elimination of redundant code;

4. eMedNY lacks a fully integrated, modular financial management system capable of processing all Medicaid financial transactions and interfacing with the NYS Central Accounting System;

5. Training for certain eMedNY users is currently limited and the delivery relies heavily on traditional classroom methods. These present access and scheduling problems that limit the reach and overall efficacy of eMedNY training efforts;

6. The current System Development Life Cycle (SDLC) methodology does not provide a well integrated approach to managing all phases of the SDLC and its artifacts. The current approach to testing is not as robust or flexible as the Department would like. The lack of automated tools in particular results in cumbersome and inefficient testing; and,

7. The current project management approach lacks an enterprise-wide project management office (EPMO) function. Such a function would support a more consistent implementation of project controls (e.g., scope definition, change control) and system development standards (e.g., an estimation methodology).

III. REPLACEMENT MMIS (R-MMIS) STATEMENT OF WORK

A. INTRODUCTION

This section presents the project statement of work organized by project phases and a series of functional activities that will occur throughout the life of the contract. Project phases include:

1. Project Planning Phase;
2. Implementation Phase (comprised of Functional Phases I, II and III);
3. Certification Phase;
4. System and Operational Enhancements Phase;
5. Operations Phase; and,
6. Turnover Phase.

Exhibit I-1 R-MMIS Project Phases on page I-3 of this RFP provides a graphical illustration of these phases.

Categories of requirements governing functional activities include:

1. Technical and System Architecture Requirements;
2. Security, Privacy and Confidentiality Requirements;
3. Functional Requirements;
4. Facility Requirements;
5. Business Continuity and Disaster Recovery Requirements;
6. Organization and Staffing Requirements;
7. Training and,
8. Contractor Performance Requirements.

Each area is described in a section that includes a narrative overview, proposal requirements and other information relevant to that area. A comprehensive listing of all detailed contractor requirements for each area can be found in Attachment J Bidder Requirements Traceability Matrix. Attachment L Deliverables List provides a comprehensive listing of required contractor documentation and deliverables. Attachment P Proposal Requirements provides a comprehensive listing of all requirements offerors must meet to ensure submission of a fully responsive proposal. Attachment B Glossary of Terms provides a listing of acronyms and terminology used throughout this RFP.

The Procurement Library includes eMedNY As Is Business Process Models and Documentation. These materials provide graphical business process models and their associated documentation and are designed to provide a clearer understanding of the As Is eMedNY business processes involved in the procurement in a manner that will facilitate analysis. The models represent the Department's current understanding of the business processes and may contain errors and/or omissions that were not identified during the business process modeling project. While the Department has made its best effort to avoid errors and/or omissions, it is not responsible for any damages arising from the use of the information contained in these models.

For purposes of this RFP, the use of the terms “shall”, “must” and “will” are used interchangeably.

The contractor’s responsibility is to ensure that the project remains within budget and resource allocations, and adheres to the development and operational schedules while maintaining the quality of the products and deliverables.

B. PROJECT PLANNING PHASE REQUIREMENTS

B.1 OVERVIEW

The offeror must provide a detailed description of its proposed approach and methodologies to the management of all aspects of the project. This section must contain a complete description of the contractor’s project management methodology and describe how its project management, quality management and software development methodologies are designed to work together and are based on industry best practices and recognized methodologies.

The focus of this phase is the development of a comprehensive series of planning documents that, when executed, ensure that the project maintains a high quality of products and deliverables, adheres to the development schedule and remains within budget. The Department considers the use of recognized methodologies to control all project activities to be critical to the success of the project. Offerors must describe what standard(s) proposed methodologies are based upon, or are consistent with, and how they are integrated into a project management methodology.

The contractor’s project management approach must promote the development of a strong working relationship and facilitate open and timely communication with the Department, other contractors and stakeholders that will support achievement of the overall goal of satisfactory performance within budget.

B.2 PROJECT MANAGEMENT PLAN AND CONTROLS

Offerors’ proposals must include a detailed Project Management Plan (PMP) that is based upon its proposed Project Management methodology and describes its overall plan and activities required to successfully complete this project within budget and on schedule. The PMP must be in sufficient detail to demonstrate to the Department that the offeror has a clear and concise understanding of the overall complexity of the project and all associated tasks to successfully implement the requirements in this RFP. The PMP must address both the technical and operational aspects of the project

The PMP must address all the major sections of this RFP and, once approved by the Department, must be continuously updated by the contractor throughout the life of the project. All System and Operational Enhancement projects must be added to the PMP in sufficient detail as to provide the Department with a clear understanding of the magnitude and steps necessary to implement the change and the tasks and resources that will be required.

Changes to the PMP must be discussed at the weekly project status meeting and submitted to the Department for approval. The contractor must make available online to the Department and the Department's contractor staff full read access to the most current version and all historical iterations of the PMP.

Offerors must propose an integrated approach to project management that includes and describes the offeror's proposed methodologies that shall be in effect throughout the life of the project for each of the major project phases and any subsequent work under the contract that will result from this RFP.

Offerors must integrate "Best of Breed" COTS project management products into its solution to meet the needs of the business functions. For purposes of this RFP, COTS solutions are those products that can be licensed and utilized by multiple industries, are commercially available from a third party, and provide a common solution throughout the application.

The Department is requiring the contractor to establish and staff an Enterprise Project Management Office (EPMO) that reports directly to the account executive. The EPMO must use the PMP to manage all aspects of the project. The EPMO must have the authority to ensure that the PMP is successfully executed on-time and within budget and has oversight authority for all aspects of the project's development and operations.

B.2.1 Proposal Requirements

As part of its Technical Proposal the offeror must describe its proposed Project Management Methodology. This methodology will serve as the foundation for the PMP and must describe the offeror's approach and plan for managing the project. The proposal at a minimum must:

1. Describe in detail the offeror's proposed Project Management Methodology and show how it provides an integrated approach to project management;
2. Describe how the proposed methodology is based on industry best practices;
3. Include a detailed narrative of its proposed PMP. This PMP narrative must be in sufficient detail to demonstrate to the Department that the offeror has a clear and concise understanding of project's overall complexity and all associated tasks to successfully implement the requirements in this RFP;
4. Describe how the offeror's implementation of its proposed PMP will address and balance such factors as quality, scope, time and cost;
5. Identify and describe all tasks and activities to be undertaken in the delivery of the R-MMIS and provide the associated timing of these activities;
6. Describe how the offeror decomposes deliverables and projects into a WBS and work packages;
7. Describe the deliverables that will be produced at different milestones in the PMP. As an appendix to the proposal supply sample copies of these deliverables;

8. Include the electronic submission of the PMP in Microsoft Office Project 2003 format. The PMP must be broken down into Work Breakdown Structures (WBS) and must include key tasks, resources, milestones, deliverables and task dependencies;
9. Describe in detail the approach the offeror will undertake to ensure that the R-MMIS will be synchronized with the eMedNY system during the Implementation Phase;
10. Describe the operation of the EPMO and how it will integrate and communicate with Department and other contractor staff;
11. Describe the staffing of the EPMO; and,
12. Describe how the PMP will be implemented within the EPMO structure and how it will integrate into the overall Project Management (PM) approach including any and all COTS tools that are integrated.

B.2.2 Quality Management

The Department is making a significant investment in procuring an R-MMIS and fiscal agent services described in this RFP. The contractor selected will perform an essential role in NYS Medicaid program administration. To maintain continuous focus on the importance of delivery of quality systems and services, the contractor must plan, implement, rigorously enforce, and constantly improve a quality management program.

Quality management encompasses taking a proactive approach to analyzing and assessing the quality and accuracy of performance within all aspects of the R-MMIS. The contractor must develop, implement, and maintain processes and procedures to assess the quality and accuracy of its performance of all operational responsibilities and correct any deficiencies. The Department requires that the contractor disclose to the Department within twenty-four (24) hours or as specified by other requirements in this RFP, any and all deficiencies found by the contractor throughout the life of the contract.

The Department requires that the contractor propose a formal quality management system. The Department desires a quality management system that is aligned with a recognized set of standards, such as the International Standards Organization (ISO) 9000:2000 and ISO 9001:2008 families of standards. However, the Department will allow the contractor to propose a system they have successfully used in projects of similar size and scope to the project.

During the planning phase of the project, the contractor must develop and implement a Quality Management Plan (QMP) for the R-MMIS that is based upon the contractor's proposed Quality Management Methodology (QMM). The methodology and subsequent plan must describe how the contractor must take a proactive approach to analyzing and assessing the quality and accuracy of performance. The methodology and subsequent plan must describe the contractor's approach to Quality Assurance (QA): the systematic process of checking to ensure that the R-MMIS, its related services and deliverables are developed to meet all specified RFP requirements.

The execution of the proposed Quality Management Plan must continuously improve work processes and efficiency in R-MMIS development, deployment, operations and enhancement. The contractor's quality management processes must be applied to the R-MMIS

for the life of the contract and are not specific to any particular phase. The contractor must implement its Quality Management Plan across the broad spectrum of the R-MMIS including but not limited to manual and automated processes (e.g., financial accountability, customer relations, image processing, call center processing, data creation, transformation and transmission) and the System Development Life Cycle (SDLC). The Department encourages responses that demonstrate a thorough understanding of QA.

Data quality is a critical component of the R-MMIS that must be specifically addressed in the contractor's Quality Management Methodology and subsequent plan. This involves managing the lifecycle for data creation, transformation, and transmission to ensure that the resulting information meets the needs of all the data consumers within the enterprise. It requires a continuous data quality management process for defining the acceptable levels of data quality required to meet business needs, and for ensuring that data quality meets these levels. This process involves analyzing the quality of data, identifying data anomalies, and defining business requirements and corresponding business rules for asserting the required data quality. Data Quality Management (DQM) involves instituting inspection and control processes to monitor conformance with defined data quality rules, as well as instituting data parsing, standardization, cleansing, and consolidation. DQM incorporates issues tracking as a way of monitoring compliance with defined data quality Service Level Agreements.

An integral part of DQM is the set of data quality improvement processes. This set of processes seeks to measure data quality (both definition and content), analyze, identify, and correct root causes of data defects, and to establish improvement processes to prevent defective data in the future. Data profiling is used to reveal data quality issues, gaps, inconsistencies, and incompatibilities within data sources, before the data is integrated and loaded into the R-MMIS. This data quality process is an ongoing process to deliver comprehensive, consistent, relevant, purposeful, and timely data to the stakeholder community. As part of the contractor's overall Quality Management Plan, the contractor must describe how data quality issues will be addressed.

Throughout the life of this contract the Department or its authorized agents will conduct QA audits and/or activities to ensure that the contractor fulfills all requirements of this RFP. The contractor must assist the Department, Office of the State Comptroller (OSC), Office of the Medicaid Inspector General (OMIG), Federal staff or the R-MMIS QA contractor in the performance of these audits. The quality process must include an approach to working with an independent R-MMIS QA contractor. The R-MMIS QA contractor must assist the Department in determining if project deliverables meet quality standards, fulfill the RFP requirements and will support CMS certification standards.

The contractor must develop and implement a Corrective Action Plan, approved by the Department, for any and all deficiencies and/or recommendations made by the Department, CMS, OSC, OMIG and the R-MMIS QA contractor. The contractor must meet the dates and deliverables in the approved Corrective Action Plan at no additional cost to the Department.

B.2.2.1 Proposal Requirements

The offeror must describe its proposed Quality Management Methodology that will be the foundation for the Quality Management Plan for the project and how it will fulfill the Department's requirements as defined in this RFP and achieve continual improvement of the contractor's performance in pursuit of the project objectives. This Quality Management Methodology must have a set of defined processes that are designed to work together to accomplish a set of quality objectives.

Offerors must meet the following proposal requirements:

1. Describe the set of quality objectives the offeror has defined for this project;
2. Describe in detail the methodology being proposed for quality management and how it will ensure a proactive approach to analyzing and assessing the quality and accuracy of performance;
3. Describe how the proposed methodology will provide a standardized approach to ensuring:
    a. Project objectives are met;
    b. Deliverables meet the Department's expectations; and,
    c. Processes are in place to continuously check quality;
4. Describe how the proposed methodology will ensure on-time and accurate completion of regular and ad-hoc tasks;
5. Describe the standard that the proposed methodology follows. State where the methodology was used on projects of similar scope and size;
6. Describe the business processes and procedures that will be used for the identification and definition of quality issues related to all manual, automated, financial and data facets of the R-MMIS;
7. Describe the processes and procedures that will be used for the identification and definition of quality issues related to the proposed System Development Lifecycle;
8. Describe the metrics that will be used to measure quality;
9. Describe how the proposed methodology will report quality issues;
10. Describe how the Quality Management Plan will be implemented within the EPMO structure and how it will integrate into the overall PM approach including any and all COTS tools that are used;
11. Describe in detail how the proposed Quality Management Plan will integrate with its approach to continuous process improvement;
12. Describe all technical components that comprise the proposed solution including all software (e. g., COTS tools); and,
13. Describe the ongoing process that will ensure data quality including:
    a. Data Profiling;
    b. Data Quality Reporting;
    c. Data Quality Assessment Techniques;
    d. Data Quality Monitoring and Measurement;
    e. Data Quality Testing and Validation;
    f. Data Quality Issues Management;
    g. Data Quality Operational Procedures;

h. Data Quality Delivery; and,
i. Data Quality Continuous Improvement.

B.2.3 Scope Management

Project Scope Management includes the processes required to ensure that the project includes all the work required, and only the work required, to complete the project successfully. The Department expects that a proactive approach to scope management will be adopted based on a Project Scope Management methodology that is integrated with the proposed Project Management Methodology. The offeror must explain how using the methodology proposed will facilitate the management of scope expansion.

A Project Scope Management Plan that documents how the project scope will be defined, verified, and controlled is essential. The contractor must develop and implement a Scope Management Plan that describes its approach to defining the project, creating WBS and controlling scope expansion while still allowing for progressive elaboration throughout the life of the contract.

The contractor must show how, by subdividing the major project deliverables and project work into smaller, more manageable components, or WBS, the contractor will be able to manage scope expansion.

B.2.3.1 Proposal Requirements

The offeror must describe its proposed Project Scope Management Methodology that will serve as the foundation for the Project Scope Management Plan for the project. The methodology should describe the offeror's approach and plan for managing scope changes.

Offerors must meet the following proposal requirements:

1. Describe business processes and procedures for controlling the scope of the project and how they will differentiate between scope changes and progressive elaboration;
2. Describe how the business processes and procedures will control schedule, cost, time and effort;
3. Describe any tools or COTS products that will be used to control scope;
4. Describe how the Project Scope Management Plan will be implemented within the EPMO structure and how it will be integrated into the overall PM approach including any and all COTS tools that are integrated;
5. Describe how changes in scope will be presented to the Department, including but not limited to prioritization of changes, budget and schedule implications; and,
6. Describe how the PMP will be used to control scope.

B.2.4 Requirements Traceability and Management

The contractor must develop and implement a standard Requirements Management and Traceability Plan approved by the Department for all projects and all system enhancements to the R-MMIS. The plan must be based upon the Requirements Management and Traceability Methodology proposed by the contractor. This plan will be used to track requirements from the time they are defined by a stakeholder to the time they are implemented within the R-MMIS. The contractor must use the approved methodology in tracing a requirement throughout all steps of the SDLC. The process for tracking and monitoring a requirement begins at the time a requirement is defined by a stakeholder.

The contractor must propose a COTS product that will support a requirements repository that will be used for requirements management and traceability throughout the SDLC. The tracking must be done in a way that allows the stakeholders to obtain the status of a particular requirement through the required COTS product. The contractor must initially populate the requirements repository with those requirements listed in Bidder Requirements Traceability Matrix of this RFP. Each of these requirements will be tracked according to the proposed methodology.

Throughout the execution of projects and major system enhancements, the contractor must use the proposed Requirements Management and Traceability Plan as approved by the Department, producing a weekly list of each requirement and its status.

The eMedNY As Is Business Process Models and Documentation included in the Procurement Library illustrates the investment that OHIP has made in the Oracle Business Process Architect. The eMedNY System Development methodology calls for Business Process Models to be updated as part of the overall system deliverable documentation. In order to protect this investment, the contractor must supply and use the Oracle Business Process Architect tool in its system development methodology. The Requirements Management and Traceability Plan must integrate this tool into its processes.

The Requirements Management and Traceability methodology must include aggressive monitoring of requirements throughout the SDLC, including the status of requirement's documentation, the test scripts associated with a requirement, and the results of the testing of the requirement.

B.2.4.1 Proposal Requirements

The offeror must describe in detail its proposed methodology for Requirements Management and Traceability for the project. The methodology will become the foundation for the Requirements Management and Traceability Plan and should describe the offeror's approach and plan for managing and tracing requirements.

Offerors must meet the following proposal requirements:

1. Describe how requirements derived from stakeholder needs, wants and expectations will be documented and categorized for inclusion in the COTS product;
2. Describe how requirements will be tracked, documented and versioned;
3. Describe in detail the documentation deliverables that will be produced as a result of the requirements analysis providing examples in the contractor's proposal appendices;
4. Describe the tools or COTS products (Use Case and Case Tools, etc.) and business processes that will be used to track requirements throughout the SDLC;
5. Describe how requirements will be stored in a repository and how the Department and stakeholders will access the information about a requirement;
6. Describe how the Oracle Business Process Architect tool set will be integrated into requirements management;
7. Describe business processes and procedures that will be used for tracking requirements from design through coding, acceptance, unit, and integration testing, as well as promotion into production; and,
8. Describe how the Requirements Management and Traceability Plan will be implemented within the EPMO structure and how it will be integrated into the overall PM approach including any and all COTS tools that will be used.

B.2.5 Issue Resolution Management

Issue Resolution Management involves capturing, reporting, escalating, tracking, and resolving issues that occur as a project progresses. The contractor must take a proactive approach to issue identification, tracking and resolution.

A key component of Issue Resolution Management is the Issue Resolution Plan to be developed and implemented by the contractor that describes its approach to issue resolution and provides the Department with the ability to monitor resolution of issues throughout the life of the contract. The primary goal of this plan is to ensure that issues are identified, evaluated, assigned for resolution, and monitored. In addition, issue resolutions or decisions must be documented and communicated to all affected parties.

The offeror must propose a COTS product that will record and track issues. This product must also be used for recording and tracking risks.

B.2.5.1 Proposal Requirements

The offeror must describe its proposed Issues Resolution Management methodology that will serve as the foundation for the Issues Resolution Management Plan for the project. The methodology should describe the offeror's approach and plan for managing issues.

Offerors must meet the following proposal requirements:

1. Describe business processes and procedures that will be used for the identification, definition and evaluation of project issues related to the R-MMIS;
2. Describe how the processes and procedures will differentiate between an issue and a risk;

3. Describe how the Issues Resolution Management Plan will be implemented within the EPMO structure and how it will be integrated into the overall PM approach;
4. Describe how the business processes and procedures will be used to resolve issues;
5. Describe the COTS product that will be used to document, track and manage issues and document issue resolutions; and,
6. Describe how the COTS product will be used to support Department and stakeholder access to information about issue resolution.

B.2.6 Risk Management

Like issue management, risk management also requires a proactive approach to analyzing and assessing the risks within all aspects of the R-MMIS. The contractor must implement its Risk Management Plan across the broad spectrum of the R-MMIS, including but not limited to, manual and automated processes and the system development life cycle.

Throughout the execution of projects and major system enhancements, the contractor must continually perform risk assessments, producing lists of identified risks. For each risk identified, the contractor must evaluate and set the risk priority based on the likelihood the risk will occur and the potential impact of the risk, assign risk management responsibility, and create a risk mitigation strategy.

The contractor must develop and implement a standard Risk Management Plan approved by the Department for all projects and all system enhancements to address potential risks that may compromise the operational readiness and continued operation of the R-MMIS. The plan must be based upon the contractor's proposed Risk Management methodology. The proposed methodology must address, at a minimum, the process and timing for risk identification, the process for tracking and monitoring risks, the identification of the contractor staff that will be involved in the risk management process, the identification of the tools and techniques that will be used in risk identification and analysis, a description of how risks will be quantified and qualified, and how the contractor must perform risk mitigation and response planning. The Risk Management Plan must include an annual R-MMIS risk assessment.

The Risk Management methodology must include aggressive monitoring for risks, identify the frequency of risk reports, and describe the plan for timely notification to the Department of any changes in risk or trigger of risk events.

The Department recognizes the risk inherent in transferring the New York requirements to a different system and at the same time moving to a new environment. The contractor must identify the risks in the R-MMIS implementation and provide aggressive mitigation strategies, including how the contractor will leverage the phased implementation to help assure a successful transition.

The COTS product that is proposed for tracking issues must also be used for tracking risks and their resolution.

B.2.6.1 Proposal Requirements

The offeror must describe its proposed Risk Management methodology that will be the foundation for the Risk Management Plan for the project. The methodology should describe the offeror's approach and plan for managing risk.

Offerors must meet the following proposal requirements:

1. Describe business processes and procedures that will be used for:
    a. Identifying and defining risks;
    b. Tracking and monitoring risks;
    c. Quantifying, qualifying and prioritizing risks; and,
    d. Mitigating of risks;
2. Describe processes and procedures that will be used for risk assessment;
3. Describe processes that will be completed annually for the R-MMIS risk assessment;
4. Describe processes and procedures that will differentiate between an issue and a risk;
5. Describe the COTS product, tools and techniques that will be used for:
    a. Risk identification;
    b. Risk documentation;
    c. Risk management;
    d. Risk analysis;
    e. Risk logging; and,
    f. Risk mitigation;
6. Describe how the Risk Management Plan will be implemented within the EPMO structure and how it will be integrated into the overall PM approach including any and all COTS tools that are used; and,
7. Describe how the Risk Management Plan will aggressively monitor risk and identify triggers to risk events.
8. Describe how the Risk Management Plan will address the risks in the R-MMIS implementation and provide aggressive mitigation strategies, including how the phased implementation will be leveraged to assure a successful transition.

B.2.7 Configuration Management

Configuration Management is a process that the contractor must employ to control the versions of software and hardware that will operate and support the R-MMIS across all environments. This applies to operating systems, applications, software, documentation, networks and all devices within the entire enterprise.

Configuration management includes but is not limited to:

1. Software version control (e.g., operating system, application, and COTS);
2. Hardware version control; and,
3. Documentation, User and Policy Manual version control.

The contractor must develop and implement a Configuration Management Plan that is approved by the Department and describes its approach to implementing the proposed Configuration Management methodology. As part of the plan, the contractor must clearly identify the process for approving and implementing new versions, including the organizational responsibility for each type of version control.

When new hardware or software becomes available or when subsequent releases to the current operating system, server(s), database management software, grouper software, COTS products, or other hardware/software supporting the R-MMIS become available, the contractor must inform the Department of the benefits that can be derived by implementing the newest version. If the Department requires the contractor to proceed with the implementation, the contractor must determine the impact of implementation and develop an upgrade plan. All such upgrades must be included under the fixed cost portion of the contract. The Department shall review and approve the plan for implementation or return the plan for modification. The contractor must not operate software for the R-MMIS that is either not supported by the vendor or is more than two (2) versions behind the software vendor's current commercial offering without prior approval from the Department.

B.2.7.1 Proposal Requirements

The offeror must describe in detail its proposed Configuration Management methodology that will serve as the foundation for the Configuration Management Plan for the project. The methodology must describe the offeror's approach and plan for managing configuration changes.

Offerors must meet the following proposal requirements:

1. Describe how changes will be tracked, documented and versioned;
2. Describe how changes will be synchronized and distributed when multiple activities are occurring simultaneously across multiple environments (e.g., development, test, and training);
3. Describe any tools or COTS products (e.g., Use Case, Case Tools and configuration management tools) and business processes that will be used to control software development, including check in/check out procedures and a responsibility audit trail;
4. Describe business processes and procedures that will be used for controlling the migration of code from design through coding, acceptance, unit, and integration testing, as well as promotion into production. Explain how proposed changes will be communicated to the stakeholder;
5. Describe how changes to the environments will be controlled so that no changes to hardware, software or operational procedures will be implemented without the Department's review and approval;
6. Describe the software development management process that will be used, including the migration of code from design to production. This description shall include diagrams and other graphical representations to communicate the processes;
7. Identify the types of configuration changes that can be made. Categorize the changes in terms of functionality, testing requirements, quality of change and the extent of the change in terms of immutability and retractability;

8. Describe how the Configuration Management Plan will be implemented within the EPMO structure and how it will be integrated into the overall Project Management (PM) approach including any and all COTS tools that are used;
9. Describe the organizational structure that will be in place to control changes; and,
10. Describe how the offeror will inform the Department of the benefits the Department would realize from any and all announcements of a new version of hardware, software or COTS product.

B.2.8 Performance Management

The contractor must develop and implement a Performance Management Plan approved by the Department for each service level agreement defined in section III.O.2 Service Level Agreements.

The contractor must develop, and provide access through the Web Portal to an R-MMIS Dashboard that will display (upon-demand) the contractor's operational performance metrics and provide the Department management with the latest statistics regarding those metrics.

B.2.8.1 Proposal Requirements

The offeror must describe in detail its proposed methodology for Performance Management for the project. This methodology will become the foundation for the Performance Management Plan that must describe the offeror's approach and plan for managing performance.

Offerors must meet the following proposal requirements:

1. Describe how performance will be measured and reported against the Service Level Agreements (SLA) listed in this RFP;
2. Describe how the Performance Management Plan will be implemented within the EPMO structure and how it will be integrated into the overall PM approach including any and all COTS tools that are used;
3. Describe the performance metrics that will be established for the project;
4. Describe the R-MMIS Dashboard that will be developed based upon the offeror's previous experience;
5. Describe any tools or COTS products that will be used to track its performance; and,
6. Describe the offeror's organizational structure that will be used to track performance.

B.2.9 Communication Management

Implementation of a project of this complexity requires daily collaboration and communication among all project stakeholders. Time is critical in communicating issues, solutions and decisions among the contractor; the Department's programmatic, technical and management staff; and other contract staff, including but not limited to, the Medicaid Data Warehouse contractor and the Quality Assurance contractor.

Effective communication among the Department, the contractor, members, the provider community and other stakeholders is essential to encourage continued participation in the NYS Medicaid program.

The contractor must provide and implement a Communication Management Plan, approved by the Department, describing how the contractor will communicate with all the stakeholders. The plan must define each stakeholder's communication needs, determine the method and frequency of communicating in order to meet those needs and allocate appropriate resources to meet the communication schedule. The schedule should address regular (on-going) communication as well as event-driven communication. This plan must be updated annually or at the direction of the Department.

The contractor must develop and implement a Communications Management Plan and process, approved by the Department, for each Service Level Agreement defined in section III.O.2.

The offeror must propose a COTS product for the Contact Management System that will be used to track and report provider written, electronic, and telephone inquiries.

B.2.9.1 Proposal Requirements

The offeror must describe in detail its proposed methodology for Communication Management for the project. This methodology will serve as the foundation for the Communication Management Plan that must describe the offeror's approach and plan for managing communications.

Offerors must meet the following proposal requirements:

1. Describe potential stakeholders based on the offeror's previous experience with Medicaid and/or Health Care Systems;
2. Describe how communication with the different stakeholders will be accomplished;
3. Describe the different communication channels that will be used;
4. Describe how the Communications Management Plan will be implemented within the EPMO structure and how it will be integrated into the overall PM approach including any and all COTS tools that are used; and,
5. Describe the Contact Management System that will be used to track and report provider written, electronic, and telephone inquiries from providers and other stakeholders; and how it will be integrated with other R-MMIS functions and accessed by Department staff

B.2.10 Enterprise Data Management

Data management as defined by the Data Management Association (DAMA) Guide to the Data Management Body of Knowledge (DAMA-DMBOK) Guide is the business function of planning for, controlling, and delivering data and information assets. This function includes the disciplines of development; execution; and supervision of plans, policies, projects, processes, practices, and procedures that control; protect; deliver; and enhance the value of data and

information assets. Data management is a shared responsibility between the data management professionals within the Information Technology (IT) organizations and business data stewards or subject matter experts representing the collective interests of data producers and information consumers.

The Department is committed to improving the quality of data produced and disseminated from the R-MMIS and to increasing the return on investment (ROI) of the system by ensuring that its data is useful to the widest possible audience. Service Level Agreements tied to the quality of the data have been included in the RFP to advance the goal of reducing the necessity for data remediation which is paramount to the success of the implementation.

The goals and objectives of data management are to:

1. Understand the information needs of the organization and all of its stakeholders;
2. Capture, store, protect, and ensure the integrity of data assets;
3. Continually improve the quality of data and information;
4. Ensure privacy and confidentiality, and to prevent unauthorized or inappropriate use of data and information;
5. Maximize effective use and value of data and information assets;
6. Promote a wider and deeper understanding of the value of data assets;
7. Manage information consistently across the enterprise; and,
8. Align data management efforts and technology with business needs.

Guiding principles of data management include:

1. Data and information assets are valuable enterprise assets;
2. Data and information must be managed carefully by ensuring adequate quality, security, integrity, protection, availability, understanding, and effective use;
3. Responsibility for data management is shared between business data stewards and data management professionals;
4. Data management is a business function and a set of related disciplines; and,
5. Data management is an emerging and maturing discipline.

Business functions within data management include the following and requirements for each are found in various sections of the RFP (e.g., Data Quality Management requirements are found in the Quality Management section).

1. Data Governance;
2. Data Architecture Management;
3. Data Development;
4. Data Operations Management;
5. Data Security Management;
6. Data Quality Management;
7. Data Receipt Management;
8. Data Delivery Management;
9. Document and Content Management;

10. Metadata Management; and,
11. Data Conversion Management.

B.2.10.1 DATA GOVERNANCE

Data governance is the exercise of authority and control (planning, monitoring, and enforcement) over the management of data assets. The data governance function guides how all the other data management functions are performed and ensures that data is accurate, consistent, available, and secure. Data governance encompasses the actions of people, processes, and technology used to ensure that key information delivered throughout the enterprise is appropriately defined and maintained. Data governance ensures that there is a mechanism to facilitate and communicate a common definition and understanding of information.

The Department recognizes the importance of the data governance function that enables the shared responsibility between business and IT management and supports an integrated view of the data. The Bureau of Data Warehouse within the Office of Health Insurance Programs has responsibility for all matters surrounding data and data governance. The contractor must interface with and take direction from that Bureau for all data and data governance issues. This responsibility includes but is not limited to: 1) data definitions, 2) data models and 3) metadata.

The Bureau is currently in the process of establishing an enterprise OHIP metadata repository which will house all data and artifacts from eMedNY and the Medicaid Data Warehouse. It is the Department's intent to expand this repository to include all aspects of the R-MMIS.

Both the R-MMIS and MDW contractors will play an integral role in supporting the Department's Data Governance organization. Both contractors will participate in the execution of the data governance program in all areas of data management as they will be responsible for providing this data management functionality to support the transactional and analytic needs of the Department.

The goals of the Data Governance organization are to:

1. Define, approve, and communicate data strategies, policies, standards, architecture, procedures, and metrics;
2. Track and enforce regulatory compliance and conformance to data policies, standards, architecture, and procedures;
3. Sponsor, track, and oversee the delivery of data management services;
4. Manage and resolve data-related issues; and,
5. Understand and promote the value of data assets.

The data governance framework and organizational structure are found in the Procurement Library. The framework depicts the processes for establishing and executing the Data Governance program. The organizational structure depicts the Department's Data Governance organizational structure, functions, and success criteria.

B.2.10.1.1 Proposal Requirements

The offeror must describe in detail its proposed approach to Data Governance and how it will fulfill the Department's requirements and achieve continual improvement of the contractor's performance in pursuit of the project objectives.

Offerors must meet the following proposal requirements:

1. Describe how the offeror will support the Department's Data Governance organization in achieving the goals identified above;
2. Describe how the Department's Bureau of Data Warehouse staff will be integrated during the data modeling activities;
3. Describe how the Department's Bureau of Data Warehouse staff will be integrated during the data conversion activities;
4. Describe how the EPMO will work with the Department's Data Governance organization; and,
5. Describe the process and procedures that will be put into place to ensure a smooth working relationship with the Department, MDW contractor and other stakeholders.

C. IMPLEMENTATION PHASE REQUIREMENTS

C.1 OVERVIEW

The R-MMIS Implementation Phase is comprised of three (3) functional phases and includes tasks required to successfully transfer, modify, design, develop, test, and implement an R-MMIS for the Department. The DDI of the R-MMIS may include the transfer an existing system, components of existing systems, COTS product(s) or any combination thereof. The transfer base may be an MMIS, components of an MMIS from several states, or commercial systems. Major tasks include:

1. Project Initiation;
2. System Development Life Cycle (including Requirements Validation, System Design, System Development and Testing);
3. Organizational Change Management;
4. Data Conversion;
5. Operational Readiness;
6. Training;
7. Implementation; and,
8. Incumbent Transition Support (including the MDW contractor).

The Department is providing offerors the freedom to develop and propose approaches to the DDI of the R-MMIS that may include the transfer an existing system, components of existing systems, COTS product(s) or any combination thereof. The proposed approach must include the modification of these system(s) and/or components to meet the needs of the NYS Medicaid program. The transfer base may be an MMIS, components of an MMIS from several states, or commercial systems. Offerors must identify "best of breed" in selecting all transfer base components and COTS products.

C.2 PROJECT INITIATION TASK

The foundation of every successful large-scale system implementation project is a solid set of methodologies that will be used in project planning and team orientation activities, as well as the establishment of the EPMO. The offeror must propose a set of project initiation tasks that set the stage for the project, ensure all infrastructure needs are met and provide a detailed orientation for staff to begin the design and development efforts.

This is also the time within the project that the contractor must implement the comprehensive series of planning documents that were developed in the Project Planning Phase described in section III.B of this RFP. It is here that the contractor lays the foundation for the project that when executed, will ensure that the project remains within budget, adheres to the development schedule and maintains a high quality of products and deliverables.

C.2.1 Proposal Requirements

The offeror must describe its proposed methodology for the Project Initiation Activities that will become the foundation for the Project Orientation Plan for the R-MMIS.

Offerors must meet the following proposal requirement:

1. Describe the Project Initiation Activities that detail the approach for orienting the project team (Department, QA contractor, MDW contractor and other State contractor staff);
2. Describe the activities that will be necessary to secure and prepare adequate facility space; and,
3. Describe the steps necessary to implement the EPMO and assemble other key staff, including specific plans for disseminating individual staff responsibilities.

C.3 SYSTEM DEVELOPMENT LIFE CYCLE (SDLC)

The Department requires that offerors propose a System Development Lifecycle (SDLC) process that will govern the initial development and implementation of the R-MMIS as well as ongoing maintenance and enhancements. This SDLC must be a proven process that the contractor has used in other large scale application development efforts. Offerors must describe, in detail, the proposed SDLC.

The Department is requiring the contractor to use at the core of their SDLC a suite of COTS products to manage the implementation and maintenance of the R-MMIS. This suite must be used at a minimum, during the following SDLC tasks: 1) Requirements Validation, 2) System Design, 3) System Development and 4) Testing.

The goals of the SDLC are to:

1. Provide a framework for developing quality systems using an identifiable, measurable, and repeatable process;
2. Establish a project management structure to ensure that each system development project is effectively managed throughout its life cycle; and,
3. Ensure that system requirements are well defined, traceable throughout each phase of the SDLC and subsequently satisfied.

Through the use of the SDLC, the contractor should achieve these goals by:

1. Establishing appropriate levels of management authority to provide timely direction, coordination, control, review, and approval of the system development project;
2. Ensuring project management accountability;
3. Documenting requirements and maintaining traceability of those requirements throughout the design, development, testing and implementation process;
4. Ensuring that projects are developed efficiently within the proposed technology infrastructure; and,
5. Identifying project issues and risks early and managing them before they have a negative impact on the project.

As the R-MMIS moves toward a Service-Oriented Architecture (SOA), the application development methodology will need to change to handle Service-Oriented Development of Applications (SODA) as well the testing of a complex set of integrated modules.

The data development component of the SDLC must address the definition and management of conceptual, logical and physical data models in support of the R-MMIS data structures. It must contain logical data depictions or models of the R-MMIS that will support the business and technical requirements outlined in this RFP. The physical data models relating to the R-MMIS must also be depicted for each deployment environment (e.g., development, test, production, training, UAT, and provider test).

eMedNY Business Process Models included in the Procurement Library illustrate the investment that OHIP has made in the Oracle Business Process Architect. The current System Development Methodology used in the eMedNY system calls for all Business Process Models to be updated as part of the overall system deliverable documentation. In order to protect this investment the contractor must supply and use the Oracle Business Process Architect tool in its SDLC to produce at a minimum the Business Process Models for the R-MMIS. The contractor must use this tool when developing the Business Process Gap Analysis. The contractor must integrate this tool into its SDLC.

At a minimum the contractor's SDLC process must produce a:

1. Business Design Document;
2. Business Process Models;
3. Detailed Design Document;
4. Technical Design Document;

5. Architecture, Network and Data Modeling Diagrams;
6. Test Plans;
7. Training Plan; and,
8. Implementation Plan.

The offeror will be required to describe in detail the artifacts generated from each step within its proposed SDLC process and provide examples of each of these artifacts in an appendix to its proposal.

As the DDI effort is underway for the R-MMIS, evolution projects for eMedNY and the MDW will continue to be initiated, designed, developed and implemented. The synchronization between the R-MMIS, eMedNY and the MDW is critical to a successful implementation. The offeror will be required to describe in detail the processes and procedures that will be put in place to ensure that the R-MMIS' development activities will be synchronized with the evolution projects being implemented in eMedNY and the MDW.

C.3.1 Proposal Requirements

The offeror must describe in detail the SDLC it will use in the requirements analysis, design, development, testing, implementation and maintenance of the R-MMIS including a definition of the methodology for gathering and validating stakeholder requirements and the methodology it will follow in the design, development, testing, training and implementation of those validated requirements.

Offerors must meet the following proposal requirements:

1. Describe in detail the SDLC the offeror will use in the requirements analysis, design, development, testing, implementation and maintenance of the R-MMIS;
2. Describe the suite of COTS products proposed and the rationalization for it being categorized "Best of Breed";
3. At a minimum describe in detail the contents of all documents and artifacts produced within the SDLC including but not limited to:
    a. Business Design Document;
    b. Business Process Models;
    c. Detailed Design Document;
    d. Technical Design Document;
    e. Architecture, Network and Data Modeling Diagrams;
    f. Test Plans for the eleven (11) categories of testing defined in section III.C.3.5 of this RFP;
    g. Requirements Traceability Matrix;
    h. Data Conversion and Cleansing Plan;
    i. Implementation Plan; and,
    j. Training Plan;
4. Include in the Appendix of the proposal a sample of the documents and artifacts described above that the contractor has produced for a previous MMIS engagement or engagement of similar size and scope;

5. Describe how the Oracle Business Process Architect tool set will be integrated into the SDLC;
6. Describe the proposed estimation methodology;
7. Describe the proposed SDLC within the context of a SODA;
8. Describe the organizational structure to control all system development and maintenance;
9. Describe how the SDLC will be implemented within the EPMO structure and how it will be integrated into the overall Project Management (PM) approach, including but not limited to, Quality Management, Change Management, Data Governance;
10. Describe the levels of management authority that will be used to ensure timely direction, coordination, control, review and approval of the SDLC process;
11. Describe the process that will be used for developing and updating Business Process Models for the R-MMIS using the Oracle Business Process Architect;
12. Describe the data modeling tool that will be used to model the conceptual, logical, and physical R-MMIS data structures. Include how the models will be managed and versioned from a single tool and central control point. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components;
13. Discuss the degree to which the physical model that is created from the tool can be used without augmenting physical characteristics after the data structure generation scripts are created; and,
14. Describe the processes and procedures that will be put in place to ensure that R-MMIS development activities will be synchronized with the evolution projects being implemented in eMedNY and the MDW.

C.3.2 Requirements Validation Task

Requirements Validation is a major component of the SDLC process which confirms that all requirements are correct, complete, consistent, and validated prior to the initiation of system design activities. This task results in a Business Process Gap Analysis that includes, at a minimum, updated Business Process Models, an updated Requirements Traceability Matrix and a Gap Analysis Report. Upon approval by the Department, the updated Requirements Traceability Matrix and repository will be used to manage the scope of the R-MMIS development.

During Requirements Validation the contractor shall confirm, document and elaborate the RFP requirements in sufficient detail to adequately support system design and development activities. This will be accomplished by conducting a series of Joint Application Design (JAD) sessions with Department staff and other stakeholders. The contractor must supplement the requirements with any additional requirements that result from this task. This additional detail and definition is considered within the scope of the original RFP requirements and contract. The contractor must also document the Department's business rules that support the Department's policies.

The approach to Requirements Validation may vary depending on whether the offeror is transferring a system or proposing the development of a new system. Offerors must clearly

describe the Requirements Validation approach and process, and ensure it meets the Department's needs.

C.3.2.1 Proposal Requirements

The offeror must describe in detail the Requirements Validation process which will be used to document and elaborate the RFP requirements in sufficient detail to adequately support system design and development activities. The offeror must define the methodology for gathering and validating stakeholder requirements through a series of JAD sessions with the Department and other stakeholders.

Offerors must meet the following proposal requirements:

1. Describe in detail the proposed approach to Requirements Validation;
2. Provide a detailed description of the Requirements Validation Methodology;
    a. Define the methodology and analytical tools that will be used to complete the requirement validation tasks. Provide examples of templates; and,
    b. Describe how the proposed methodology and proposed suite of COTS products will enhance requirements validation and be supported by experienced staff;
3. At a minimum the contractor's proposal must:
    a. Define the goals, expectations, and output of the JAD sessions;
    b. Define how the Joint Application Design sessions will be conducted;
    c. Define how demonstrations of functionality will occur in the JAD sessions;
    d. Define how the requirements will be identified and documented. Provide templates and examples;
    e. Define how the Department's business processes will be identified and documented in the JAD sessions; and,
    f. Define the documentation that will be provided to staff attending the JAD sessions;
4. Describe how the offeror has planned, organized and facilitated requirements sessions in the development and/or transfer, design and implementation of an R-MMIS or other Health Care Systems;
5. Describe how Department staff (State, Department contractor and QA contractor) and other stakeholder participating in JAD sessions will be oriented into the processes and trained to participate in the JAD sessions;
6. Describe any tools that will be used in these sessions and the orientation and training participants will receive in using these tools;
7. Describe how the documentation from the JAD Sessions (e.g., Department decisions, approved notes and updated requirements) will be collected and stored in an online repository. This description must include the process for collecting the data that will update the Requirements Traceability Matrix;
8. Explain the process for finalizing requirements, documenting the results and incorporating information from the JAD Sessions, maintaining a Requirements Repository throughout the life of the project and ensuring the requirements continuously reflect the approved project scope. The requirement repository must reflect the current scope of the project;

9. Describe the process that will be used to identify new requirements and describe how these will be presented to the Department;
10. Describe the process for developing the Business Process Gap Analysis including how changes to the Business Process Models and Requirements Traceability Matrix will be tracked, and the content of the Gap Analysis Report; and,
11. Describe the interface and interaction that will take place among the contractor's staff and the Department's Business Analysts and Technical Review Teams during the Requirements Validation process.

C.3.3 System Design

System design, a major component of the overarching SDLC methodology, focuses on developing the business and technical design of the system, including the development of detailed stakeholder requirements; conceptual and detailed design documents; programming and technical specifications; technical architecture; security requirements; and workflow requirements. The foundation for the design task is approved and validated requirements.

System design also includes related activities that define changes in the current technical environment; set performance parameters; and set the baseline for the development and testing tasks to come.

C.3.3.1 Proposal Requirements

The offeror must describe in detail the System Design Methodology that will be used in the design of the R-MMIS.

Offerors must meet the following proposal requirements:

1. Describe in detail the System Design Methodology which at a minimum must:
    a. Describe how the SDLC will be applied to accomplish the System Design Task;
    b. Explain how Quality Management, PM and SDLC methodologies will be employed to control the development of deliverables;
    c. Describe the format and medium that will be used for the design documents and demonstrate how the design will be presented in a fashion that can be understood by a wide range of users using the COTS products to cross reference requirements;
    d. Provide a narrative description of system design deliverables and artifacts, and provide examples in the proposal's appendices;
    e. Describe the Technological Overview of the proposed architecture and clearly describe how the design and development approach will be specifically tailored to this technology;
    f. Describe how the integrated suite of COTS products will be configured to assist both contractor and the Department staff in the system design tasks;
    g. Describe the process that will be used for the review and walk-thru of the design documents; and,

h. Describe the interface and interactions that will take place among the contractor's staff and the Department's Business Analysts, Technical Review Teams and other stakeholders during the System Design process.

C.3.4 System Development

System development, also a part of the overarching SDLC methodology, involves the construction of the system that will be implemented into production. It addresses system development activities, including establishing the development and testing environments; development of new programs, objects, services and processes; enhancement or modification of existing programs, objects, services and business processes; and unit testing. The contractor must ensure that the development is based on Department-approved system design deliverables and complies with all current State and Federal requirements.

As part of the proposed SDLC, the contractor must develop and implement a System Design methodology. The proposed methodology, as approved by the Department, must outline the processes and procedures that will be used in the system design tasks, and must include a discussion of the use of the COTS product and how it will be integrated into those processes and procedures.

The key activities in this task are the construction and unit testing of the software, which is an iterative process of coding, testing and performing software quality control checks. System development activities must occur in a controlled environment governed by the contractor's configuration management program, subject to a daily program of process and progress monitoring.

C.3.4.1 Proposal Requirements

The offeror must describe in detail the System Development Methodology it will use in the development of the R-MMIS.

Offerors must meet the following proposal requirements:

1. Describe in detail the System Development Methodology which at a minimum must:
    a. Explain the relationship between the System Development Task and other SDLC tasks;
    b. Provide an overview of software development activities that will be performed by the contractor and the environment in which this work will be completed. This will include issues such as security, privacy, standards, and interdependencies in hardware and software development;
    c. Describe the software development methods that will be used, including the use of iterative or phased development, if appropriate. This should include descriptions of manual and automated tools and procedures that will be used in support of these methods;
    d. Specify development tools that will be used, and explain its specific roles;

e. Describe the approach that will be used for unit and integration testing and the tools developers will have available to ensure testing is thorough and accurate;
f. Describe the approach that will be followed for tracking requirements during development;
g. Describe the approach that will be followed for allocating computer hardware resources and monitoring their utilization;
h. Describe the method to be followed for recording issues and information that will be useful to the Department for key decisions made during development activities;
i. Describe the quality assurance methodology and activities that will be used to ensure adherence to design requirements;
j. Describe how developer performance will be monitored against defect tracking and the corrective measures taken to improve developer performance; and,
k. Describe the process that will be used for the review and walk-thru of the source code; and,

2. Describe how the integrated suite of COTS products will be configured and assist in the system development tasks.

C.3.5 Testing

Testing is also a part of the overarching SDLC methodology. In-depth, process driven, fully documented testing is required for the R-MMIS. The contractor must provide and implement a Comprehensive Test Plan for the R-MMIS based upon the proposed Comprehensive Testing Methodology, which describes how the contractor will perform testing of the R-MMIS.

The contractor must automate the testing process through the use of COTS product(s). To the extent possible test results should be automated, test scripts and test cases should be automatically generated, and results from regression tests should be automatically compared to previous regression test.

The contractor must provide accurate test data while protecting privacy.

The contractor must provide a comprehensive report documenting all test results for Department approval prior to any software or COTS product being implemented in the production environment. The report will delineate the results of each testing phase, problems identified and the resolution.

The methodology must include the testing that is performed at all stages of SDLC, including but not limited to:

1. Unit Testing is done at the lowest level. It tests the basic unit of software, which is the smallest testable piece of software, and is often called “unit,” “module,” or “component” interchangeably. Unit testing is required during the initial construction of an R-MMIS module(s) and whenever any enhancements/modifications are made. Prior to the initiation of SIT, adequate unit testing must have been conducted to uncover defects.

2. **Integration Testing** is performed when two or more tested units are combined into a larger structure. This test is done on both the interfaces between the components and the larger structure being constructed. Integration testing is required during the initial construction of an R-MMIS module(s) and whenever any enhancements/modifications are made. Prior to the initiation of SIT, adequate integration testing must have been conducted to uncover defects.

3. **System Integration Testing (SIT)** is done when the system is handed over from the developers to the Testing Unit and tends to affirm the end-to-end quality of the entire system. System integration testing is often based on the functional/requirement specification of the system. Quality attributes, such as reliability, security, and maintainability, are also checked. System Integration Testing verifies that related groups of functionality are correct and that the R-MMIS is free from defects and functions as required by validated requirements and approved system design documents. SIT includes testing of functionality that is related because of the underlying business problem they solve or based on functionality that is technically related such as elemental utilities like data access, logging/auditing and error handling. The contractor's Testing Unit must develop a test plan, test cases and test scripts for SIT. The test plan must test all requirements for the release and all test cases and scripts must be tied back to requirements. Upon completion of SIT, the contractor must ensure the R-MMIS functions as required by the approved design prior to the Department's initiation of User Acceptance testing.

4. **User Acceptance Testing (UAT)** is done when the completed project is released from the Testing Unit to the Department. The purpose of UAT is for users to test the system in a pseudo environment to verify that the system is performing to specifications. User Acceptance Testing is the final phase before the R-MMIS is moved to production and begins after the contractor successfully completes system integration testing. UAT provides the users of the system an opportunity to review and accept system components prior to production implementation of the R-MMIS. The acceptance test demonstrates that the system software meets the detailed functional requirements and specifications and that the system infrastructure works within the defined constraints. UAT is required throughout the life of the contract when enhancements or modifications to the R-MMIS have successfully completed SIT.

5. **Stress / Performance Testing** is performed to ensure that the technical, application, data and network architectures are sufficiently designed and sized to meet the anticipated transaction volume or workload. Stress and Performance Testing is intended to demonstrate that the software and hardware will provide the intended functionality and meet SLA requirements under production conditions. Stress Testing introduces greater and greater loads on the hardware and software until it fails, while Performance Testing measures software response time under light, average and heavy loads.

6. **Regression Testing** allows a consistent, repeatable validation of each new release of the R-MMIS component(s) or COTS version. Such testing ensures reported defects have been corrected for each new release and that no new quality problems were introduced in the maintenance process. The contractor must perform Regression Testing. This testing will demonstrate the R-MMIS functions properly by demonstrating that it produces the same result as the production system under the same conditions or that the difference is expected due to a

known change from the existing system. The contractor must compare the results and explain any differences; identify, track and resolve all problems; and conduct additional regression testing on any test cases or scripts that detected a system, data or programming error.

7. **System Recovery Testing** is performed to ensure that the system will meet the business continuity requirements in this RFP. The contractor must perform System Recovery Testing and must develop and execute test scripts or automated testing processes that are specifically designed to exercise both routine and non-routine system recovery processes. The contractor is responsible for tracking and resolving any issues with their system recovery processes and updating system documentation as required.

8. **Parallel Testing** is performed for the six (6) month period prior to the Operations Phase of the system. During this period the contractor will be responsible for conducting parallel testing with the eMedNY system and the MDW. Prior to the start of the Operations Phase, the contractor must work with Department staff, Department contractor staff, the R-MMIS QA contractor staff, MDW contractor staff and the current fiscal agent staff to develop a Parallel Test Plan and Acceptance Test cases. The Parallel Test Plan is based upon the contractor's proposed Parallel Test methodology that documents the approach to parallel testing the R-MMIS and the eMedNY systems and becomes the "blueprint" for conducting the parallel test. This Plan must be approved by the Department.

Determining the scope of the R-MMIS functionality that is to be parallel tested is the responsibility of the Department, and may range from testing all automated system functionality to testing only selected critical business functions; testing associated manual processes (e.g., call center and check distribution); and testing provider support processes.

The Parallel Test Plan documents the scope of the testing effort and will include a schedule for the execution of tests, expected outputs, the definition of an automated process to compare test results and the requirements for the delivery of system output.

Acceptance test cases and supporting test scripts will be created to assist the Department with system validation ensuring the R-MMIS meets the approved requirements and functionality, and that the designed functionality is appropriately implemented in the R-MMIS. Test scripts are step-by-step instructions and data required to perform the test. The Acceptance Test Plan lists the test cases, as well as a procedure for developing and approving test scripts that implement the test cases. The scripts developed for the parallel test will become the basis for future regression testing.

The contractor must contract with an independent firm, approved by the Department, who will observe the Parallel Testing effort and document its observations in an independent report to the Department. After review of the report the Department will determine if the R-MMIS and all the associated manual processes are ready for operations.

9. **Network Intrusion Testing** is performed annually to verify the integrity of the network security. The contractor must contract with an independent firm, approved by the Department, who will annually perform the Network Intrusion Testing effort and document its

observations and findings in an independent report to the Department. The contractor must be responsible for correcting any and all deficiencies listed in the report without any additional cost to the Department.

10. **Certification Testing** is performed to substantiate that all Federal certification requirements have been met.

11. **Provider Testing** is performed to ensure providers can submit transactions over appropriate channels and send and receive the proper acknowledgements and negative responses (such as TA1/997) including the testing of timeframes between receipt of transaction and notification/response to submitter for all modes of transmission.

The **Integrated Test Facility (ITF)** is an environment that will be used by Department staff and Department contractor staff to test system processing and ensure that 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 R-MMIS and to test the production system by processing test data and other transactions through the system using the automated testing capability of the COTS product, without affecting normal operations. The contractor must have processes in place to routinely load into the ITF, at the Department's request, production and other data used by the system to perform its automated processes (e.g., reference values such as system parameters, system lists, reference tables, edits, dispositions, and security tables).

The contractor must support the testing initiatives of the Department and Department contractor staff in the ITF environment.

C.3.5.1 Proposal Requirements

The offeror must describe in detail its proposed Comprehensive Testing Methodology that will become the foundation for the Comprehensive Test Plan for the R-MMIS. This methodology must include a description of the testing that will be performed at all stages of SDLC.

Offerors must meet the following proposal requirements:

1. Describe the contractor's proposed methodology for executing the eleven (11) required types of testing (Unit, Integration, System Integration, User Acceptance, Stress/ Performance, Regression, System Recovery, Parallel, Network Intrusion, Certification, and Provider);
2. Describe the COTS product that will be used by the contractor, the rationale used to select the product and how the Department will have access to it;
3. Describe to what extent the COTS product being proposed will automate the testing process;
4. Describe the COTS product that will be used for the automatic generation of test transactions;
5. Describe how test cases and test scripts will be tied back to requirements;

6. Describe the methodology that will be used for Parallel Testing including the Department's requirement for an independent observer;
7. Describe the approach to parallel testing and, based on past experience, identify potential risks and problem areas.
8. Describe the methodology that will be used for the testing during the data conversion task;
9. Describe how defects will be tracked and reported;
10. Describe the processes, procedures and tools that will be in place for problem identification and resolution;
11. Define how defect tracking will be used to identify organizational or procedural weaknesses and track the resulting corrective actions;
12. Describe the contractor's proposed organizational structure and management of the testing function;
13. Define how defects and other issues reported by the Department will be analyzed, tracked, resolved; required system changes implemented; and integrated with other project phases;
14. Describe the support that will be provided to Department and Department contractor staff for the ITF;
15. Describe how the contractor must maintain the ITF including loading test data routinely used by the system to perform its automated processes (e.g., reference values such as system parameters, system lists, reference tables, edits, dispositions, and security tables) and convert business data from the R-MMIS;
16. Address the division of responsibilities between the contractor, the Department and R-MMIS QA contractor;
17. Describe how the contractor will work with the Department and R-MMIS QA contractor to develop the Acceptance Test Plan and Test Cases;
18. Describe how the contractor's testing methodology and COTS product will support the Department's requirement to move toward a SOA environment:
    a. Describe how XML will be tested and verified;
    b. Describe how services that execute on the Enterprise Service Bus (ESB) will be unit, integrated and SIT tested;
    c. Describe how performance and stress testing of services will be accomplished; and,
    d. Describe how message-oriented interactions will be accomplished;
19. Describe how the testing methodology will accommodate workflow testing;
20. Describe the parallel testing strategy, methodology and schedule; including a description of the tool(s) for tracking and reporting of testing activities including, but not limited to, documentation of test scripts, test results, error resolution and re-testing; and,
21. Describe the strategy for coordinating the parallel test, including the respective responsibilities of the contractor, the Department and the QA contractor.

C.4 ORGANIZATIONAL CHANGE MANAGEMENT TASK

The implementation and introduction of the R-MMIS will produce significant changes to work processes and the overall work environment for all stakeholders. The contractor must provide its expertise in business change management to address and mitigate the impact.

Transition also requires coordination of all information technology organizations and applications affected by the R-MMIS. Virtually all State agencies supporting the statewide information technology infrastructure and all organizations currently sharing data with eMedNY will be required to update their interfaces or other data sharing methods to accommodate the new technology and processes.

Organizational change management focuses on understanding the level of change that the R-MMIS will bring to the Department, its staff, and its stakeholders. A primary objective is to determine the level of organizational support needed to promote the change, proactively develop strategies and action plans to manage the impact, and develop strategies to manage resistance to the changes. The results of this task will drive how the system will be designed and the content of the training materials.

Much of the work in this task will be done in conjunction with Task C.3.2 Requirements Validation and will provide critical information for Task C.3.3 System Design. The offeror must clearly describe how the Business Process Gap Analysis developed during Requirements Validation will be used to identify the tasks that will be necessary to implement the R-MMIS within the Department. Since these activities will occur concurrently with task C.3.2 Requirements Validation, the offeror must describe how the artifacts developed by task C.3.2 will be used in fulfilling this part of the RFP.

The contractor must develop and implement an Organizational Change Management Plan based upon its proposed Organizational Change Management Methodology.

C.4.1 Proposal Requirements

The offeror must describe its proposed Organizational Change Management Methodology which will be the foundation for the Organizational Change Management Plan and how it will fulfill the Department's requirements while minimizing the disruption to the organization during the implementation of new applications and all subsequent enhancements. This Organizational Change Management Methodology should have a set of defined processes designed to assist the Department's workforce and other stakeholders in managing change.

Offerors must meet the following proposal requirements:

1. Describe the approach to Organizational Change Management and the methodology that will be employed to assist the Department in envisioning the R-MMIS and Medicaid enterprise and document associated business processes;
2. Describe how the contractor's methodology will assist the Department in:
    a. Assessing the impact of change upon jobs, roles, workflows and skill requirements needed to ensure successful deployment;
    b. Performing the Business Process Gap Analysis;
    c. Performing organizational readiness assessments; and,
    d. Planning and conducting workforce transition activities;

3. Identify any potential organizational issues anticipated with the implementation of a Service-Oriented Architecture and describe how these will be addressed through its organizational Change Management Methodology;
4. Describe how the contractor plans to evaluate the changes necessary to the Department's business processes in order to benefit from the COTS products being proposed;
    a. How will business processes that will benefit from workflow, business rules engine and/or content management be identified;
    b. How will recommendations be made to the Department regarding changes to these business processes; and,
    c. How will the contractor's organization and staff be used to assist the Department in implementing these recommendations;
5. Describe the contractor's staffing organization and how it will provide technical assistance to the Department's stakeholders with regard to the identification and definition of their functional requirements;
6. Describe how the Organizational Change Management tasks integrate with Requirements Gathering, Business Process Gap Analysis and Training; and,
7. Describe how the proposed methodology will measure the results of a change.

C.5 DATA CONVERSION TASK

The Department considers the data conversion task critical to the success of the project. Conversion activities are often the source of failure in projects due to the volume of data; complexities inherent in defining the relationship between source and target data structures; the differences in the data required for processing between legacy and new systems; and the history of changes to processing requirements and valid codes that may result in data inconsistencies and missing data conditions. The data conversion methodology must clearly identify and define the strategies and activities required by the data conversion task including those required for contingency planning in the event that it is determined that conversion cannot be accomplished as scheduled. The Data Conversion Plan will be based on the data conversion methodology.

The objectives of data conversion management include:

1. The accurate, timely, consistent, and complete conversion of data from eMedNY to the R-MMIS;
2. The verification of data conversion processes through systemic testing;
3. The validation of completeness by mapping data from the eMedNY data structures to the R-MMIS data structures;
4. The effective and timely management of data conversion issues using procedures that tracking issues from identification through correction; and,
5. Minimizing and mitigating data conversion risks with thorough and detailed contingency planning.

All data stored by eMedNY and for drug rebate processing must be converted to the R-MMIS unless it is specifically identified as unnecessary during the requirements validation JAD sessions. While an itemized list of eMedNY data can be found in the Procurement Library, the

Department will require the validation of this information during the requirements validation phase and the inclusion of any data identified during that phase.

The data conversion task will continue throughout the lifetime of the contract. The proposed data conversion methodology will be used whenever a project requires that data in the R-MMIS be converted to new data structures.

The Department is requiring the contractor to provide and use a COTS extraction, transformation, and load (ETL) tool for the conversion of the data from eMedNY to the R-MMIS and throughout the life of the contract.

C.5.1 Proposal Requirements

The offeror must describe in detail its proposed data conversion methodology that will become the foundation for the Data Conversion Plan. This methodology must include a description of the processes, procedures and tools to be used to complete the conversion effort.

Offerors must meet the following proposal requirements:

1. Describe the data conversion methodology and approach that will be used to convert data from eMedNY to the R-MMIS data structures including a description of the contents of the Data Conversion Plan. The methodology must include all technical components that comprise the proposed solution including all software (both COTS and custom-developed), hardware, and environments;
2. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components;
3. Detail the proposed solution by describing how the data conversion effort will be:
    a. Designed;
    b. Developed;
    c. Tested;
    d. Implemented;
    e. Documented;
    f. Managed; and,
    g. Run in parallel with other R-MMIS project tasks;
4. Explain the interdependencies between the conversion efforts and other development tasks;
5. Address all data conversion methods and requirements, regardless of whether an automated or manual method is recommended;
6. Describe the COTS products or tools and how they will be used for converting the data; and,
7. Describe any COTS products or tools and how they will be used for validating the data.

C.6 OPERATIONAL READINESS TASK

This task includes completion of an Operational Readiness Review (ORR), a formal inspection of the R-MMIS conducted to determine if the system is ready for release into production environment. The ORR includes verification of all R-MMIS components including

operations, hardware, software, network, and telecommunications. All components of the R-MMIS must be evaluated against the ORR checklists.

The contractor must contract with an independent firm, approved by the Department, who will observe the Parallel Testing effort, review manual processes and procedures, and other functions defined in the ORR, and document its observations in an independent report to the Department. After review of the reports the Department will determine if the R-MMIS and all associated manual operational processes are ready for operations.

C.6.1 Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the offeror's proposed approach to the operational readiness review;
2. Describe the systems, business processes and procedures included in the ORR to ensure the system is ready for operations;
3. Describe the processes and procedures that will be used to ensure that the evolution projects that were implemented in the eMedNY and MDW systems were accurately and successfully migrated to the R-MMIS; and,
4. Describe the methodology that will be used to fulfill the Department's requirement for obtaining an independent observer.

C.7 IMPLEMENTATION TASK

During the implementation task, data conversion activities will be completed; a parallel operations period will be completed; and the R-MMIS, including all hardware, software and functionality, will be fully implemented in the production environment. To be ready for implementation, the R-MMIS must satisfy all requirements specified in this RFP and documented during the requirements validation and systems design activities. The offeror must provide a system implementation strategy detailing its approach to implementation.

The R-MMIS and all associated operational processes must be ready for a parallel operations period within thirty (30) months from the contract start date or as agreed to during the Project Planning Phase. The implementation process must establish a clean cutover from the eMedNY to the R-MMIS. The implementation cannot proceed until the parallel operations period has successfully concluded and all operational readiness tasks have been successfully completed and certified by the Department.

The contractor must develop and implement an Implementation Plan based upon its proposed Implementation Strategy.

C.7.1 Proposal Requirements

The offeror must describe its proposed strategy for the implementation activities that will become the foundation for the Implementation Plan for the R-MMIS.

Offerors must meet the following proposal requirements:

1. Describe in detail the proposed Implementation Strategy including the approach to ensuring that the system and all operations processes are ready to be implemented and how Department approvals will be obtained to initiate operations of the R-MMIS.; and,
2. The Implementation Strategy must clearly address implementation and contingency planning, and define the offeror's approach to implementation assurance support including how the system will be measured against the required thresholds and how outstanding issues will be addressed.

C.8 INCUMBENT TRANSITION SUPPORT TASK

The contractor must work in conjunction with the Department, the incumbent eMedNY, MDW and QA contractors to successfully implement the R-MMIS. During the planning and implementation phase, the contractor must work closely with the incumbent eMedNY contractor to synchronize the R-MMIS with eMedNY to ensure that all maintenance and development projects promoted during the procurement process and contract period or in progress within the eMedNY environment are coordinated with the Implementation Plan and schedule for the R-MMIS. The contractor must work closely with the incumbent eMedNY contractor during the turnover phase, coordinating efforts with Department and Department contractor staff. The contractor must also work with the MDW contractor to supply data to the MDW and coordinate R-MMIS certification activities.

C.8.1 Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe the Incumbent Transition Support Strategy that details the proposed approach to supporting transition activities with the incumbent eMedNY, MDW and QA contractors.

D. CERTIFICATION PHASE REQUIREMENTS

D.1 OVERVIEW

The R-MMIS must be certified by the Centers for Medicare and Medicaid Services (CMS) during the Certification Phase of the project. The Certification Phase begins upon implementation of the R-MMIS at which time it must meet all requirements for Federal MMIS certification. During this phase the contractor must complete all activities necessary to substantiate compliance with CMS requirements and obtain Federal certification (Attachment K contains the MMIS Certification Checklists).

As stated in the CMS Certification Toolkit Overview:

“Federal MMIS certification is the procedure by which CMS validates that State Medicaid systems are designed to support the efficient and effective management of the program

and satisfy the requirements set forth in Part 11 of the State Medicaid Manual (SMM) , as well as subsequent laws, regulations, directives, and State Medicaid Director (SMD) letters. The certification process also validates that the systems are operating as described in the prior approval documents, i.e., APDs, RFPs, and all associated contracts submitted to CMS for the purpose of receiving FFP. The CMS authority for requiring Federal certification is based, in part, on language found at Public Law 92-603, and the Code of Federal Regulations (CFR) at 42 CFR 433 and 45 CFR 95.611(d). In the absence of Federal certification, Medicaid systems are not authorized to receive enhanced Federal matching funds for their operation."

Offerors should note that the Department plans to satisfy Federal MMIS certification requirements through the implementation of both the R-MMIS and the MDW. This approach will require close cooperation between the R-MMIS and MDW contractors to ensure that compliance with each Federal certification requirement is substantiated and documented.

The Department anticipates that the MDW will satisfy the following Federal MMIS certification requirements:

1. Program Management: Decision Support System/Data Warehouse, Federal Reporting, and Management and Administrative Reporting Subsystem (MARS);
2. Program Integrity: Surveillance and Utilization Review Subsystem (SURS), Retrospective Drug Utilization Review (R-DUR) and other analytical requirements; and,
3. Care Management: Early and Periodic Screening and Diagnostic Treatment (EPSDT).

D.2 PROPOSAL REQUIREMENTS

The offeror must describe in detail its proposed Certification strategy that will become the foundation for the Certification Plan for the R-MMIS. This strategy must include a description of the processes, procedures and tools to be used to complete the certification effort.

Offerors must meet the following proposal requirements:

1. Provide a Certification strategy that defines the offeror's approach to Federal MMIS certification. The Certification Strategy must describe the processes and procedures that will be used to manage Certification requirements throughout the Planning and Implementation Phases;
2. Describe how the Certification Plan will be implemented within the EPMO structure and how the management of certification requirements will be integrated into the overall Project Management (PM) approach;
3. Describe how this strategy has been used in the past to support the successful certification of an R-MMIS; and,
4. Describe how certification activities will be coordinated with the MDW contractor.

E. SYSTEM AND OPERATIONAL ENHANCEMENTS REQUIREMENTS

E.1 OVERVIEW

System Operational Enhancements and Maintenance activities include maintenance and enhancement tasks that the contractor must perform throughout the life of the contract to modify the R-MMIS in accordance with new State and Federal mandates, program policy changes, program growth and emerging technologies. These activities also include the implementation of a series of enhancements designed to attain the Department's targeted MITA maturity levels which are described in the MITA State Self-Assessment that can be found in the Procurement Library.

E.2 MAINTENANCE

The contractor must perform maintenance support for the R-MMIS within the base fixed-price. No additional dollars shall be provided by the Department for maintenance activities. It is the Department's intent to control maintenance activities through the use of processes and reporting mechanisms that will be developed during the Planning Phase. Furthermore, when maintenance personnel are not engaged in maintenance tasks, at the Department's sole discretion, the Department may approve the use of the maintenance personnel to perform system enhancement tasks. Since the costs associated with these staff are included in the base fixed-price, no additional charge to the Department shall be incurred.

Maintenance will result from one of six (6) conditions: 1) the need to make operational improvements or increase the operational efficiency; 2) the correction of a deficiency or defect in the system, whether identified by the Department or by the contractor; 3) the addition, deletion or change of a value that is manipulated by an existing edit; 4) the addition or deletion of a coded value or entry to an existing table that doesn't change the table structure; 5) the correction of data that is found in error as a result of deficiency or defect in the system, or (6) the installation of new hardware or software or subsequent releases to the current operating system, server(s), database management software, grouper software, COTS products, or other hardware/software supporting the R-MMIS.

To the extent that a defect or deficiency is found in the logic or construction of the R-MMIS that results in erroneous data in the R-MMIS database, all remedial work that is necessary to correct the data will fall under the category of maintenance. To the extent that such defects or deficiencies send erroneous data to the MDW, the MDW contractor must submit to the Department for approval an estimate for the level of effort to remediate the erroneous data. Upon Department approval of the estimate, the MDW contractor must correct the MDW and the R-MMIS contractor must make a direct payment to the MDW contractor for the remediation based upon the lesser of the actual cost or the approved estimate.

Maintenance of the system is a fundamental contractor responsibility and is expected to be funded from the fixed administrative fee. Examples of maintenance include but are not limited to:

1. Activities necessary to correct a defect or deficiency within the operational R-MMIS, including defects and deficiencies resulting from modifications or enhancements;
2. Activities necessary to ensure that all data files, programs and documentation are current and that errors are found and corrected;
3. Activities necessary to correct data corruption;
4. The addition, deletion or change of a value that is manipulated by an existing edit;
5. The addition, deletion or change of a coded value or entry to an existing table;
6. Changes to operational job control language and scripts;
7. File maintenance activities for updates to all files; and,
8. Changes to system parameters.

The Department shall not require specific numbers of maintenance personnel. However, the Department expects the contractor to provide sufficient numbers and skill set mix to manage the maintenance tasks as directed by the Department. In the event that the Department believes that approved maintenance work is not being completed in a timely manner or fails to meet the quality requirements necessary for the R-MMIS, the Department maintains the right to require the contractor to increase the R-MMIS maintenance staffing requirements at no additional cost to the Department.

E.3 SYSTEM ENHANCEMENTS

Throughout the life of the contract the Department will direct the contractor to implement changes to the system that are outside the scope of maintenance. These requests will be made in the form of a System Change Request (SCR), in a format approved by the Department. The offeror must propose its approach for managing these requests within the framework of their proposed SDLC and EPMO.

To assist Department staff in establishing reasonable completion dates and setting priorities for modifications, the contractor must maintain a Change Control Management System. This system will allow Department and contractor management staff to review current priorities and timeliness; change priorities by adding new tasks and target dates; and immediately see the impact of these new priorities on pre-existing priorities and their target dates. This reporting will allow review of slack time, status of phase completion, and the rapid readjustment of target dates based on staff availability.

E.4 PROPOSAL REQUIREMENTS

The offeror must describe in detail its proposed approach to System and Operational Enhancements and how it will fulfill system maintenance needs and the Department's requests for changes to the system within the offeror's proposed SDLC and EPMO.

The Department requires that the contractor continues to use the proposed methodologies described in section III.C of this RFP. However, the Department understands that some of these methodologies may require modification as the R-MMIS project moves from the initial Implementation Phase to the System and Operational Enhancements Phase.

Offerors must meet the following proposal requirements:

1. Describe the strategy and approach that will be used in the System and Operational Enhancements process within the R-MMIS;
2. Describe what controls and processes will be put in place within the SDLC process;
    a. Describe any modifications to the SDLC process including:
        i. Requirements Gathering and Validation;
        ii. System Design;
        iii. System Development;
        iv. Testing; and;
        v. Organizational Change Management;
3. Describe how the maintenance and system enhancement processes will work within the proposed EPMO structure;
4. Describe the governance structure that will be put in place for system changes;
5. Describe the proposed methodology for processing SCRs, and how this methodology will be used to determine if the request is a progressive elaboration of an existing requirement or a new requirement and therefore out-of-scope;
6. Describe the proposed work authorization process; and,
7. Describe how additional work will be prioritized.

F. OPERATIONS PHASE REQUIREMENTS

F.1 OVERVIEW

The Operations Phase will begin upon completion of the Implementation Phase. The contractor must perform all functions necessary to operate a complete and certifiable R-MMIS in accordance with Federal and State policy. It must ensure that transactions and payments are processed in an accurate and timely manner; reports and other information are produced that allow the Department and other stakeholders to monitor the R-MMIS and contractor performance; and manage the interactions and relationships with providers related to the functions of the R-MMIS.

During the Operations Phase, the contractor must operate, maintain, and enhance the R-MMIS, and perform all operational responsibilities described in this RFP over the life of the contract. Performance must meet or exceed all service levels defined in section III.O.2 Service Level Agreements and be in compliance with the Performance Management Plan approved by the Department.

Upon implementation, the R-MMIS must meet Federal certification requirements defined in the most current version of Part 11 of the State Medicaid Manual and other authoritative Federal publications.

Throughout the life of the contract, the contractor must fully cooperate with Department staff and Department contractors assigned to the project, the Department Medicaid Data Warehouse staff and the Department's R-MMIS QA contractor.

F.2 CONTINUOUS IMPROVEMENT

Throughout the life of the contract the contractor must be responsible for the continuous improvement of the R-MMIS. This process must be independent of the other change management activities described in this RFP. The contractor must provide the Department quarterly, at minimum, recommendations on improving the R-MMIS.

F.2.1 Continuous Improvement Plan

In order for the Department to stay abreast of evolving technologies and standards and to provide the most flexible system to the stakeholder community, the contractor must develop and implement a Continuous Improvement Plan for the Department's approval. The purpose of this plan is to increase automation and system integration and to reduce manual processes and procedures. This plan must describe the contractor's approach to implementing its proposed Continuous Improvement Methodology and be applied to all facets of the R-MMIS (e.g., system, hardware and network enhancements; introduction of new COTS products; operational and manual processes).

F.2.1.1 Operations Phase Continuous Improvement Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe in detail the proposed Continuous Improvement Methodology which will serve as the foundation for the Continuous Improvement Plan;
2. Describe the proposed:
    a. approach, plan, business processes and procedures for the identification and evaluation of improvements;
    b. process and procedures to be used for assessing areas where improvements can be made; and,
    c. process and procedures to be used for measuring improvements.
3. Describe the proposed process and procedures to be used for evaluating COTS products.

F.2.2 Business Reengineering Studies

The contractor must perform business reengineering studies of the NYS Medicaid program's business processes and work flows. The purpose of these studies is to provide a mechanism to regularly reexamine the business processes that are an integral part of the NYS Medicaid program in order to identify changes that would improve the administrative efficiency and responsiveness of the program; improve quality control; and/or facilitate the Department's attainment of the primary objectives for the NYS Medicaid program.

The contractor must reassess the effectiveness and efficiency of the reengineered business processes and work flows. The contractor must refine and upgrade the business processes (including automated and manual processes) as necessary throughout the life of the contract. The contractor must provide State staff with complete and timely training on the refined and upgraded business processes and work flows.

The contractor must 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 must be documented and undertaken in close coordination with Department management, staff and other stakeholders.

F.2.2.1 Business Reengineering Studies Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe in detail the proposed approach to conducting business reengineering studies.

F.3 OPERATIONS PHASE BUSINESS REQUIREMENTS

The operation of the R-MMIS includes all activities required to operate, support, maintain and manage the R-MMIS technical and business functions. The Operations Phase requirements have been organized into seven (7) operational areas. Each of these areas includes operational requirements that are common to all MITA business areas and, where appropriate, operational requirements specific MITA business areas. These areas include:

1. Customer Service Center;
    a. Call Center;
    b. Correspondence Processing; and,
    c. Web Portal;
2. Transaction Processing Services;
3. Financial Services;
4. Support Services;
5. Expert and Consulting Services;
6. Reporting; and,
7. Archiving.

F.3.1 General Operations Phase Business Requirements

The general operations business phase activities reflect those that support the operation of the R-MMIS including but not limited to the development and maintenance of operational policy and procedure manuals; notification to the Department of operational issues and problems; contract administration; and systems availability.

F.3.1.1 General Operations Phase Business Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. develop and maintain operational policy and procedure manuals for all R-MMIS and fiscal agent business processes;
    b. notify the Department of all discrepancies, errors, failed file transmissions, or abnormal interactions with external interfaces during any file transfer process;
    c. inform the Department immediately of any issues identified with information contained in the R-MMIS and of any incidents that cause the failure of any component of the R-MMIS; and,
    d. maintain all records and reports of administrative expenses including those concerning Contractor internal administrative processes necessary to enable the Department to verify the validity and accuracy of all bills for service and the applicability of Federal matching funds for Fiscal Agent contract costs.

F.3.2 Customer Service Center Operational Requirements

The Customer Service Center will be the focal point for the Customer Relationship Management activities required to respond to inquiries from providers, rebate labelers and members received through the Call Center, correspondence and the Web Portal. Inquiries will cover a wide variety of topics including provider enrollment, member benefits, transaction processing and payment.

F.3.2.1 Customer Service Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will provide Customer Service Center functions for providers, rebate labelers, and members via the following channels: Call Center, Correspondence and Web Portal;
2. Describe how they will:
    a. receive, track and resolve provider, rebate labeler and member inquiries and complaints;
    b. log inquiries that require policy determinations or other information from Department staff;
    c. route inquiries via the workflow management system;
    d. track and monitor the status of the inquiries; and,
    e. respond to the inquirer as appropriate; and,
3. Trend inquiries for quality improvement initiatives.

F.3.3 Call Center Operational Requirements

The Call Center is a key component of the Customer Service Center. Providers, members and rebate labelers rely on accurate and prompt responses to their inquiries and questions. The effective and efficient operation of the Call Center is critical to the success of the R-MMIS operation. The training and retention of Call Center representatives is of paramount importance in achieving Call Center objectives.

The Call Center must be operational 24 hours per day, 7 days per week for providers, members and rebate labelers. Call Center technologies, including Interactive Voice Response systems, are expected to play a major role in facilitating the successful operation of the Call Center.

Call Center functions include the immediate processing of Prior Approval (PA) transactions from pharmacies. These transactions must be completed while the prescriber is on the phone with the Call Center PA representative.

F.3.3.1 Call Center Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will provide call center services to providers, rebate labelers, and members twenty- four (24) hours a day, seven (7) days a week;
2. Describe how they will:
    a. utilize Interactive Voice Response (IVR) and other Call Center technologies to provide Customer Relationship Management, facilitate Call Center operations, improve customer service, limit menu selection, and reduce wait times; and,
    b. provide dedicated toll-free call center telephone number(s) for the continental United States.
3. Describe how they will:
    a. receive and respond to provider, rebate labeler and member inquires from providers, rebate labeler, members, stakeholders or business associates; receive and respond to inquiries regarding the Pharmacy Benefit Management programs; and,
    b. provide call center service representatives with the ability to transfer calls to Department staff based on Department-approved policies and procedures;
4. Describe how they will prepare and maintain standard response templates or scripts for routine provider, rebate labeler and member inquiries regarding eligibility, billing, service limits, enrollment, drug rebate invoices, etc. for use by call center staff. Provide a "knowledge database" for use by call center staff with Department review and approval; and,
5. Describe how they will provide on-going training for call center personnel to ensure that they are knowledgeable about the functional and technical aspects of the R-MMIS and Medicaid policy.

F.3.4 Correspondence Operational Requirements

The Customer Service Center must respond to written and electronic communications received from providers, rebate labelers and members. It is critical to log and track all communications received from and sent to providers, rebate labelers and members. Access to these communications must be available through the web-based application for Department and other authorized users.

F.3.4.1 Correspondence Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. produce and transmit, at the request of the provider, specific information related to that provider;
    b. receive, acknowledge, image, index and route correspondence for processing via the workflow management system;
    c. review, track and respond to all written inquiries;
    d. produce and distribute correspondence responding to inquiries from providers, rebate labelers, members and other stakeholders; and,
2. Trend correspondence for quality improvement initiatives.

F.3.5 Web Portal Operational Requirements

The Web Portal serves as a critical resource for providers, rebate labelers, and members to access information related to all aspects of the NYS Medicaid program. Current and comprehensive information must be available through the Web Portal to facilitate self-service thereby reducing the volume of Call Center and correspondence inquiries.

The information required is associated with a range of MITA Business Areas and business processes including Provider Management, Operations Management, Business Relationship Management and Manage Drug Rebate. The proposal requirements have been organized by MITA Business Area.

F.3.5.1 Web Portal Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will develop and post stakeholder alerts or other information on the Web Portal as required by the Department;
2. Describe how they will provide technical support for stakeholders requesting to subscribe for program alerts; and
3. Describe how they will measure effectiveness of communications on portal.

F.3.5.1.1 Web Portal - Provider and Operations Management

Offerors must meet the following proposal requirement:

1. Describe how they will:
    a. develop, maintain and periodically review provider support materials on the Web Portal; and,
    b. provide technical support for providers using the provider area of the Web Portal.

F.3.5.1.2 Web Portal - Member Management

Offerors must meet the following proposal requirement:

1. Describe how they will develop, maintain and periodically review member information materials on the Web Portal.,

F.3.5.1.3 Web Portal - Rebate Labeler Management

Offerors must meet the following proposal requirement:

1. Describe how they will:
    a. develop, maintain, and periodically review rebate labeler support materials on the Web Portal; and,
    b. provide technical support for rebate labelers using the rebate labeler Web Portal application.

F.3.5.1.4 Web Portal - Business Relationship Management

Offerors must meet the following proposal requirement:

1. Describe how they will:
    a. develop and maintain all trading partner and security agreements, ETIN applications, EFT applications, Web Portal User IDs and related instructions on the Web Portal; and,
    b. provide technical support for providers and rebate labelers using the Web Portal to enter transactions for trading partner and security agreements, ETINs, EFT and Web Portal user IDs.

F.3.6 Transaction Services Operational Requirements

Transaction processing will be an essential function of the R-MMIS and the operational activities required to process transactions are critical to its successful operation. The R-MMIS must process a variety of transactions including all HIPAA and NYS proprietary transactions including but not limited to: claims, service authorizations (prior approvals, prior authorizations, and service authorizations), eligibility inquiries, and provider enrollment transactions.

The operational requirements for transactions are organized by MITA Business Area where the requirements apply only to a specific MITA Business Area. Requirements that cover multiple MITA Business Areas are combined wherever possible.

F.3.6.1 Transaction Processing Services – General Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:

a. support the receipt of, processing of and response to HIPAA and NYS proprietary transactions through all channels;
b. support and monitor the receipt and processing of files received from all sources;
c. support and monitor the generation of files to be distributed to all sources;
d. support and monitor transactions received in files, identify transaction discrepancies including errors and pends and perform notification processes based on Department business rules;
e. support and monitor real time transactions; and,
f. support and monitor all channels approved by the Department applicable to the specific transaction

2. Describe how they will provide technical support through all channels required by the Department to assist providers with issues and problems processing HIPAA and proprietary transaction sets.

F.3.6.2 HIPAA Transaction Sets Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will maintain and operate the R-MMIS in full compliance with the Health Insurance Portability and Accountability Act (HIPAA) including but not limited to the transaction and code set standards, privacy and security standards, and the identifier standards; and,
2. Describe how they will support all electronic transactions covered under HIPAA in the approved electronic format using HIPAA standard codes and messages.

F.3.6.3 Provider Enrollment Transaction Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. receive, review for completeness and process: hard copy provider enrollment applications and supporting documentation; hard copy and fax disenrollment requests; and hard copy and fax maintenance requests;
    b. route through the workflow management system in accordance with Department business rules; provider enrollment applications, disenrollment requests, maintenance requests, and all supporting documents; and,
2. Describe how they will develop and manage a provider recertification process.

F.3.6.4 Claims/Encounter Adjudication Transaction Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. receive, log, review for completeness, image and process paper claim transactions and claim attachments;

b. develop and maintain broadcast messages for inclusion on paper remittances; and,

2. Describe how they will perform manual review and resolution of pended claims and refer claims requiring policy decisions to the Department in accordance with Department approved rules and procedures.

F.3.6.5 Prepare EOBs Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will prepare, produce and distribute EOBs.

F.3.6.6 Service Authorization Transaction Operational Proposal Requirements (Prior Approval, Prior Authorization and Service Authorization)

Offerors must meet the following proposal requirements:

1. Describe how they will:
   a. receive, review for completeness and process hard copy and fax Prior Approvals and supporting documentation;
   b. route Prior Approval transactions and supporting materials through the Workflow Management System in accordance with Department business rules;
   c. prepare, produce and distribute rosters;
2. Describe how they will enter, review, and make Prior Approval determinations as required by the Department; and,
3. Describe how they will support and monitor individual or mass updates to the Service Authorization Registry.

F.3.6.7 Pharmacy Benefits Management - Prior Approval Adjudication Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
   a. conduct PA request adjudication in real-time based on Department-approved criteria and procedures;
   b. perform the initial telephone PA request determinations with trained, clinical professionals available for consultation with the prescribers, as necessary;
   c. provide a "second level review" process for complex PA requests that require escalation to a higher level clinician for final adjudication as defined in Department-approved procedures. The "second level review" or reconsideration must be performed by a party other than the party who made the initial determination that an approval would not be granted; and,
   d. provide a physician review process for PA requests that must be completed within 24 hours of escalation based on Department guidelines.

2. Describe how they will provide an emergency process so that members can obtain an initial supply of medication in the event that a PA decision cannot be made and/or applied to the R-MMIS for claims processing within the required timeframe.

F.3.6.8 Utilization Threshold Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will:
   a. Receive and determine approval/cutback of requests for service limitation increases for services with benefit limits;
   b. Receive, review for completeness and process hard copy and fax Threshold Override Applications (TOAs) and cancellations; and,
   c. Review and make determinations on TOAs.

F.3.6.9 Manage Drug Rebate Operational Proposal Requirements (OBRA, Supplemental and Other Rebate Programs)

Drug manufacturers are required to enter into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) for their drugs to be reimbursed in the Medicaid Program. Manufacturers that do not sign an agreement with CMS are not eligible for Federal Medicaid coverage of their products. Manufacturers are invoiced quarterly by the Department based on the number of units reimbursed by NYS Medicaid for each product type.

Rebate Labeler Information Management

Offerors must meet the following proposal requirement:

1. Describe how they will:
   a. Search, view, add, update and terminate rebate labeler information as required to respond to inquiries or process transactions; and,
   b. Support, monitor and perform the process to add, update and terminate rebate labelers based on the CMS listing of rebate labelers.

Quarterly Invoice Pre-processing

Offerors must meet the following proposal requirements:

1. Describe how they will perform statistical analysis to identify clinical outlier claims and other issues with the quarterly rebate amounts and submit findings to the Department for review;
2. Describe how they will:
   a. Adjust the OBRA, Supplemental and other rebate program units for specific NDC/HCPCS/UPN codes based on Department approval;

b. Maintain information related to providers that are public health service entities that have separate agreements with rebate labelers and insure that the invoice process includes or excludes the related claims; and,
c. Maintain information related to units to be excluded or included from drug rebate invoices.

Invoice Generation

Offerors must meet the following proposal requirement:

1. Describe how they will perform and manage the OBRA, Supplemental and other rebate program invoice generation and notification processes.

Payment Receipt & Account Management Process

Offerors must meet the following proposal requirements:

1. Describe how they will:
   a. Manage the OBRA, Supplemental and other rebate payment receipt and account management processes. Establish and manage rebate accounts with the designated financial institution;
   b. Reconcile rebate accounts with the designated financial institution based on the exchange of files;
   c. Manage, oversee and reconcile invoice payments received by EFT;
   d. Manage and oversee and reconcile invoice payments received by check ;
   e. Verify and accurately apply payments to outstanding rebate invoices;
   f. Process transactions for payments that have been inappropriately deposited as drug rebate payments; and,
   g. Process accounts payable transactions to resolve outstanding credit balances as required by the Department.

Outstanding Accounts Receivable Collection Process

Offerors must meet the following proposal requirements:

1. Describe how they will:
   a. Manage accounts receivable and collection activities;
   b. Develop an Accounts Receivable Management Plan, to be approved by the Department, including the management of delinquent accounts;
   c. Monitor, manage and report on accounts receivable activity; and,
2. Describe how they will identify payer issues and develop and implement action plans to improve collections.

Dispute Resolution Process

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. Review invoice and dispute information for rebate labelers (e.g., claims included on the invoice for the NDC/HCPCS/UPN code being disputed and the disputed NDC/HCPCS/UPN code); note review comments; send email or letter requesting information to the rebate labeler; set dispute determination status; and update quantity for substantiated disputes; and,
    b. Track dispute resolution contacts including but not limited to rebate labelers, pharmacies, and other billing providers.

Rebate Reference Information Management Process

Offerors must meet the following proposal requirements:

1. Describe how they will support and monitor the receipt and processing of the CMS and other rebate files;
2. Describe how they will:
    a. Review and recommend automated conversions to resolve inconsistencies in measurement units between CMS and MMIS drug reference data;
    b. Exclude specified drugs and supplies from rebate information processing based on Department criteria;
    c. Support and monitor the processing of CMS's listings of labelers with rebate agreements as required by the Department; and,
    d. Support and monitor the processing of the listing of Supplemental and other rebate program rebate labelers with rebate agreements as required by the Department.

Rebate Reporting and Export Process

Offerors must meet the following proposal requirement:

1. Describe how they will:
    a. Support and monitor the transmission of the CMS quarterly files and provide reports and/or files required to meet Federal reporting requirements; and,
    b. Support and monitor the export of information to the MDW.

F.3.6.10 Manage Benefit/Reference Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will support the receipt and maintenance of the:
    a. ICD-9 & ICD-10 Diagnosis and Procedure files from CMS;
    b. DRG Code Interface, E-APG grouper and other grouper files;
    c. Prescription Serial Number data file as required by the Department;
    d. CMS Mandate Lab Update file, HCPCS update files and other procedure code files;
    e. Health Professional Shortage Areas files; and,

f. Revenue code information from the National Uniform Billing Committee (NUBC) files.

ProDUR Edit Status

The ProDUR program provides an alert to the pharmacist regarding a patient's drug therapy at the point of sale (POS) before a prescription is dispensed. The review compares the new claim to a patient's ninety (90) day claim history, and alerts the pharmacist to potential therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or clinical abuse/misuse at the POS.

Offerors must meet the following proposal requirement:

1. Describe how they will accept and apply changes to ProDUR criteria as requested by the Department.

F.3.6.11 Pharmacy Benefit Management Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will
   a. Add, change, or delete drugs in the Pharmacy Management Programs at the Department's direction;
   b. Update and maintain all variations of lists of drugs that apply to specific Pharmacy Management Programs including but not limited to preferred and non-preferred drugs, CDRP drugs, MGDP and brand less generic;
   c. Apply manual updates to the drug formulary as requested by the Department;
   d. Update the SMAC list and make corresponding updates to the drug formulary for pricing claims on a schedule determined by the Department. Examples include, SMAC prices for new products, and changes to previously determined SMAC prices for drugs that have been reclassified (changed GSNs) or otherwise modified to cause a different SMAC price to apply; and,
2. Describe how they will resolve provider appeals related to SMAC pricing directly with the pharmacy in accordance with procedures developed by the contractor and approved by the Department.

F.3.6.12 Business Relationship Management Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will receive, review, and process applications, maintenance transactions and termination requests for: trading partner and security agreements, ETINs, EFTs, and, Web Portal Users
2. Describe how they will support and monitor the annual ETIN re-certification process; and,
3. Describe how they will communicate with partners regarding the Business Relationship process for trading partner and security agreements, ETINs, EFTs, and Web Portal users

including but not limited to the following types of requests: applications, maintenance, and terminations.

F.3.7 Financial Services Operational Requirements

The Financial Services operational requirements focus primarily on two MITA Business Areas: Program Management and Operations Management. These requirements are organized by general financial operational requirements that reflect requirements for both Program Management and Operations Management; the Program Management sub-business processes: Perform Accounting Functions, Manage 1099s, and banking services; and the Operations Management sub-business process: Prepare Checks/EFT.

F.3.7.1 Financial Services – General Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will produce and maintain Department-approved comprehensive, accurate, written procedures documenting all major aspects of the financial management system and ensure strict adherence to the procedures unless otherwise directed by the Department;
2. Describe how they will provide and execute quality assurance procedures to ensure that the financial management system disburses, tracks, and accounts for Medicaid payments accurately; and,
3. Describe how they will monitor the weekly payment processing cycle, perform balancing tasks and provide payment information (including shares information and other funding information) to the Department, or other NYS agency responsible for processing check and EFT payments on a schedule determined by the Department; and,
4. Describe how they will ensure that returned or refund checks received by the contractor are logged each business day with disposition noted, date, time and identity of the contractor staff that processed the check.

F.3.7.2 Banking Services Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will:
    a. Perform all banking services necessary to maintain the provider payment function;
    b. Maintain a bank account for special payments. Reimbursement from this account shall be at the direction of the Department. Transfer special payment account funds to the designated bank account at the direction of the Department;
    c. Contract for and maintain Department-approved banking services for Depository and Disbursing Accounts;
    d. Reconcile accounts with the designated financial institution based on the exchange of files containing information related to the status of checks;
2. Describe how they will receive, log, process and track payments received from providers for outstanding accounts receivable balances based on the Department's business rules;

3. Describe how they will:
    a. Support and monitor the production of letters to providers for checks that have not cleared within a period established by the Department; and,
    b. Support and monitor the production of stop payment orders for checks that have not cleared within a period established by the Department.
4. Describe how they will provide the capability to transmit a test Electronic Funds Transfer (EFT) to the designated Financial Institution and verify that the EFT transaction was processed in accordance with Department policies and procedures.

F.3.7.3 Prepare Provider EFT/Check Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. Support and monitor the production of EFT/checks;
    b. Support and monitor the release of certain provider checks or EFT transactions prior to the normal weekly release date;
    c. Manage all aspects of the EFT process including the capability to reprocess failed EFTs;
    d. Remove EFT payments from the banking file prepared for EFT transfer file; pull and remove associated remittance advices;
    e. Produce hard-copy checks for the payment cycle and maintain control of all hard copy checks until distributed to providers. Monitor security of checks during matching, stuffing and mailing process;
    f. Issue manual checks to providers on an as-needed basis for special payments as directed by the Department;
    g. Manually pull and void provider check(s) and associated remittance advice(s) after printing; Adjust (void) any claims associated with the payments (check or EFT) when the Department directs the voiding of a check/EFT.
2. Describe how they will:
    a. Hold checks and check stock in secure storage, and carefully audit and control check numbers and check stock;
    b. Acquire and maintain adequate check stock with security features acceptable to the Department.
3. Describe how they will:
    a. Arrange for the special delivery of provider checks; and,
    b. Manage provider pickup for checks and their associated remittances at locations specified by the Department.

F.3.7.4 Perform Accounting Functions Operational Proposal Requirements

Accounts Receivable

Offerors must meet the following proposal requirement:

1. Describe how they will:

a. Maintain Accounts Receivable, including the handling and accounting for emergency provider payments, liens, and recoupments;
b. Monitor and report on the status of each accounts receivable, including but not limited to provider and Drug Rebate labeler;
c. Maintain lien information;
d. Collect principal and interest owed by providers and rebate labelers on accounts receivable;
e. Log receipt data of each withholding and penalty request and completion date of withholding or penalty; and provide reporting to the Department on same; and,
f. Maintain the capability to identify providers with accounts receivable balances and no claim activity by program during a Department-specified number of months.

Accounts Payable

Offerors must meet the following proposal requirement:

1. Describe how they will support and monitor the process to generate checks to providers for accounts payable balances.

Recoupment Funds Received, Lump Sum Payment and Cash Advance Transaction

Offerors must meet the following proposal requirement:

1. Describe how they will create financial transactions and process accounts receivable transactions, funds received transactions, Lump Sum payment transactions and Cash Advance transactions.

F.3.7.5 Manage 1099 Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
   a. 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;
   b. Produce and mail hard copy 1099 forms to providers as specified by the Department;
   c. Support and monitor the production and distribution of 1099 files to the IRS, NYS Department of Taxation and Finance, and other entities specified by the Department;
   d. Update the status of entities exempt from the 1099 reporting process
2. Describe how they will respond to and resolve all 1099 inquiries and issues regarding correct reporting of tax information based on the Federal 1099 and NYS policies;
3. Describe how they will produce and track replacement or corrected 1099s based on provider request, State or contractor review.

F.3.8 Support Services Operational Requirements

Support Services provide the day-to-day support required to produce and distribute mail, notifications, and publications, as well as data entry, imaging, and optical character recognition (OCR) services. The requirements in each of these areas are organized by MITA Business Area where appropriate.

F.3.8.1 Support Services – General Operational Proposal Requirement

Offerors must meet the following proposal requirement:

1. Describe how they will produce and distribute notifications, publications and related materials to educate providers, members, and other stakeholders regarding program guidelines, policies, and procedures.

F.3.8.2 Production/Distribution Mail Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will:
   a. Prepare and maintain control of incoming and outgoing NYS Medicaid program mail;
   b. Deliver to the Department and pick up at the Department: contractor mail, reports, and other deliveries; and,
   c. Monitor, triage and route for resolution all returned undeliverable mail sent to providers, members, and other entities.

F.3.8.3 Production/Distribution of Notifications Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will distribute notifications to members, providers and other stakeholders as specified by the Department via mail, electronic and/or Web Portal.

Member Management

Offerors must meet the following proposal requirement:

1. Describe how they will prepare, produce and distribute member notifications and member labels.

Provider Management

Offerors must meet the following proposal requirement:

1. Describe how they will prepare, produce and distribute provider notifications.

Operations Management

Offerors must meet the following proposal requirement:

1. Describe how they will prepare, produce and distribute:
   a. Notifications to providers of stop payment orders for checks;
   b. Notifications to inform providers and members of the outcome of TOA processing;
   c. Rebate labeler notifications including but not limited to: Invoices, Dispute Resolution, and Accounts Receivable;
   d. EOB notifications to selected members;
   e. Notifications to inform both members and providers regarding Prior Approvals;
   f. Notifications and attachments to inform either members or providers of Prior Approval determinations;
   g. Service request determinations to the provider and member or appropriate designee;
   h. Personal Care and Transportation Rosters to the Local Social Service District offices, ordering providers, and billing providers;
   i. Written notice of pharmacy PA approvals to affected providers and members; and,
   j. Written notices to members and prescribers regarding their hearing rights following a pharmacy PA request denial.

Drug Rebate Management

Offerors must meet the following proposal requirement:

1. Describe how they will prepare, produce and distribute:
   a. rebate labeler invoices; and,
   b. notices to rebate labelers regarding outstanding accounts receivable balances.

Program Management

Offerors must meet the following proposal requirement:

1. Describe how they will prepare, produce and distribute:
   a. Notifications of Accounts Receivable balances to providers; and,
   b. 1099s to providers.

Business Relationship Management

Offerors must meet the following proposal requirement:

1. Describe how they will prepare, produce and distribute Business Relationship Management related notifications including but not limited to trading partner and security agreements; EFT agreements; ETIN agreements; and Web Portal user agreements.

F.3.8.4 Production/Distribution Mail Publications Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will:
   a. Prepare, produce and distribute publications;
   b. Notify affected providers of changes to their provider manual;
   c. Support and monitor the posting of Medicaid Updates on the Web Portal;
   d. Prepare, produce and distribute the Provider Enrollment forms;
   e. Design, prepare, produce and distribute NYS proprietary forms;
   f. Support and monitor the ordering of Department forms when the provider's inventory falls below Department-specified levels;
   g. Support and monitor the automatic generation of orders for Department forms when the provider's inventory falls below Department specified levels;
   h. Process and track provider's orders for Department forms;
   i. Manage and maintain inventory control on all forms and attachments and report to the Department monthly; and,
   j. Prepare, produce and distribute packets.

F.3.8.5 Data Entry Services Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will provide data entry services to the Department for all transactions and forms that require processing and cannot be accommodated using OCR services.

F.3.8.6 Image/OCR Services Operational Proposal Requirements

Offerors must meet the following proposal requirement:

1. Describe how they will provide imaging services for all customer service requests and transactions including but not limited to: forms, attachments, correspondence and other documents. Imaging services will include the electronic association of the document to the appropriate provider, member or transaction stored within the R-MMIS data stores.

Provider Management

Offerors must meet the following proposal requirements:

1. Describe how they will image, edit, OCR and/or data enter, verify, index and route for processing enrollment applications, disenrollment requests; provider information maintenance requests, and supporting documents.
2. Describe how they will provide imaging services for all existing hard copy provider enrollment files within 24 months of the R-MMIS implementation including the electronic association of the documents to the appropriate provider.

Operations Management

Offerors must meet the following proposal requirement:

1. Describe how they will:
    a. Image; edit, OCR and/or data enter, verify; and index paper claims (e.g., UB04, NY CMS 1500 &150002, and Transportation Claims) and claim attachments;
    b. Image and index recoupment payments and associated documents received from providers;
    c. Image, edit, OCR and/or data enter, verify, and index prior approvals and associated materials; and,
    d. Image; edit, OCR and/or data enter, verify, and index paper Threshold Override Applications (TOAs) received.

Manage Drug Rebate

Offerors must meet the following proposal requirement:

1. Describe how they will:
    a. Log, image, electronically associate, OCR and/or data enter and verify hard copy Resolution of State Invoice (ROSI) information and supporting documents received. Route transactions through the workflow management system based on Department business rules;
    b. Log, image, electronically associate to the invoice and route through the workflow management system checks received for invoice payments and reconcile those payments to invoices;
    c. Log, image, electronically associate, dispute resolution agreements and route transactions through the workflow management system based on Department business rules; and,
    d. Log, image, electronically associate, data enter, and verify Supplemental and other rebate program information and supporting documents as directed by Department. Route transactions through the workflow management system based on Department business rules.

Business Relationship Management

Offerors must meet the following proposal requirement:

1. Describe how they will image, edit, verify, index and route for processing via the Workflow Management System the following: hard copy and fax Trading Partner and Security Agreement applications, maintenance and termination requests, hard copy and fax ETIN applications, maintenance and termination requests, hard copy and fax Web Portal user applications, maintenance and termination requests; and hard copy and fax EFT applications, maintenance and termination requests.

F.3.9 Expert and Consulting Services Operational Requirements

Expert and consulting services are critical to the successful operation of the R-MMIS. These services range from providing expert testimony at hearings and trials to providing support for audits to supporting policy development.

The **Pharmacy Benefit Management Program** has unique requirements for expert and consulting services to support the variety of programs including the Preferred Drug Program, Clinical Drug Review Program, and Mandatory Generic Drug Program. The management of the drug formulary and pricing are key areas requiring expert and consulting services. In addition, the various Drug and Supply Rebate programs require a wide range of consulting services.

Mandatory Generic Drug Program: With the exception of drugs subject to the Preferred Drug Program, NY's Medicaid program excludes coverage of brand-name drugs when the Federal Food and Drug Administration (FDA) has approved a generic product, unless a prior authorization (PA) is received. More information can be found at https://newyork.fhsc.com/

Preferred Drug Program: The Medicaid Preferred Drug Program (PDP) promotes the use of less expensive, equally effective prescription drugs when medically appropriate. All drugs currently covered by Medicaid remain available under the PDP and the determination of preferred and non-preferred drugs does not prohibit a prescriber from obtaining any of the medications covered under Medicaid. Providers must obtain prior authorization for their patients to receive non-preferred drugs. Four classes of drugs, Atypical anti-psychotics, anti-depressants, anti-rejection drugs used for the treatment of organ and tissue transplants and anti-retroviral drugs used in the treatment of HIV/AIDS, are excluded by State statute from the Preferred Drug Program. The most recent version of the Preferred Drug List (PDL), which lists the therapeutic classes of drugs included on the PDL and the drugs in the classes that are preferred and non-preferred, is available at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf, or by calling1-877-309-9493. More information on the PDP can be found at https://newyork.fhsc.com/

Clinical Drug Review Program (CDRP): The CDRP utilizes prior authorization to ensure specific medications are used in a medically appropriate manner. This program is designed to address safety issues, public health concerns, the potential for fraud and abuse, or significant overuse and misuse. Request for a PA of these drugs must meet specific clinical criteria and written documentation may be required. More information can be found at https://newyork.fhsc.com/

F.3.9.1 Legal Research and Expert Testimony Support Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. Provide expert testimony in support of the pursuit of indictments and convictions of providers for Medicaid fraud;

b. Provide support to the Special Prosecutor and testify at grand juries or trials; and,
c. Provide research and documentation to support administrative hearings, appeals, and court cases. Participate in these activities upon request.

F.3.9.2 Audit Support Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. Assist audit staff from the Department, the Office of the State Comptroller (OSC), the Federal Department of Health and Human Services (DHHS), Office of Attorney General (OAG), Office of Medicaid Inspector General (OMIG) or other authorized personnel who perform audits relating to the services rendered by the contractor and any subcontractors;
    b. Provide support to the audit staff as directed by the Department; and,
    c. Notify State or Federal audit staff of any changes made to the R-MMIS and adjustments to edits; and,
2. Describe how they will assist Department staff in responding to audit findings or requests for information.

F.3.9.3 Pharmacy Benefit Management Support – General Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will provide a semi-annual Pharmacy Benefit Management Plan that includes but is not limited to: analysis and report of program goals and objectives as compared to actual financial and operational performance; recommendations for future improvements and enhancements to the programs; and analysis of changes to the pharmacy industry best practices and technical innovation that would enhance program performance and provide cost savings;
2. Describe how they will assist with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate program modifications resulting from legislation, or within the statutory discretion of the Department. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed program modifications and contemplated benefit design changes on members;
3. Describe how they will:
    a. Provide information and recommendations to the Department on new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm;
    b. Utilize resources to ensure that the Department will be kept abreast of the latest developments in the prescription drug field. Describe how trends and industry information will be communicated to the Department;
    c. Make available to the Department one or more members of the clinical or account management team to discuss the implications of these new trends and developments;

4. Describe how they will:
    a. Analyze, report on, and recommend utilization controls for consideration by the Department based on utilization and prescribing patterns using information from the MDW, Customer Service Center contacts and other sources;
    b. Analyze, report on and recommend utilization controls for consideration by the Department based on aberrant utilization and prescribing patterns for prescribers, providers, and members using information from the MDW, Customer Service Center contacts and other sources;
5. Describe how they will establish preliminary formulary coverage parameters for new drugs based on FDA- approved indications, Federal Medicaid requirements and the pharmacy program benefit structure and obtain Department approval before activating the new drugs. Coverage parameters include but are not limited to quantity, frequency and duration limits and age/gender restrictions;
6. Provide a flow chart and step-by-step description of its proposed methodology for the regular review and evaluation of for coverage of new drugs included in the drug file obtained from the drug file vendor(s). Include in its description the process and turnaround time for obtaining Department approval and updating the system. Coverage criteria would include, but not be limited to: Drug-gender interaction; Drug-age interaction; Quantity or refill limitations; Maximum Daily Dosage; Non- covered drugs and/or devices, as determined by the Department; Preferred or Non Preferred status; and Other plan limitations or coverage requirements, as determined by the Department (i.e., carve out drugs).
7. Describe how they will:
    a. Develop a SMAC list using a Department-approved process and criteria for determining SMAC prices that are in accordance with New York State legislation and Departmental policy and make the SMAC price list available to pharmacy providers via the provider area of the Web Portal and upon request;
    b. Maintain a SMAC list on a schedule specified by the Department. that reflects changing market conditions including market availability of drugs, fluctuating drug prices, and other conditions established by the Department such as regional shortages;
    c. Attest that the contractor's process and criteria for selecting/eliminating drugs and determining SMAC prices is in accordance with New York State legislation;
    d. Analyze and report actual cost savings resulting from SMAC pricing periodically, as defined by the Department;
8. Describe how they will provide identification and evaluation on a schedule determined by the Department of new drugs to market identifying implications for the Pharmacy Management programs including but not limited to Preferred Drug Program (PDP), CDRP, MGDP and brand less than generic;
9. Explain in detail how it will manage the regular review of the formulary to ensure its accuracy including, but not limited to the evaluation of the following parameters: drug-gender interaction; drug-age interaction; quantity or refill limitations; Maximum Daily Dosage; non-covered drugs and/or devices, as determined by the Department; Preferred or Non-Preferred status; other plan limitations or coverage requirements, as determined by the Department (i.e., carve out drugs); coverage parameters for Blood Products; rebate labeler changes; CMS terminated and/or reinstated NDC information; coverage and pricing of OTC products ; and coverage of non drug items included but not limited to durable medical equipment, supplies, and enteral formulas.

10. Describe how they will:
    a. Develop web-based information to assist providers and members in understanding all Pharmacy Management Programs;
    b. Describe its capabilities for developing letters and educational materials designed to be promote the acceptance of the Preferred Drug Program, the Mandatory Generic Program and the Clinical Drug Review Program; and,
11. Describe how they will inform the Department in a timely manner concerning matters that may affect the Program;

Designate Approved Service/Drug Formulary – Preferred Drug Program (PDP)

Offerors must meet the following proposal requirements:

1. Describe how they will administer the Preferred Drug Program (PDP) aimed at selected therapeutic classes or new product introductions, including operation of a PA function for non-preferred drugs and the realization of supplemental rebates;
2. Describe how they will:
    a. Prepare and present recommendations regarding selected drugs/classes based on clinical evaluations, utilization/market and analysis of relative costs to ensure the highest overall effectiveness of the Preferred Drug Program (PDP);
    b. Develop clinical evaluations of relative clinical effectiveness based on thorough evidence-based reviews of current literature;
    c. Recommend and advise on the management of drugs/classes based on market analysis;
    d. Present reviews of all drug/classes and make recommendations for program controls and improvements to reflect updated clinical and financial information at least quarterly;
3. Describe how they will incorporate PA review criteria and written guidelines for PA request processing as approved by the Department;
4. Describe how they will:
    a. Develop educational materials to be used to encourage Preferred Drug Program (PDP) compliance by providers, prescribers, and members; and,
    b. Design and implement targeted educational interventions aimed at changing prescribing patterns of outlier prescribers, including but not limited to: mailings, electronic messages, face-to-face meetings, web seminars and other direct interaction with prescribers.

Designate Approved Service/Drug Formulary - Clinical Drug Review Program

Offerors must meet the following proposal requirements:

1. Describe how they will administer the Clinical Drug Review Program (CDRP) that defines prior authorization requirements for specific drug products for specific patients based on the clinical requirements and established guidelines for the drug's appropriate use;
2. Describe how they will:
    a. Recommend and advise on the management of drugs/classes that meet legislative criteria for the CDRP;

   b. Prepare and present recommendations regarding selected drugs/classes based on clinical evaluations and utilization/market analysis to ensure the highest overall effectiveness of the CDRP program;
3. Describe how they will incorporate PA review criteria and written guidelines for PA request processing as approved by the Department; and,
4. Describe how they will design and implement targeted educational interventions aimed at changing prescribing patterns of outlier prescribers, including but not limited to, mailings, electronic messages, face-to-face meetings and other direct interaction with prescribers.

Designate Approved Service/Drug Formulary - Mandatory Generic Drug Program

Offerors must meet the following proposal requirements:

1. Describe how they will administer the Mandatory Generic Drug Program (MGDP) which identifies brand name drugs that require prior authorization based on the availability of an A-rated generic equivalent;
2. Describe how they will:
   a. Monitor the pharmaceutical industry to identify generic drugs expected to enter the market;
   b. Review and evaluate the availability and net cost of generic drugs and at a minimum monthly make recommendations for program inclusion/exclusion;
   c. Inform the Department as soon as possible but no later than 14 calendar days after the first date of shipment (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution;
   d. Notify the Department of drugs that will result in a lower net cost to the program by enforcing mandatory generic substitution, and with Department approval, begin enforcement as soon as possible but no later than 14 calendar days after the first date of shipment provided that the network pharmacies are able to obtain the generic drug;
   e. Notify the Department as soon as possible of drugs that could potentially result in a higher net cost to the Program by enforcing mandatory generic substitution;
   f. Assist the Department in determining whether or not mandatory generic substitution should be enforced. The contractor must also survey retail pharmacies to identify the pharmacies that are unable to obtain the new generic drug within 21 days after the first date of shipment. The contractor must submit this information to the Department and provide any additional information as required by the Department to reach a determination;
3. Describe how they will design and implement targeted educational interventions aimed at changing prescribing patterns of outlier prescribers, including but not limited to, mailings, electronic messages, face-to-face meetings, web seminars and other direct interaction with prescribers;
4. Describe how they will incorporate PA review criteria and written guidelines for PA request processing as approved by the Department; and,
5. Describe how they will review ongoing, program and financial results and make recommendations for program improvements.

Manage Drug Rebate Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
    a. Provide, manage, and execute a Supplemental Rebate Management Plan that includes but is not limited to: methodology to identify rebate labelers and drugs/supplies that have potential for inclusion in the supplemental rebate program; strategy and standards for negotiating supplemental rebate agreements; and process for monitoring supplemental rebate agreements;
    b. Conduct meetings with the Department to develop a supplemental rebate and drug pricing strategy with pharmaceutical manufacturers;
2. Provide a detailed description of how it would administer the State's Supplemental Rebate program. Explain how it would incorporate the utilization of the Medicaid Pharmacy and Therapeutics Committee;
3. Provide an implementation plan (narrative, diagram and timeline) which illustrates how it will implement a new supplemental rebate program. Explain how it will ensure that the Department will achieve savings equal to or better than the current Supplemental Rebate Program;
4. Describe how they will develop and executive a plan to transition the State's current rebate agreements to the proposed plan, which guarantees that current supplemental rebates are not put at risk;
5. Describe how they will identify Supplemental rebate labelers and drugs/supplies for potential rebate agreements and submit recommendations to the Department for approval;
6. Describe their supplemental rebate negotiation process including:
    a. How they will negotiate and obtain competitive supplemental rebate and drug pricing contracts and submit to the Department for approval;
    b. Their experience in negotiating rebates and implementing Supplemental Rebate Programs;
    c. Provide a detailed description and flow chart of its supplemental rebate negotiation process; and,
    d. How they will ensure that Medicaid supplemental rebates are over and above the Federal rebates and in compliance with Federal law;
7. Describe how they will oversee and administer the supplemental rebate solicitation and negotiation process, including but not limited to sending out contracts and soliciting quotes, analyzing financial impact of quotes and impact on market share, and attending P&TC committee meetings to review financial and market share analyses; and,
8. Describe how they will monitor Supplemental rebate agreements with rebate labelers subject to Department policy and submit for Department approval.

F.3.10 Reporting Operational Requirements

Reporting is critical to the monitoring and analysis of the performance of the Medicaid program.

F.3.10.1 Reporting Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will:
   a. Support and monitor the production of reports;
   b. Distribute reports via hard copy, electronic, reporting repository and/or the web-portal; and,
2. Describe how they will support and monitor the production and distribution of the reports necessary to perform, manage, and control the drug rebate process.

F.3.11 Archiving Operational Requirements

Periodic archiving of information is essential to the functioning of the R-MMIS. The contractor must archive, maintain and store documentation in accordance with State and Federal retention requirements.

F.3.11.1 Archiving Operational Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how they will support and monitor the periodic archiving of selected information based on criteria and schedules specified by the Department; and,
2. Describe how they will support and maintain all hard-copy forms, attachments, and other documents in accordance with State retention requirements and dispose of in accordance with Department-approved procedures.

G. TURNOVER PHASE REQUIREMENTS

G.1 OVERVIEW

The Turnover Phase represents a period of transition during which the R-MMIS and all related operational and technical support activities that have been maintained and operated by the contractor must be turned over to the Department or successor contractor(s).

The contractor must provide turnover planning and the requisite services in support of the following Department turnover objectives:

1. Provide for an orderly, complete, and controlled transition to the Department or successor contractor(s);
2. Avoid disruptions of processing and services provided to members, providers, and operational users of the system during the turnover period;
3. Maintain fiscal agent responsibility through the effective date of the transfer of responsibility and through the completion of the reconciliation of final cycle processing conducted by the fiscal agent, including cycle data and report output; and,
4. Provide technical and operational services and information as needed to facilitate an informed, coordinated, and complete transfer of activity.

The contractor must provide full support and assistance in the transition of fiscal agent operations and operations of the R-MMIS to a successor contractor or to the Department. The offeror must state in its proposal a commitment to working with the Department and successor contractor(s) in planning and performing the Turnover activities.

No later than one (1) year from the start of full operations of the R-MMIS, the contractor must provide a Turnover Plan to the Department. The plan must include:

1. Proposed approach to turnover;
2. Turnover work plan, including detailed tasks and subtasks;
3. Schedule for turnover; and,
4. Procedures for maintain up-to-date documentation during turnover.

Thereafter, the Turnover Plan must be updated annually prior to the start of the next year of operations.

Along with the Turnover Plan, the contractor must submit a statement of the resources that would be required by the Department or a successor contractor to take over operation of the R-MMIS. The Requirements Statement must include:

1. An inventory of all application software used to perform the functions of all components of the R-MMIS;
2. An inventory of all hardware, system software, and other technical environment resources required to operate all components of the R-MMIS; and,
3. 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 must be based on the contractor's experience in the operations of the R-MMIS and must include actual contractor resources devoted to the operation of the system and other functions. This Resource Statement must be updated annually and must be submitted as part of the Turnover Plan and updates.

G.2 PROPOSAL REQUIREMENTS

The offeror must describe its proposed methodology for turning the system over to a successor contractor or to the Department. This methodology will be the basis for the Turnover Plan. The methodology should describe the contractor's approach and plan for turnover.

Offerors must meet the following proposal requirements:

1. Describe the approach for training Department staff, Department contractor staff or the successor contractor;
2. Describe how the contractor will manage the transition while maintaining production schedules;
3. Describe the staff responsible for transition; and,

4. Include a statement that the contractor is committed to working with the Department and successor contractor(s) in planning and performing the Turnover activities.

H. TECHNICAL AND SYSTEM ARCHITECTURE REQUIREMENTS

H.1 OVERVIEW

The technical and system architecture will provide the underlying computing infrastructure (e.g., hardware, software, network, database management system) that enables and supports the R-MMIS. The technical architecture design, proposed by the contractor, must address the requirements of scalability, capacity, extensibility, adaptability, performance, availability, stability security and flexibility.

The proposed R-MMIS architecture must meet specific technical requirements as defined in Attachment J as well as operational performance and availability requirements defined in section III.O.2 Service Level Agreements.

In addition, the proposed technical and system architecture must address the business continuity requirements (i.e., backup/recovery, failover, disaster recovery) which are deemed necessary to effectively manage and operate the R-MMIS. These requirements are defined in section III.L Business Continuity and Disaster Recovery requirements.

The Department requires the contractor to integrate "Best of Breed" COTS products into its solution to meet the needs of the business functions. For purposes of this RFP, COTS solutions are those products that can be licensed and utilized by multiple industries, are commercially available from a third party, and provide a common solution throughout the application.

The contractor must be responsible for the provision and maintenance of all hardware, computer network, personal computer-based workstations, printers, supporting modems, and software needed for the R-MMIS. The contractor must arrange for and coordinate the maintenance of all equipment and software.

H.2 ENVIRONMENT DESCRIPTION

During the R-MMIS Project Planning and Implementation Phases, the contractor must establish several environments within its technical architecture that will be supported and maintained throughout the life of the contract. An environment is defined as the infrastructure needed to support a functional requirement, such as development, training, etc. Individual components (e.g., servers and storage arrays) can be used in more than one environment. The environments that must be supported include:

1. **Production Environment** used to deploy the R-MMIS production solution;
2. **Test Environment** used to perform full-scale system integration testing (SIT) and regression testing for the R-MMIS solution. This environment must meet production capability and capacity but not affect production data;

3. **Development Environment(s):** used to develop and unit test all software contained within the R-MMIS;
4. **User Acceptance Testing (UAT) Environment:** used by the Department to test the applications and data provided within the R-MMIS. This environment must be sized the same as production and be capable of performing complete end-to-end testing;
5. **Training Environment:** used to support provider and user training of applications;
6. **Failover Environment:** used to support the business continuity failover capabilities;
7. **Provider Test Environment:** used to support provider testing and therefore needs to support any and all channels that a provider may use to interact with the system;
8. **Disaster Recovery Environment:** used to support the business continuity disaster recovery capabilities;
9. **Integrated Test Facility Environment (ITF):** used by Department staff to test all components of the system. Must be a replica of the current production system and contain a copy of production data as directed by the Department; and,
10. **Cert Environment:** used to test transactions received and transmitted to the Welfare Management System (WMS). This environment must support full raw data files being received via all channels.

All environments must comply with the backup/recovery requirements defined in this RFP.

H.3 R-MMIS ARCHITECTURE

H.3.1 Technical and Application Architecture

The Department intends to implement a system that is aligned with the CMS Medicaid Information Technology Architecture (MITA) and select a contractor with the capability and corporate planning, support, and vision to achieve successive MITA maturity levels. The Department seeks to advance the MITA maturity level of eMedNY by replacing manual or inefficient automated processes with more efficient processes.

The MITA Application Architecture is a component of the MITA Technical Architecture. MITA approaches application integration using standards that are based on Service-Oriented Architecture (SOA), a modular component design approach that allows for interoperability across components and with external applications and across data sources. The basic SOA principles are:

1. The system must be modular;
2. The modules must be distributable;
3. Module interfaces must be clearly defined and narrow;
4. Interface layer is separate from the processing layer; and,
5. Service provider modules must be sharable.

The Department believes that MITA enabling guidelines, processes and tools provide a framework for the continuous improvement of service delivery and business process based on efficient technology utilization. The Department understands that MITA is an evolving set of

standards that is not fully developed and is not requesting "full adherence" to all specifications nor the highest maturity levels. However, the Department is requiring the contractor to identify and explain in their proposal their proposed systems' alignment with the SOA principles defined above and their corporate vision for addressing MITA requirements.

The Department will use MITA as a tool to assist in the strategic application of technology and enhancements that provide value and contribute to continuous improvements in the Medicaid program's maturity. To this end, the Department is interested in implementing an R-MMIS that will:

1. Enhance its maturity in all areas;
2. Employ a Service-Oriented Architecture (SOA) that takes advantage of COTS products and allows for the reuse of system functionality. The contractor must utilize proven COTS tools that are flexible and reusable for various functions; and,
3. Serve as both a foundation and a catalyst for the Department to continuously improve the efficiency of its business and service delivery capabilities throughout the life of the contract.

H.3.2 Data Architecture

At the center of any transactional system is the data architecture. The contractor must design, develop, implement and maintain this architecture based on the direction provided by the Department. Managing the Data Architecture is the process of defining the needs of the enterprise and designing the master blueprints to meet those needs. It is an integrated set of specification artifacts used to define data requirements, guide data integration, control data assets, and align data investments with business strategy. It includes formal data names, comprehensive data definitions, effective data structures, precise data integrity rules, and robust data documentation. It also includes ensuring the integrity of the data, managing the data throughout its lifecycle, and optimizing performance of database transactions. Core activities include:

1. Defining and maintaining the data technology architecture; and,
2. Defining and maintaining the data integration architecture.

H.3.3 Network Architecture

The network architecture is one of the key components necessary to provide data privacy, security and confidentiality. The proposed architecture must: restrict access through authentication and authorizations; be able to audit stakeholder and system activity; and shield data from unauthorized access during data transmission. Network components need to work together to secure the infrastructure against accidental misuse and malicious attacks. The proposed network architecture must provide the infrastructure necessary to protect PHI.

The contractor must ensure that the network meets the minimum security requirements for a Level 3 cryptographic module as defined in Section 5131 of the Information Technology Reform Act of 1996 and further defined FIPS publication 140-2 issued May 25, 2001.

H.3.4 Proposal Requirements

Offerors must meet the following proposal requirements:

As part of its Technical Proposal, the offeror must describe in detail its proposed Technical Architecture for the project with a description provided as to the offeror's approach and plan for supporting the multiple environments described in this RFP.

These architectures must be based upon MITA requirements and show how the contractor has integrated COTS products into its solution to meet the requirements in this RFP. The offeror must:

1. Describe in detail its proposed Technical Architecture for the project with a description provided as to the offeror's overall solution, approach and plan for supporting the multiple environments described in this RFP. For each of the ten (10) environments list all hardware, software, network and database components being proposed as well as ***detailed schematics*** and a detailed explanation of the connectivity between components;
2. Provide separate ***detailed schematics*** and associated narrative of the technical, application, network and data architectures being proposed. These architectures must be based upon MITA requirements and the schematics and associated narrative must show how the contractor has integrated COTS products into its solution to meet the requirements in this RFP;
3. Identify how the application, technical, data and network architectures will meet the Department's requirements and concerns in the areas of:
    a. Scalability;
    b. Capacity;
    c. Extensibility;
    d. Adaptability;
    e. Performance;
    f. Availability;
    g. Stability;
    h. Security; and,
    i. Flexibility;
4. Describe how each of the architectures being proposed meets the Department's requirements in the areas of Business Continuity, including Backup/Recovery, Failover and Disaster Recovery;
5. Describe how each of the architectures being proposed meet the Department's requirements in the areas of employing a Service-Oriented Architecture;
6. Describe how the proposed R-MMIS will be planned, designed and implemented as modular business services to achieve SOA principles;
7. Describe how its implementation of MITA principles and SOA in the overall architecture will help eliminate the integration problems associated with the introduction of multiple COTS products;
8. Describe how each of the architectures being proposed will assist the Department in advancing its MITA maturity level throughout the life of the contract;
9. Describe in detail how each of the architectures being proposed meet the MITA technical capability categories of:

a. Business-enabling services;
b. Access channels;
c. Interoperability channels;
d. Data management and data sharing;
e. Performance;
f. Security and privacy; and,
g. Adaptability and extensibility;

10. Describe in detail how each of the proposed architectures will evolve over the life of this contract in the MITA technical capability categories of:
    a. Business-enabling services;
    b. Access channels;
    c. Interoperability channels;
    d. Data management and data sharing;
    e. Performance;
    f. Security and privacy; and,
    g. Adaptability and extensibility;
11. Describe the proposed process for developing the data architecture;
12. Describe in detail how the proposed application architecture meets the key components of the MITA Application Architecture including but not limited to:
    a. ESB and access channels;
    b. Service management engine;
    c. Service gateways and mediators;
    d. Business service;
    e. Performance management; and,
    f. Security and privacy;
13. Describe how the proposed architecture support the Department's requirement to use COTS products to meet the needs of the business functions:
    a. Describe how the integration of the COTS products being proposed will be implemented; including but not limited to:
        i. Correspondence Management System;
        ii. Contact Management System;
        iii. Document Management System;
        iv. Content Management System;
        v. Workflow Management System; and,
        vi. Business Rules Engine;
14. Describe how the Development environment supports the ability for:
    a. Multiple developers to work concurrently on the same module; and,
    b. Multiple releases of the R-MMIS to be developed concurrently;
15. Describe how the proposed architecture provides the capability to easily promote code and maintain fidelity from one environment to another (e.g., development to test; and test to UAT); and,
16. Describe how the network meets at a minimum security requirements for a Level 3 cryptographic module.

H.4 WEB PORTAL

The Web Portal will serve as the gateway for all stakeholders to access information related to the NYS Medicaid program and web-based applications. The Web Portal will serve as the interface to the Department's web-based application and internal information that must be restricted to authorized users based on the Department's security requirements. It will also serve as the interface for providers, rebate labelers, and members to access information related to the NYS Medicaid program and the web-based applications for providers and rebate labelers that support the business functions specified in this RFP. It is critical that the Web Portal be easy to navigate with comprehensive, understandable information and documentation related to program benefits, transaction processing and other program requirements.

The Web Portal will, at a minimum, support the execution of web-based applications, allow service providers and rebate labelers to view, enter, access, and update information; and provide information on the status of various transactions to end users.

The contractor must develop a Web Portal that will allow users, based on role security, to access, add, update and delete information across all MITA business areas supported by the R-MMIS. It will be the contractor's responsibility to register users and define their roles based upon criteria specified by the Department.

H.4.1 Proposal Requirements

1. Describe how the proposed approach to meeting the requirements for a Web Portal is integrated into the application, technical, network and data architectures;
2. Discuss how information and business processes will be controlled within the portal (need to know basis);
3. Discuss how providers and rebate labelers will interface with the portal;
4. Discuss how information and training will be disseminated through the portal; and,
5. Describe how the portal will advance the Department's desire to achieve a higher MITA maturity level.

H.5 WEB APPLICATION

The contractor must develop web-based applications that must be accessible through various communication channels. The applications must enforce compliance with HIPAA security requirements and be accessible through the Web Portal.

The R-MMIS must have an integrated on-line help function for all applications that is designed independently of the application code.

H.5.1 Proposal Requirements

As part of its Technical Proposal, the offeror must describe in detail its proposed methodology for Web application development. The methodology should describe the offeror's approach and plan for managing changes to applications.

Offerors must meet the following proposal requirements:

1. Describe how the proposed methodology for writing web applications is integrated into the MITA technical and application architectures;
2. Discuss how the proposed methodology for developing web applications will ensure application access through the Web Portal;
3. Describe how applications will be run as a service on the ESB;
4. Describe the proposed technical features of the proposed web application methodology including but not limited to languages, and development tools; and,
5. Describe how on-line help will be implemented and any tools that will be used in its development.

H.6 BUSINESS RULES ENGINE

The contractor must employ a state-of-the-art COTS Business Rules Engine (BRE) or a Business Process Management System (BPMS) that has a BRE component to record business rules across all MITA Business Areas supported by the R-MMIS. The Business Rules Engine must at a minimum allow policy changes and table changes to be entered into the R-MMIS quickly and without developer intervention. Changes to the business rules enforced through the Business Rules Engine must be able to be applied to the R-MMIS immediately if desired by the Department.

The contractor must describe within their proposal the rationale for selecting the proposed BRE, (e.g., types of pre-existing edits and areas of coverage, total cost of ownership, overall level of effort for maintenance, etc.)

H.6.1 Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the proposed COTS Business Rules Engine will be integrated into the technical and application architectures;
2. Describe in detail the types of changes that can be made within the Business Rules Engine without developer intervention, including a listing of the types of objects that will be available (e.g., code tables, and business rules);
3. Describe in detail how the Business Rules Engine will be implemented in each of the MITA business areas supported in this RFP, describing the tables, codes, values and other edits that can be made without developer intervention;

   a. Describe the integration of the Business Rules Engine into the Content Management System and the Workflow Management System; and,
   b. Discuss the integration with other components in a SOA environment; and,
4. Describe the rationale for selecting the proposed Business Rules Engine. Identify any and all benefits that would be realized by the Department. Examples of these may include but not be limited to:
   a. total cost of ownership;
   b. advantages of pre-configured solutions;
   c. level of effort for maintenance;
   d. pre-existing edits and areas of coverage; and,
   e. functionality provided for operational use.

H.7 DOCUMENT MANAGEMENT

The contractor must provide and implement a Document Management Plan based upon the proposed Document Management Methodology that describes how the contractor will electronically manage the documents and attachments produced throughout the life of the project. Documents and deliverables must be electronically stored and easily retrievable via an electronic Document Management System with a centralized Document Repository that can be accessed outside the R-MMIS environment and must contain an online help facility. Documents can include but are not limited to all correspondence, electronic images of paper documents, design documents, technical documents, planning documents and all other deliverables. All documents will be produced in a format approved by the Department.

The contractor must use a COTS Correspondence Management System to manage official correspondence between the contractor and the Department, providers, members, and all other stakeholders. The offeror must also propose a correspondence tracking methodology for Department review and approval. This methodology must include, but not be limited to, a systematic approach to management and tracking of all correspondence, including deliverables, between the Department and contractor, a transmittal memorandum to accompany each communication, a coding scheme to identify the initiator and recipient of the communication, project phase and applicable functional area.

One of the primary sources of information that flows between the contractor and the Department are project deliverables. To ensure an effective and efficient deliverable management process, offeror must describe its approach to the timely design, development, submission, revision and final approval of project deliverables. The contractor must propose and implement, upon Department approval, a Deliverable Submission, Review and Approval Process. This process must include a strategy to provide draft deliverables for Department review and approval. Delivery of these items and time for review must be reflected as milestones in the project plan.

All written and official electronic correspondence between the Department and the contractor must be in a format prescribed by the Department and logged, archived and maintained by the contractor for seven (7) years beyond the term of the contract. The contractor

must provide the Department with electronic access to this correspondence, including access to images of all written correspondence.

H.7.1 Proposal Requirements

As part of its Technical Proposal, the offeror must describe its proposed Document Management Methodology that will be the foundation for the Document Management Plan for the project. The methodology should describe the offeror's approach and plan for managing changes to documents.

Offerors must meet the following proposal requirements:

1. Describe the COTS Correspondence Management System being proposed;
2. Describe the Document Management System and document repository being proposed;
3. Describe the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components;
4. Describe how documents are tracked, documented and versioned;
5. Describe how changes to documents are reported, synchronized and distributed;
6. Describe any tools and business processes used for document management, including check in/check out procedures and a responsibility audit trail;
7. Describe how the Document Management Plan will be implemented within the EPMO structure and how it will integrate into the overall PM approach including any and all COTS tools that are integrated;
8. Describe how document changes will be controlled so that no changes will be implemented without sound audit trail practices; and,
9. Detail the proposed solution by describing how the following functions will be accomplished:
    a. Acquire/receive documents;
    b. Store documents;
    c. Version documents;
    d. Archive documents;
    e. Purge documents;
    f. Backup/Recovery documents;
    g. Secure documents; and,
    h. Provide reporting of content of document repository; and,
10. Describe the Deliverable Submission, Review and Approval Process.

H.8 CONTENT MANAGEMENT

The R-MMIS must have the capability to capture, consolidate and archive all incoming documents, as well as all documents developed by the contractor in satisfying the requirements in this RFP. These documents must be maintained in a centralized Document Repository. The contractor must develop and implement a Content Management Plan that is based upon the contractor's proposed Content Management Methodology. The proposed Content Management Methodology must include a description of the technologies, strategies, methods, and tools used to capture, manage, store, preserve, and deliver all content including but not limited to data,

images, transactions, attachments and documents related to an organization, member, provider, case and its processes.

The contractor must use a COTS Content Management product that operates within the R-MMIS across all MITA business areas. The product must have a document repository and library services that will integrate with the proposed Document, Correspondence, Workflow and Contact Management Systems.

H.8.1 Proposal Requirements

As part of its Technical Proposal, the offeror must describe its proposed Content Management Methodology that will be the foundation for the Content Management Plan for the project. The methodology should describe the offeror's approach and plan for integrating data, documents and other artifacts.

Offerors must meet the following proposal requirements:

1. Describe how the proposed COTS Content Management System is integrated into the MITA technical and application architectures;
2. Discuss how the documents in the document repository can be linked to a member, provider, or transaction;
3. Describe how images will be integrated with data and other documents;
4. Describe how the COTS product will integrate with the Document, Correspondence, Workflow and Contact Management Systems;
5. Describe how new documents will be integrated with the historic images from eMedNY;
6. Describe the business processes and procedures for controlling and processing paper documents, electronically recording images and attaching supporting documentation to data base records;
7. Describe the strategy and approach that will be used to provide document and content management. Include all technical components that comprise the proposed solution including all software (both COTS and custom-developed) and hardware; and,
8. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components;

H.9 WORKFLOW MANAGEMENT

The R-MMIS must have the capability to move, control and track content through business processes. The R-MMIS will be required to use a COTS workflow product to track the movement of information and documents through the business processes. The COTS product must support a sequential progression of work activities and/or a complex set of processes each taking place concurrently, eventually impacting each other according to a set of rules, routes, and roles.

The COTS Workflow Management Systems will allow the Department to define and control the various activities associated with the business processes. In addition, it must provide

the Department, through a series of reports, the opportunity to measure and analyze the execution of the processes so that continuous improvements can be made.

H.9.1 Proposal Requirements

As part of its Technical Proposal, the offeror must describe in detail its proposed COTS Workflow Management System and how it will move, control and process data, documents and other artifacts throughout a business process.

Offerors must meet the following proposal requirements:

1. Describe in detail the COTS workflow product being proposed and the tools used to define a business process within the workflow product;
2. Describe how the proposed COTS Workflow Management System will be integrated into the technical, application, network and data architectures;
3. Describe the areas in the R-MMIS where the Workflow Management System is implemented;
4. Describe how the product will route, track and control work items;
5. Describe how the product will provide Department and contractor management with visibility into staff workloads and performance;
6. Describe the integration of the workflow product into the Content Management System and the Business Rules Engine; and,
7. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components.

H.10 REPORTING

The contractor must provide a mature, intuitive, easy-to-use Web-based COTS tool that meets the reporting requirements within this RFP with one comprehensive tool suite. This reporting toolset will provide the capability to build and publish a library of canned reports, as well as provide stakeholders with ad-hoc reporting capability. The reporting tool must be integrated with the proposed Web Portal technology and Document Repository.

The reports currently produced by eMedNY are listed in the Procurement Library. It is anticipated that some of these more analytic reports will be produced by the MDW in the future, and not be required to be produced by the R-MMIS. During the Requirements Definition Phase of this project, each existing report will be evaluated and a determination will be made on whether the development and implementation of the report is a better fit for the R-MMIS or the MDW.

H.10.1 Proposal Requirements

As part of its Technical Proposal, the offeror must describe in detail its proposed COTS Reporting tool and how it will be used for the creation of operational and ad-hoc reports

Offerors must meet the following proposal requirements:

1. Describe the COTS Reporting Tool being proposed for all operational and ad-hoc reporting;
2. Describe the tool's scalability, ease of use, and features;
3. Describe how reports can be stored in a report repository and accessed by Department authorized staff;
4. Describe how reports produced by the COTS reporting tool can be attached to other documents using the proposed Content Management COTS product and integrated into the proposed Workflow Management Product; and,
5. Describe in detail the conversion strategy that will be used to convert historical eMedNY reports from the eMedNY report repository into the proposed document repository.

H.11 AUTOMATED LETTER GENERATION

The contractor must provide a mature, intuitive, easy to use COTS product to automatically generate letters to providers, members and other stakeholders. The letters generated by the COTS product must be able to integrate with the proposed Content Management and Workflow Management products.

These letters must be maintained and stored in the document management repository.

H.11.1 Proposal Requirements

The offeror must describe in detail its proposed approach to Automated Letter Generation and how it will fulfill the Department's requirements.

Offerors must meet the following proposal requirements:

1. Describe the COTS tool being proposed for the automatic generation of letters; and,
2. Describe the features that will be available with the automatic generation of letters and how it will interface with the proposed COTS Document, Correspondence, Content and Workflow Management Systems.

H.12 CONTACT MANAGEMENT

The contractor must log, track, and report all written, electronic, and telephone inquiries in a proposed COTS Contact Management System. At a minimum, the contractor must log the date and subject of the inquiry; the member or provider identifier, provider type, and member or 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.

These contact records must be integrated with the proposed Content Management and Workflow Management products. Most contacts will be made through the Customer Service Center where hardware must be installed to answer calls from providers and members.

H.12.1 Proposal Requirements

The offeror must describe its proposed approach to Contact Management and how it will fulfill the Department's requirements.

Offerors must meet the following proposal requirements:

1. Describe the proposed COTS product that will be used to log, track, and report contacts with providers, rebate labelers and members; and,
2. Describe how the COTS product will integrate with the proposed Document Management, Content Management and Workflow Management Systems.

H.13 DATA RECEIPT MANAGEMENT

The data receipt component is the mechanism that accepts data into the R-MMIS in a secure fashion in a variety of formats. This component will allow for the receipt of data into the R-MMIS.

The eMedNY receives data from a variety of entities, both internal and external to the Department. See the Procurement Library for a listing of data that is currently received inbound to eMedNY.

H.13.1 Proposal Requirements

The offeror must describe its proposed approach to Data Receipt Management and how it will fulfill the Department's requirements.

Offerors must meet the following proposal requirements:

1. Describe the strategy and approach that will be used to receive process, verify, notify, report, monitor, administer, and secure the data received inbound to the R-MMIS via the proposed data receipt solution;
2. Describe all technical components that comprise the proposed solution including all software (both COTS and custom-developed) and hardware;
3. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components; and,
4. Detail the proposed solution by describing how the following functions will be accomplished:
    a. Receipt of inbound data;
    b. Processing of inbound data;
    c. Verification of inbound data sets;
    d. Notification to the submitter;
    e. Reporting of successful processing and errors;
    f. Monitoring of processing;

g. Administrative; and,
h. Security.

H.14 DATA DELIVERY MANAGEMENT

The data delivery component is the mechanism that distributes R-MMIS maintained data in a secure fashion to requestors in a variety of formats. This component will allow the scheduled extraction and delivery of data from the R-MMIS.

eMedNY distributes data to a variety of internal and external entities. In some cases, the MMIS "pushes" data to other entities, including the eMedNY Data Warehouse. The eMedNY Data Warehouse "push" is currently done on a weekly basis. The Department is requiring that the R-MMIS push data to the MDW, at a minimum, once a day. In other cases, subscribers "pull" data from the current MMIS. The Procurement Library includes a listing of data feeds to be created and supported in the proposed solution, as described in the data delivery section.

The Department is requiring the contractor to provide a COTS product to schedule, create, publish/distribute, notify, report, monitor, administer, and secure the data extracts of the proposed data delivery solution.

H.14.1 Proposal Requirements

The offeror must describe in detail its proposed approach to Data Delivery Management and how it will fulfill the Department's requirements and achieve continual improvement of the contractor's performance in pursuit of the project objectives.

Offerors must meet the following proposal requirements:

1. Describe the strategy and approach that will be used to schedule, create, publish/distribute, notify report, monitor, administer, and secure the data transmitted via the proposed data delivery solution;
2. Describe all technical components that comprise the proposed solution including a detailed description of the COTS product and hardware;
3. Describe how the technological architecture will support a "push" to the MDW and other sources at a minimum of daily;
4. Describe how the technological architecture will support a "pull" by other subscribers;
5. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components; and,
6. Detail the proposed solution by describing how the following functions will be accomplished:
    a. Scheduling of outbound data;
    b. Creation of outbound data sets;
    c. Publish/distribution of outbound data;
    d. Notification to recipients of data;
    e. Reporting of success and errors;

f. Monitoring of outbound data sets;
g. Administrative; and,
h. Security.

H.15 METADATA MANAGEMENT AND DELIVERY

The centralized Managed Metadata Environment (MME) is deemed critical to the success of both the R-MMIS and MDW. Metadata is vital because it tells stakeholders and technologists where to find the exact data that they need and helps them understand what it means. Metadata makes it easier to use the R-MMIS and MDW by allowing faster turnaround for information requests, which equates to higher productivity and confidence in the data retrieved.

The Department defines this component as the integrated Web-based systems environment that will be used to contain both business and technical descriptions of the data that is stored in the R-MMIS and MDW. It will be used by both business and technical users to enhance their understanding of the data and the processes that populate and distribute the data contained in the R-MMIS and MDW.

The MME objectives are to:

1. Provide uniformity in the description and sharing of information;
2. Make reliable information available quickly;
3. Increase the visibility of information across the enterprise;
4. Increase accuracy of stakeholder analysis of the data;
5. Increase stakeholder confidence in the R-MMIS and MDW;
6. Reduce new employee training costs;
7. Reduce operational costs by eliminating redundant data;
8. Identify errors and problems with source systems;
9. Reduce time to perform change impact analysis; and,
10. Shorten development times.

The enterprise MME repository and application will be built and maintained by the MDW contractor. The R-MMIS contractor must collect, extract, and distribute the required metadata content to the enterprise MME in a timely fashion, with refresh frequencies defined during requirements gathering sessions.

Metadata is information about the physical data, technical and business processes, data rules and constraints, and logical and physical structures of the data, as used by the enterprise. These descriptive tags describe data (i.e., databases, data elements, data models), concepts (i.e., business processes, application systems, software code, technology infrastructure), and the connections (relationships) between the data and concepts.

Types of metadata include definition (both business and technical definitions), transformation (source to target mappings, business rules, domain values, etc.), and process control (warehouse usage metrics, quality and audit metrics, operational messages, application run-time) metadata. This knowledge base contains information about data, process, and control

in the R-MMIS and MDW and as such represents a facility for centralized management and control of the R-MMIS and MDW. Metadata sources could include software tools, stakeholders, documents, spreadsheets, messaging and transactions, Web-sites and third parties.

H.15.1 Proposal Requirements

The offeror must describe its proposed approach to Metadata Management and how it will fulfill the Department's requirements and achieve continual improvement of the contractor's performance in pursuit of the project objectives.

Offerors must meet the following proposal requirements:

1. Describe the strategy and approach that will be used to capture and extract the metadata content within the R-MMIS;
2. Include all technical components that comprise the proposed solution including all software (both COTS and custom-developed) and hardware;
3. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components; and,
4. Detail the proposed solution by describing how the metadata content will be:
    a. Sourced (e.g., data modeling tool, and database catalog);
    b. Captured from the sources;
    c. Refreshed from the sources; and,
    d. Extracted and distributed to the MME.

H.16 DATA MANAGEMENT

Data Management is the development and execution of architectures, policies, practices and procedures that properly manage the full data lifecycle needs of an enterprise. The architecture centers on the Relational Database Management System (RDMS). The contractor must provide a comprehensive RDMS that is based on an open architecture that provides application program interfaces and open database connectivity.

H.16.1 Proposal Requirements

The offeror must describe in detail its proposed Relational Database Management System and how it will fulfill the State's requirements and achieve continual improvement of the contractor's performance in pursuit of the project objectives.

Offerors must meet the following proposal requirements

1. Describe the RDMS being proposed and the features that will be used in the proposed R-MMIS solution;
2. Include all technical components that comprise the proposed RDMS;

3. Discuss the RDMS in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components;

H.17 DATA MODEL

The data model technical component addresses the definition and management of logical and physical data models in support of the R-MMIS. It contains logical depictions or models of the database that will support the business and technical requirements outlined in this RFP. The physical models relating to the R-MMIS will also be depicted for each deployment environment (i.e., development, test, production, training, UAT). The Department is requiring the contractor to use a data modeling COTS product and provide Department and Department contractor staff access to the tool and data models.

H.17.1 Proposal Requirements

The offeror must describe in detail its proposed approach to Data Modeling and how it will fulfill the State's requirements and achieve continual improvement of the contractor's performance in pursuit of the project objectives.

Offeror must meet the following proposal requirements:

1. Describe the data modeling COTS product that will be used to model the conceptual, logical, and physical R-MMIS data structures.
2. Describe how the models will be managed and versioned from a single tool and central control point.
3. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components.
4. Discuss the degree to which the physical model that is created from the tool can be used without augmenting physical characteristics after the data structure generation
5. Describe the mechanism that will be used to provide state staff access to the most current copy of the R-MMIS data models.

I. SECURITY, PRIVACY AND CONFIDENTIALITY REQUIREMENTS

I.1 OVERVIEW

The contractor must comply fully with all security policies and procedures of the Department, as well as with all applicable State and Federal requirements, in performance of this contract. The contractor must not, without written authorization from the Department, divulge to third parties any confidential information obtained by the contractor or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing contract work. This information includes but is not limited to: security procedures, business operations information or commercial proprietary information in the possession of the Department, Protected Health Information (PHI) or other data.

The contractor must take steps to ensure that their staff, agents and subcontractors are educated in specific security, privacy and confidentiality requirements as applied to this contract, explaining its responsibilities in maintaining security, privacy and confidentiality and reviewing all policies, processes and procedures that will be used for this project.

All activity covered by this RFP must be fully secured and protected by satisfactory security arrangements approved by the Department. The Department and the contractor must establish a joint security management team to accomplish these objectives. The contractor must treat all information obtained through its performance under the contract as confidential information and will not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securing of its rights, or as otherwise provided. State or Federal officials, or representatives of these parties as authorized by State or Federal law or regulations, will have access to all confidential information in accordance with the requirements of State and Federal laws and regulations. The Department will have absolute authority to determine if, and when, any other party is allowed to access R-MMIS information. Confidentiality is the concept that data will be viewable only by those who are explicitly permitted to view it.

The R-MMIS must be compliant with:

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
2. The Privacy Act of 1974;
3. The American Recovery and Reinvestment Act of 2009 (ARRA);
4. New York State Office of Cyber Security and Critical Infrastructure Coordination, Cyber Security Policy P03-002, New York State Information Technology Policies, Standards and Guidelines (http://www.cscic.state.ny.us/lib/policies);
5. New York State Information Technology Policies, Standards and Guidelines G07-001, Identity and Access Management: Trust Model;
6. National Institute of Standards and Technology SP 800 series;
7. The Certification Commission for Health Care Information Technology Security Criteria for 2007 Certification of Inpatient Electronic Health Records (EHRs); and,
8. FIPS publication 140-2 issued May 25, 2001.

The contractor must also meet all privacy and security requirements of HIPAA regulations, and provide training to State and contractor staff on privacy and security procedures.

I.2 SECURITY, PRIVACY AND CONFIDENTIALITY PLAN

The contractor must develop and implement a Security**,** Privacy and Confidentiality Plan approved by the Department for the R-MMIS and all subsequent projects and major system enhancements to address security and privacy issues/risks and the steps that the contractor has taken to ensure these issues/risks will not compromise the operation of the R-MMIS. The plan must be an overarching plan for all levels of security, including but not limited to:

1. HIPAA Security and Privacy;
2. Data Security;

3. Network Security;
4. Application Security; and,
5. Physical Security.

I.2.1 HIPAA Security and Privacy

The contractor must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Privacy Act of 1974 and the American Recovery and Reinvestment Act of 2009 (ARRA).

The contractor must employ systems, procedures and practices that protect the confidentiality of member information. This requirement is not only applicable to the contractor and the contractor's employees, but to subcontractors and service vendors. The contractor must ensure that all employees are aware of the provisions of the Privacy Act of 1974 and the HIPAA Privacy standards and the consequences for violation of those provisions.

The HIPAA privacy rules set a floor of privacy standards. In addition to the Federal standards, New York, has given additional protections of individual privacy rights (e.g., HIV, mental health, and alcohol and substance abuse records). The contractor must comply with all additional protections enacted by the State of New York.

I.2.2 Data Security

The confidential nature of medical data requires that stakeholder access to detail service data must be validated before use. The Department requires that the security of data access be restricted to specified stakeholders. The Department shall determine which stakeholders should have access, and how much data shall be made available to each type of stakeholder. The R-MMIS must be designed to maintain records of attempts to access data whether authorized or not. The contractor must follow all applicable technical standards for site and system security during the takeover. These standards are currently defined in Federal Information Processing Standards Publications 31, 41, and 73 published by the National Technical Information Service, the Privacy Act of 1974, the American Recovery and Reinvestment Act of 2009 (ARRA) and the HIPAA Security standards. As security standards are revised, the contractor is required to meet the revised standards.

Data Security is the concept that data will only be accessible by those who are explicitly permitted to view or receive it. The contractor's proposed security model must be based upon security access roles and organizational affiliation. A role base access control method is one that groups resources (i.e., business activities, business functions, screens) into roles. Employees are then assigned roles based on their need to know information or their need to accomplish a particular business function. A stakeholder's organizational affiliation will also determine what data is available to them.

I.2.3 Network Security

Network Security is the concept of protecting the network components from physical and logical intrusion. The contractor's proposed security model must address, but not be limited to: firewalls, encryption, authentication and interfacing with the State's NYeNet, Human Services Enterprise Network (HSEN) and the Department's HealthCom Network.

The Department is requiring the contractor to install, operate and support a network that meets the security requirements for a Level 3 cryptographic module as defined in Section 5131 of the Information Technology Reform Act of 1996, and further defined FIPS publication 140-2 issued May 25, 2001.

I.2.4 Application Security

The contractor's security model must address areas within application security such as system configuration management, application change management, the physical separation of environments, user ID and passwords, and database security. Applications must not be accessible to any stakeholder unless that stakeholder has the proper role based security code(s).

I.2.5 Physical Security

As part of its plan, the contractor must enforce effective physical security measures for all proposed R-MMIS equipment, sites, processing areas, mail rooms, and storage areas. At a minimum, the contractor must restrict perimeter access to equipment sites, processing areas, mail rooms and storage areas through a card key or other comparable system, as well as provide accountability control to record access, including attempts at access by non-authorized individuals. In addition, the contractor must provide adequate security and safeguards to protect Department and contract employees from harm and to protect all equipment from unauthorized access and harm.

I.3 PROPOSAL REQUIREMENTS

The offeror must discuss in detail its proposed approach to Security**,** Privacy and Confidentiality for the project. The contractor must describe its approach to the development of the Security**,** Privacy and Confidentiality Plan.

Offerors must meet the following proposal requirements:

1. Describe how the Security, Privacy and Confidentiality requirements listed in this RFP will be implemented, addressing at a minimum but not limited to:
    a. HIPAA Security;
    b. HIPAA Privacy;
    c. Data Security;
    d. Network Security;
    e. Application Security;

   f. Physical Security; and,
   g. Role Based Security;
2. Describe how the different components of the proposed architecture (e.g., Web Portal, COTS products, and metadata) will integrate into the proposed security architecture;
3. Describe how you will achieve Level 3 cryptographic module as defined in Section 5131 of the Information Technology Reform Act of 1996, and further defined FIPS publication 140-2 issued May 25, 2001;
4. Describe how breaches in security will be reported, mitigated and how they will be corrected;
5. Describe the organizational structure that will be put into place to track security compliance;
6. Describe any COTS products or tools that will assist in administration of security across all components being proposed;
7. Describe how the security system being proposed will meet the security requirements of HIPAA and preserve the member Protected Health Information (PHI);
8. Describe all audit trails that will be available in the R-MMIS to track changes to data, programs, hardware, etc.;
9. Describe the technical components that comprise the proposed solution including all software (both COTS and custom-developed) and hardware; and,
10. Discuss the solution in terms of its degree of integration, flexibility, scalability, extensibility, supportability/maintainability, and affinity/relationship with other proposed components.

J. FUNCTIONAL REQUIREMENTS

R-MMIS functional requirements described in this section have been designed to support the Department's primary objective to implement a Federally certifiable R-MMIS. To support offeror planning and workload estimation, R-MMIS functional requirements have been divided into three overlapping Functional Phases:

Functional Phase I includes the development and implementation of a Federally-certifiable R-MMIS that meets all Federal and NYS requirements specified in this RFP including enhanced Provider and Pharmacy Benefit Management functionality; support for the Health Insurance Portability and Accountability Act (HIPAA) version 5010 and NCPDP D.0 Electronic Data Interchange (EDI) standards; and implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding.

Functional Phase II includes the implementation of a COTS Financial Management System.

Functional Phase III includes the implementation of capabilities to broaden the application of information technology and system interoperability for Medicaid systems and transition to a MITA maturity level of 3 for most business processes.

The Department is providing offerors the freedom to develop and propose earlier implementations of Functional Phase II and III requirements where it is feasible and would not adversely impact the successful, timely implementation of Functional Phase I requirements.

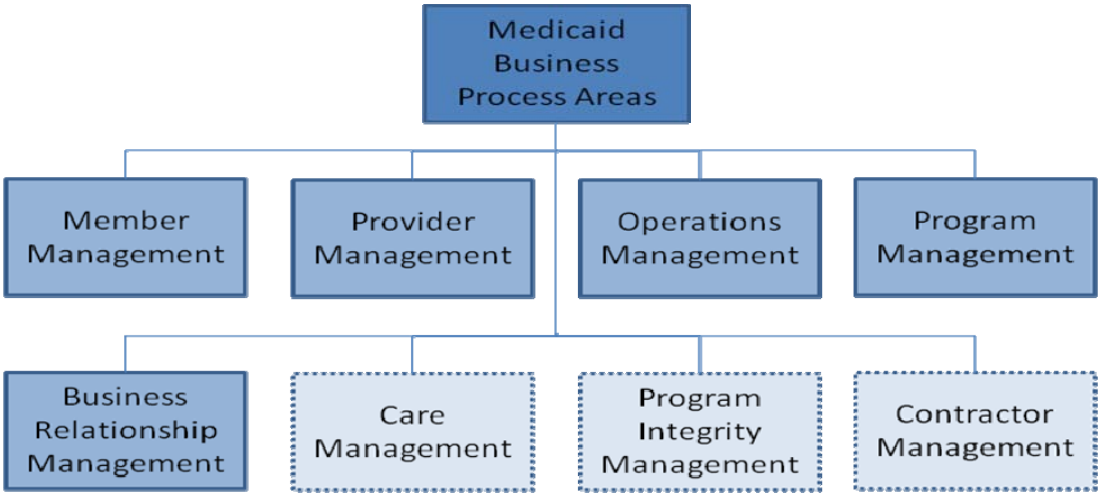
J.1 FUNCTIONAL PHASE I REQUIREMENTS

J.1.1 Overview

During Functional Phase I the contractor must initiate the DDI of a Federally-certifiable R-MMIS in accordance with project management and system development lifecycle methodologies specified in sections III.B and III.C. This phase will include Provider and Pharmacy Benefit Management functionality not supported by the current MMIS and will require an extensive requirements definition period. Functional Phase I requirements also include support for the Health Insurance Portability and Accountability Act (HIPAA) version 5010 and NCPDP D.0 Electronic Data Interchange (EDI) standards.

All functional requirements are organized by the MITA business areas to be supported by the R-MMIS and the contractor. The exhibit below illustrates the structure of these business areas.

Exhibit III-1: R-MMIS MITA Business Area Structure to Support Functional Requirements



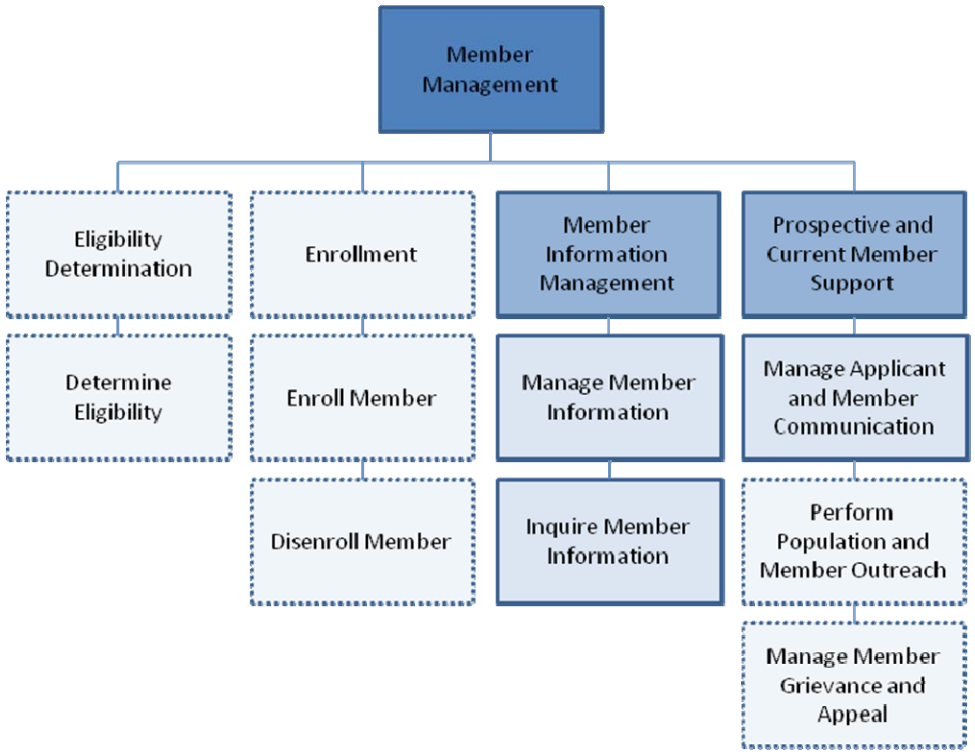
Note: There are no related R-MMIS and-or contractor Functional Requirements in the Care Management, Program Integrity Management and Contractor Management Business Areas.

Offerors must meet all requirements contained in Attachment J Bidder Requirements Traceability Matrix. Offerors must evaluate current functionality by reviewing the supporting documentation found in the Procurement Library, including the As Is Business Process Models and Documentation to ascertain the requirements of the business processes to be supported in the R-MMIS. All requirements are subject to further definition and finalization during the requirements validation task described in section III.C.3.2.

J.1.2 MEMBER MANAGEMENT

The Member Management Business Area is comprised of four sub-business areas: Eligibility Determination, Enrollment, Member Information Management and Prospective and Current Member Support. The R-MMIS will support only two of these: Member Information Management, and Prospective and Current Member Support. In the Member Information Management sub-business area, both the Manage Member Information and Inquire Member Information business processes are supported. In the Prospective and Current Member Support sub-business area, the Manage Applicant and Member Communication business process is supported. Functional R-MMIS requirements are organized based on the MITA business areas, sub-areas and processes illustrated in the exhibit below.

Exhibit III-2: R-MMIS MITA Member Management Business Area



Functional requirements are presented only for those business processes for which there are R-MMIS and contractor requirements (shown by solid borders in this Exhibit).

In New York State, Medicaid Eligibility Determination and Enrollment sub-business areas and their business processes are carried out by the Local Department of Social Services or, in certain circumstances, at a clinic, hospital or State agency. Eligibility determination and enrollment transactions are processed through the Welfare Management System (WMS), the eligibility system developed and maintained by the Office of Temporary and Disability Assistance (OTDA). The WMS is comprised of two separate and distinct eligibility systems: New York City Human Resource Administration and Upstate Social Services Districts and State Agencies.

The WMS is legally the source of record for NYS Medicaid eligibility information and eMedNY maintains its member registry based on the WMS eligibility information. eMedNY receives nightly extracts from the WMS to update the eligibility information registry. The member registry is used by the Medicaid Eligibility Verification System (MEVS) for verifying member eligibility; claims processing and other functions. In addition to eligibility information, the member registry also receives nightly extracts from the WMS for Principal Provider (Long Term Care Facilities), PCP (Managed Care Prepaid Capitation Plans), RRE (member restrictions, exceptions and exemptions).

While the WMS is the source of record for eligibility information, eMedNY captures and maintains additional member information including: Member Managed Care Scope of Benefits, Restricted Transportation, Service Utilization Limits/Thresholds, Co-Pay information and Third

Party Liability information. Third Party Liability information consists of Medicare, Medicare Buy-In, Medicare Savings Program and Commercial Insurance information. NYS is an "SSI auto-accrete" state for the Medicare Part B Buy-In. NYS also has a signed agreement with SSA to auto accrete Qualified Medicare Beneficiaries (QMB) to the Medicare Part A Buy-In.

NYS is in the process of implementing a centralized statewide Enrollment Center that will process applications and renewals for individuals eligible for NYS public health insurance programs based on criteria specified by the Department. The Enrollment Center will augment the role of the local Departments of Social Services (LDSS), by providing additional capacity for the timely processing of enrollments and renewals, among other responsibilities.

It is anticipated that the new Federal health insurance reform initiatives will alter the current eligibility determination and enrollment business processes. These changes may result in the receipt of eligibility information from Federal government and other sources that must be processed to maintain accurate and up-to-date eligibility information.

J.1.2.1 Member Information Management

The Member Information Management business process consists of two business processes:

1. Manage Member Information; and,
2. Inquire Member information.

J.1.2.1.1 Manage Member Information

The Manage Member Information business process maintains the Member registry created based on the eligibility information received from the WMS. This business process also captures and maintains Third Party Liability Information, Managed Care Scope of Benefits, Co-Payments, Restricted Transportation; and Utilization Threshold data. Information in the Member registry maintained by the Manage Member information process supports transaction processing including, but not limited to: claims processing, service authorization, eligibility verification and reporting.

Manage Member Information Proposal Requirements

Offerors must meet the following proposal requirements:

General Proposal Requirements

1. Describe how the R-MMIS will maintain current and historical member information in the Member registry. Specifically address how eligibility information including eligibility spans will be stored.
2. Describe how the R-MMIS will capture member data not received via the WMS interface and how this information will be maintained.
3. Describe how the R-MMIS will:

   a. accept and process inbound eligibility information files from both WMS eligibility systems and update the Member registry;
   b. accept and process the "member 621 eligible" file from OHIP and apply updates to the Member registry; and,
   c. accept and process files with member offender information and apply to the Member registry.
4. Describe how the web-based application will provide the capability to search, inquire on and retrieved member information.
5. Describe how the R-MMIS will produce and transmit files containing case information; member demographics; and member eligibility information to the Third Party Contractor and other entities as needed.

Multiple Member Proposal Requirements

1. Describe how the R-MMIS will accept and process the WMS Multiple ID file with multiple member information and apply corrective actions to the Member registry;
2. Describe how the R-MMIS will maintain a process that automatically identifies members who are suspected of having multiple member IDs for further processing; and,
3. Describe how the web-based application will provide the capability to search for, inquire on, update, link and unlink members identified as having suspected multiple member IDs.

Co-Pay Proposal Requirements

1. Describe how the R-MMIS will initialize Co-Pay amounts annually for each member; and,
2. Describe how the R-MMIS will identify members who are exempt from Co-Pay or have reached their annual Co-Pay limit.

Utilization Threshold Proposal Requirements

1. Describe how the R-MMIS will initialize utilization limits annually for each member;
2. Describe how the R-MMIS will maintain UT information for members; and,
3. Describe how the R-MMIS will accept and process utilization threshold limits file(s) and update the Member registry.

Common Benefit Identification Card (CBIC) Proposal Requirements

1. Describe how the R-MMIS will accept, process and respond to CBIC card transactions;
2. Describe how the R-MMIS will identify CBIC cards which have been swiped for the first time and how the first time transactions will be captured and transmitted to the OTDA CBIC IT unit; and,
3. Describe how the web-based application will provide the capability to view and inquire on CBIC information.

Reconciliation Proposal Requirement

1. Describe how the R-MMIS will accept and process inbound reconciliation files from both WMS eligibility systems to support the reconciliation process.

Managed Care Proposal Requirements

1. Describe how the R-MMIS will accept and process files received from WMS with Managed Care Enrollment information and apply to the Member registry.
2. Describe how the R-MMIS will maintain current and historical Managed Care member information in the Member registry.
3. Describe how the web-based application will provide the capability to view, inquire on, add, change and delete Managed Care benefit plan information.
4. Describe how the R-MMIS will:
    a. produce and transmit a file for the Manage Care Broker of Manage Care members whose eligibility has been added, modified or removed; and,
    b. produce and transmit a file to the WMS containing updates made to the Manage Care Scope of Benefits information.

Medicare, Buy-In and Medicare Savings Program Information General Proposal Requirement

1. Describe how the R-MMIS will maintain current and historical Medicare Eligibility information in the Member Registry.

Medicare Proposal Requirements

1. Describe how the R-MMIS will process Medicare Information.
2. Describe how the R-MMIS will:
    a. accept and process the monthly TPL Contractor Resource update file from the Third Party Contractor to update the Member Registry; and,
    b. accept and process the daily Electronic Eligibility Decision Support System (EEDSS) Resource Update File from WMS to update the Member Registry.
3. Describe how the web-based application will support inquiring on, entering and updating Medicare information.

Buy-In Proposal Requirements

1. Describe how the R-MMIS will perform CMS Medicare Buy-In functions.
2. Describe how the R-MMIS will:
    a. accept and process the daily Buy-In response file from CMS to update the Member Registry;
    b. accept and process the Buy-In monthly billing file from CMS; and,
    c. accept and process the monthly SDX file from WMS to update the Member Registry.
3. Describe how the web-based application will support inquiring on, entering and updating Buy-In and Medicare Saving Program information.
4. Describe how the R-MMIS will track and audit all transactions related to Buy-In.
5. Describe how the R-MMIS will produce and transmit a daily TPL Buy-In Part A and a TPL Buy In Part B file for CMS.

Medicare Modernization Act (MMA) (Part A, Part B, Part C and Part D) Proposal Requirements

1. Describe how the R-MMIS will:
    a. automatically identify current and prospective dual eligible members;
    b. automatically produce and transmit the MMA File to CMS;

   c. automatically accept and process the MMA File received from CMS;
   d. automatically process and maintain Medicare data from the MMA file as specified by the Department; and,
   e. automatically terminate Medicare Part D entitlement when all Medicare eligibility has ended.
2. Describe how the R-MMIS will:
   a. obtain and process all Medicare Part C Advantage Plan and the Medicare Part D Prescription Plan information from CMS; and,
   b. create and maintain registries with Medicare Part C Advantage Plan and the Medicare Part D Plan information.
3. Describe how the R-MMIS will maintain crosswalk between:
   a. Contract IDs, Carrier Name and current Carrier Code for Medicare Part D Plan information; and,
   b. Contract IDs, Carrier Name and current Carrier Code for Medicare Part C Plan information.
4. Describe how the web-based application will provide the capability to:
   a. inquire on Medicare Part D and Medicare Part C Contract ID and Benefit Plan ID information without navigating to another area of the web-based application; and,
   b. inquire on, enter and update Medicare Part D information.
5. Describe how the R-MMIS will produce and transmit a file to WMS to generate the "Reduction In Benefit" notification letter.

Commercial Insurance Proposal Requirements

1. Describe how the R-MMIS will:
   a. maintain current and historical Commercial Insurance, Carrier Data and Employer Data information in the Member Registry; and,
   b. track and maintain an audit trail for all transactions related to Commercial Insurance.
2. Describe how the R-MMIS will:
   a. accept and process the Third Party Liability Contractor Resource update file received from the Third Party contractor to update the Member Registry;
   b. accept and process the Personal Injury Clearing House information file received from within the Department;
   c. accept and process the daily EEDSS Resource Update File received from WMS to update the Member Registry; and,
   d. accept and process the SSI Referral file received from SSA.
3. Describe how the R-MMIS will maintain the integrity of Commercial Insurance information based on a hierarchy of business rules established by the Department.
4. Describe the process the R-MMIS will use to automatically create and close Medicare Part C records based on Department rules.
5. Describe how the web-based application will:
   a. support entering, inquiring on and updating Commercial Insurance, Carrier data, and Employer data;
   b. support performing mass changes to Carrier data;
   c. maintain a "Good Cause" indicator; and,

d. provide the capability to enter and maintain text notes associated with the Commercial Insurance information.

J.1.2.1.2 Inquire Member Information

The Inquire Member Information business process includes providing and maintaining a Medicaid Eligibility Verification system that allows providers to verify member eligibility 24 hours a day, 7 days a week through all available channels.

Inquire Member Information Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will provide a Medicaid Eligibility Verification System (MEVS) to accept and respond to member eligibility inquiries;
2. Describe how the R-MMIS eligibility verification system will support the variety of access channels; and,
3. Describe how the R-MMIS will accept, process and respond to electronic eligibility inquiry transactions.

J.1.2.2 Prospective and Current Member Support

The Prospective and Current Member Support sub-business area consists of three business processes. The MMIS will support only the Manage Applicant and Member Communication. This business process includes member notifications and letters generated by the MMIS.

Manage Applicant and Member Communication Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will:
    a. automatically generate letters to members who have reached their Co-Pay maximum amount; and,
    b. automatically generate letters regarding Third Party status changes;
2. Describe how the R-MMIS will provide the capability to request (including sort options) and generate member address labels based on a variety of member attributes via the web-based application; and,
3. Describe the types of member support material to be included on the web portal.

J.1.3 Provider Management

The Provider Management business area contains the source of information for Medicaid and other Department health insurance program providers and provider groups, service bureaus, trading partners, and applicants for provider enrollment. The Provider Management business area is comprised of the following three sub-business areas:

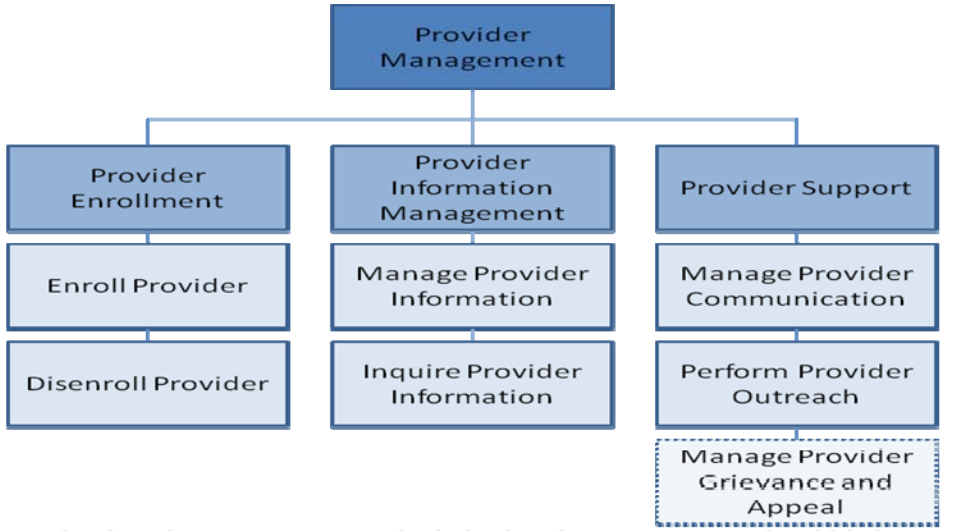
Provider Enrollment includes business processes necessary for processing provider enrollment applications, maintaining provider information, and recertifying and disenrolling providers.

Provider Information Management includes processes necessary to maintain the Provider Registry and respond to inquiries related to provider enrollment and status information. The Provider Registry contains provider information, enrollment status, category-of-service data, associates individual providers with their related organizations, associates group and individual providers, and maintains provider taxpayer information. Information is also carried for service bureaus and trading partners is also contained on the Provider Registry.

Provider Support includes processes necessary to support providers through providing access to current program information, provider manuals, training, responding to inquiries from providers, and performing provider outreach.

Functional requirements are presented only for those business processes for which there are R-MMIS and contractor requirements. Functional requirements are organized based on MITA business domains illustrated in the exhibit below.

Exhibit III-3 R-MMIS MITA Provider Management Business Area



Functional requirements are presented only for those business processes for which there are R-MMIS and contractor requirements (shown by solid borders in this Exhibit).

J.1.3.1 Provider Enrollment

The Provider Enrollment sub-business area includes the business processes for enrolling and disenrolling Medicaid providers. This includes the receipt and processing of provider enrollment applications in accordance with State and Federal requirements.

There are a number of areas crucial to understanding and responding to the functional requirements specified in Attachment J Bidder Requirements Traceability Matrix. They include:

Implementation of the National Provider Identifier (NPI)

The implementation of the NPI resulted in the addition of an organizational level (entity) between the Taxpayer and Provider Identifier (either NPI or MMIS Provider ID). This level is automatically created during the Provider Enrollment Process, but can be changed to allow the Provider Identifier to be reassigned to another existing entity. The entity is used during claims processing for a variety of purposes including the identification of Prior Authorizations/Approvals which may have been processed under an associated Provider Identifier and the identification of potential duplicate services provided under an associated Provider Identifier.

Providers Not Qualified for NPI

There are a variety of providers that are enrolled in Medicaid that don't qualify for a National Provider Identifier (NPI). These providers are assigned a proprietary MMIS Provider Identifier that must be accommodated in the proposed system.

Creation of Internal Provider Identifiers

Currently all NPIs have a corresponding internal Provider Identifier. During NPI implementation, providers were allowed to consolidate or expand existing proprietary MMIS Provider Identifiers without re-enrolling. In order to accomplish this, NPIs that required consolidation or expansion resulted in the creation of new internal Provider Identifiers with links to their original internal Provider Identifier. These links must be accommodated in any proposed solution because they are critical to processing and maintaining a complete history.

Single Provider Registry

Currently information related to service providers, participating plans, service bureaus, and HIPP payees are stored in a single registry. Solutions that propose maintaining separate repositories for these must identify a conversion strategy for this information.

J.1.3.1.1 Enroll Provider

The Enroll Provider business process is responsible for managing providers' enrollment in programs, including the receipt of enrollment applications; processing of applications; primary source verification of provider credentials and sanction status with external entities; determining contracting parameters (i.e., category of service for which the provider can bill); establishing payment rates and funding sources; and supporting receipt of program Managed Care Plans service providers.

Enroll Provider Proposal Requirements

Offerors must meet the following proposal requirements:

General Proposal Requirements

1. Describe how the R-MMIS will:
    a. support the provider enrollment activities for the variety of provider types; and,
    b. capture enrollment information and provide the flexibility to respond to changes in information requirements;
2. Describe the process for accepting provider enrollment applications and supporting materials through each channel;
3. Describe the tools and methodology proposed for retrieving and batching provider enrollment files;
4. Describe how the R-MMIS will process files for mass enrolling Managed Care network providers; and,
5. Describe how the R-MMIS will support the provider recertification process.

Enrollment Application Process: Hard Copy or Fax Proposal Requirements

1. Describe how the R-MMIS will:
    a. provide and integrate the imaging, OCR, data entry, editing and verification of enrollment applications and supporting materials;
    b. electronically associate enrollment applications and all supporting materials. In particular, describe how supporting materials received prior to or after the original application will be associated; and,
    c. route enrollment applications and all supporting materials through the Workflow Management System and the features that will be used.
2. Describe the method that will be used to generate receipt notices for enrollment applications and propose information to be included in the notice. Specifically address the notification process for applications that do not contain an email address and for handling email delivery failures.

Enrollment Application Process: Provider Area of the Web Portal Proposal Requirements

1. Describe how the web portal user interface will allow providers to:
    a. enter application information (specifically address the method for customizing the data requirements by COS while minimizing the maintenance effort as data requirements change);
    b. upload supporting materials in industry standard formats;
    c. modify, save and delete application information prior to submission; and,
    d. review and print application information.
2. Describe how provider area of the web portal will accommodate inquiries on provider enrollment transactions;
3. Describe the method to be used for developing and maintaining the business rules to enforce the required edits. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change. Address the way in which the user interface will return and identify errors.

4. Describe how the application and supporting materials will be routed using the Workflow Management System. Describe the method that will be used to generate receipt notices for enrollment applications, propose information to be included in the notice. Specifically address the process for handling email delivery failures.

Application Processing Proposal Requirements

1. Describe how the web-based application will:
    a. support the enrollment application review process (specifically identify the integration with any COTS tools);
    b. provide the capability to enter and maintain text notes associated with the enrollment application;
    c. display the message and process the request to combine provider information when a new application is submitted for an already enrolled NPI.
2. Describe the process for tracking enrollment applications and the features of the Workflow Management System to be used.
3. Describe how the R-MMIS will electronically associate and route supporting materials. In particular, describe how supporting materials received after the original application will be associated.
4. Describe how the R-MMIS will:
    a. ensure that enrollment status, assigned data identifiers and all related enrollment data is immediately available in the Provider registry; and,
    b. maintain information from approved and denied applications.
5. Describe the process for implementing electronic verification interfaces. Specifically address how the electronic verification will be integrated into the web-based application and how data received through the interface will be stored and maintained.
6. Describe how the provider area of the web portal will support uploading supporting materials for previously submitted enrollment applications; associate the materials with the application and route through the Workflow Management System.

J.1.3.1.2 Disenroll Provider

The Disenroll Provider business process manages providers' disenrollment from Categories of Service. Disenrollment requests can be: initiated by the provider; due to receipt of information about a provider's death or corporate dissolution; due to sanction or other disciplinary action; due to a failure to maintain required licenses or certification; or due to inactivity. The R-MMIS must tracks disenrollment requests throughout the process including monitoring the status of the request. The process includes validation that the disenrollment meets Department business rules for substantiating the basis for disenrollment.

Disenroll Provider Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the process for accepting provider disenrollment requests through each channel.
2. Describe how the R-MMIS will:
    a. image and index hard copy and fax disenrollment requests;

b. route disenrollment requests for processing via the Workflow Management System;
c. track disenrollment requests through all steps in the disenrollment process; and,
d. automatically end date information associated with the terminated enrollment.

3. Describe the process to automatically disenroll providers based on provider related criteria or based on files received.
4. Describe how the web-based application will support the processing of:
   a. disenrollment requests received from the provider; and
   b. disenrollment requests received from external agencies.
5. Describe how providers will enter disenrollment requests via the provider area of the web portal and how those requests will be routed for processing via the Workflow Management System.

J.1.3.2 Provider Information Management Requirements

The Provider Information Management sub-business area includes managing all operational aspects of the Provider Registry which is the source of information about prospective, enrolled, and disenrolled providers. The provider registry is the "source of truth" for provider demographic, business, credentialing, enumeration, payment processing, and tax information.

Two areas are crucial to understanding and responding to the functional requirements specified in Bidder Requirements Traceability Matrix. They are:

1. The Entity level between the Taxpayer and Provider Identifier (either NPI or MMIS Provider Identifier) assigned during enrollment can be changed to allow the Provider Identifier to be reassigned to another existing Entity. The linkage between entity, taxpayer and provider identifier must allow for date specific association periods;
2. Internal Provider Identifiers maintain the links to the original MMIS Provider Identifiers for processing transactions against history. These links are critical to maintaining a complete history and must be accommodated in any proposed solution.

J.1.3.2.1 Manage Provider Information

The Manage Provider Information business process is responsible for managing all operational aspects of the Provider Registry, which is the source of comprehensive information about providers. The Provider Registry is the Medicaid enterprise "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. In addition, the Provider Registry stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses. The Provider Registry validates data upload requests, applies business rules, and tracks activity.

Manage Provider Information Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will maintain:
    a. information related to an enrolled provider;
    b. facility information related to an enrolled provider; and
    c. Public Goods Pool information related to an enrolled provider.
2. Describe how the R-MMIS will maintain information received from external sources for both enrolled and unenrolled service providers.
3. Describe the process for accepting provider maintenance updates through each channel.
4. Describe how the R-MMIS will track maintenance requests through all steps in the maintenance process.
5. Describe how alerts related to licensing and/or certification will be provided using the Workflow Management System.
6. Describe how the web-based application will:
    a. support the review and update of provider information;
    b. provide the capability to view, add and update provider information;
    c. support the inquiry on and update of information received from external sources for unenrolled service providers;
    d. allow the maintenance of the associations (affiliations) between various providers and the information related to that relationship;
    e. provide the capability to enter and maintain text notes associated with the enrollment application; and,
    f. display the message and process the request to combine all provider information when processing maintenance requests for providers changing their NPI.
7. Describe how the batch process will maintain the associations (affiliations) between various providers and the information related to that relationship.
8. Describe how the R-MMIS will produce and transmit extract files to external entities containing provider information in a format and at a frequency specified by the Department.

Maintenance Requests - Hard Copy Proposal Requirements

1. Describe how the R-MMIS will image and index hard copy or fax provider information maintenance requests. Describe how these requests will be routed for processing via the Workflow Management System.

Maintenance Requests - Provider Area of the Web Portal Proposal Requirements

1. Describe how the R-MMIS will associate supporting materials with provider maintenance requests and route them through the Workflow Management System.
2. Describe how the provider area of the web portal will:
    a. allow maintenance requests and supporting materials to be modified, saved and deleted prior to submission;
    b. allow maintenance requests and supporting materials to be reviewed and printed; and,
    c. support the uploading of materials in industry standard formats.
3. Describe the web portal user interface proposed for maintaining provider information. Specifically address the method for minimizing the maintenance effort required to modify the contents of the user interface. Describe how the R-MMIS will flag

information that has been modified through the provider area of the web portal for review and route through the Workflow Management System.

4. Describe the method to be used for developing and maintaining the business rules to enforce the required edits. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change. Address the way in which the user interface will return and identify errors.
5. Describe the method that will be used to generate receipt notices for provider maintenance transactions and propose information to be included in the notice. Specifically address the process for handling email delivery failures.

J.1.3.2.2 Inquire Provider Information

The Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business associates.

Inquire Provider Information Proposal Requirement

Offerors must meet the following proposal requirement:

1. Describe how the R-MMIS will respond to requests for provider enrollment status and other provider information from providers, stakeholders, or business associates via the provider area of the web portal and the Customer Service Center.

J.1.3.3 Provider Support Requirements

The Provider Support sub-business area is comprised of the Manage Provider Communications and Performing Provider Outreach business processes.

J.1.3.3.1 Manage Provider Communication

The Manage Provider Communication business process receives requests for information, provider publications, and assistance from prospective and current providers. For example, inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched; responses are developed and produced for distribution via Send Outbound Transaction process. Note: Inquires from prospective and current providers are handled by the Manage Provider Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications.

Manage Provider Communication Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the method that will be used to generate letters and/or electronic notifications to provider applicants and enrollees.

2. Describe the process for:
    a. producing and distributing correspondence related to the provider enrollment process;
    b. automatically producing and distributing correspondence related to changes in provider enrollment status including appeal rights when a provider is suspended or terminated;
    c. automatically producing and distributing correspondence related expiring licenses and certifications.
3. Describe how the R-MMIS will generate and track recertification notices.
4. Describe how the R-MMIS will support the capability to tailor standard letters and electronic messages.
5. Describe the process for providers to:
    a. order Department forms through the provider area of the web portal and track the order from receipt through fulfillment with order tracking available via the provider area of the web portal; and,
    b. automatically generate orders for Department forms based on the provider's inventory levels and how the inventory level will be maintained.

J.1.3.3.2 Perform Provider Outreach

The Perform Provider Outreach business process originates internally within the Agency in response to multiple activities (e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, and changes in the Medicaid program policies and procedures). For Prospective Providers not currently enrolled, provider outreach information is developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers). For Providers currently enrolled, information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction. All outreach communications and information package production and distribution is tracked and materials archived according to State archive rules.

Perform Provider Outreach Proposal Requirements

Offerors must meet the following proposal requirements:

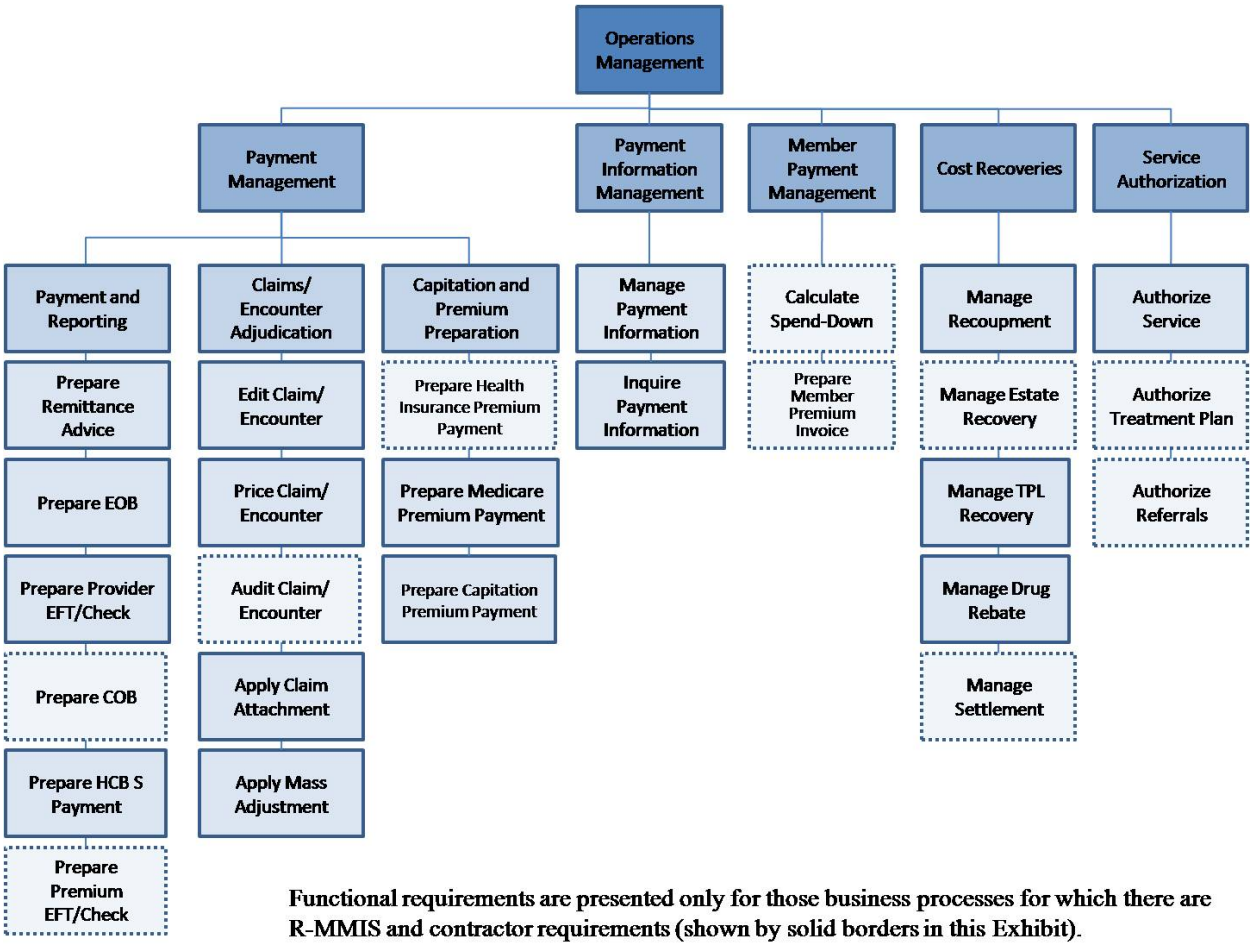
1. Describe how provider support material will be maintained on the provider area of the web portal and the process for review, approval and posting;
2. Describe the methods proposed to display and archive alert messages on the provider area of the web portal; and,
3. Describe the process proposed to send electronic alerts targeted to specific providers.

J.1.4 OPERATIONS MANAGEMENT

The Operations Management business area is comprised of five (5) sub-business areas: Payment Management which is sub-divided into Claim/Encounter Adjudication, Payment and Reporting, and Capitation and Premium Preparation; Payment Information Management; Member Payment Management; Cost Recoveries; and Service Authorization. The R-MMIS will support business processes in all sub-business areas except Member Payment Management.

These are the core business transaction processes of the R-MMIS running the gamut from service authorization to claims adjudication to payment that enforce NYS policy related to coverage and pricing of Medicaid services. The functional requirements for each business process represent the complex and unique nature of NYS Medicaid. They are organized based on MITA business areas illustrated in the exhibit below.

Exhibit III-4 R-MMIS MITA Operations Management Business Area



Functional requirements are presented only for those business processes for which there are R-MMIS and contractor requirements (shown by solid borders in this Exhibit).

J.1.4.1 Service Authorization

In NYS, the Authorize Service business process of the Service Authorization business area is split into three major component processes: Prior Approval, Prior Authorization and Service Authorization. While transactions for each of these components are submitted using the same HIPAA X-12 transaction or the appropriate paper transaction, processing requirements vary based on the type of service authorization being requested.

Prior Approval processing is used for specific services that require professional review before the practitioner is authorized to provide the service or supply item.

Prior Authorization processing is used when automated rules can be invoked to make the determination for specific services without professional review.

Service Authorization processing is used to determine whether the member has sufficient utilization credits available for the services to be provided. The Service Authorization process also supports the fraud-avoidance Post and Clear and Card Swipe initiatives.

Prior Approval, Prior Authorization and Service Authorization General Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the process for supporting Authorizations through each channel.
2. Describe how prior approval, prior authorization and service authorizations with date specific history will be maintained in the Authorization registry.
3. Describe how the R-MMIS will:
    a. accept, process and respond to authorizations received in the each format;
    b. allow multiple procedures and procedure types and/or modifiers in a single prior approval/authorization;
    c. provide the ability to authorize several periods of time with different procedures within a single prior approval/authorization.
4. Describe the method to be used for developing and maintaining the business rules to enforce the required Prior Approval, Prior Authorization and Service Authorization edits including the role of the business rules engine. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change.
5. Describe how the web-based application will provide the capability to enter criteria based individual or mass authorizations updates.

J.1.4.1.1 Prior Approvals

Prior Approval processing is used for transactions that require professional review and approval to authorize the service. The Prior Approval should be obtained before the servicing provider performs the specified service and must be approved prior to claims payment. Upon

submission, Prior Approvals are issued a Prior Approval Number used to track the request that must be included by servicing providers on the claim(s).

Depending on the specific services, these professional reviews are performed by staff from the following organizations:

1. Department of Health;
2. Fiscal Agent review staff;
3. Other external review staff; and,
4. Local Social Service Districts.

Prior Approval Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will:
    a. accept and process real time prior approval transactions received from the Preferred Drug Program, Clinical Drug Review Program or other pharmacy prior authorization programs as determined by the Department;
    b. process electronic prior approvals received via the IVR;
    c. process electronic prior approvals in HIPAA X12 standard and NYS proprietary formats;
    d. assign a unique PA number to each prior approval and use that number for tracking and monitoring purposes;
    e. track prior approvals using the Workflow Management System;
    f. enter and maintain text notes associated for each service line and document for all prior approval formats; and,
    g. capture name and address information on transportation prior approvals when submitted using 5010 standards;
2. Describe how the R-MMIS will process dental prior approval transactions with dental specific data including but not limited to: tooth, site, arch, quadrant as determined by the Department. Specifically address the proposed use of any commercially available packages for dental prior approvals;
3. Describe how the R-MMIS will:
    a. override prior approval requirements based on prescriber specialty, dispensing provider qualifications or other criteria established by the Department;
    b. establish a prior approval that will override one type of service restriction, a combination of service restrictions, and to establish multiple prior approvals for the same service to override multiple service restrictions separately; and,
    c. automatically apply an effective time period for prior approvals; and,
4. Describe how the R-MMIS will produce Rosters for specific prior approval types.

Prior Approvals - Paper Proposal Requirements

1. Describe how the R-MMIS will provide and integrate the imaging, OCR, data entry, editing and verification of paper prior approvals; and,

2. Describe how paper prior approvals will be routed and tracked using the Workflow Management System.

Prior Approvals – Supporting Materials Proposal Requirements

1. Describe how the R-MMIS will electronically associate prior approvals and all supporting materials. In particular, describe how supporting materials received prior to or after the original application will be associated; and,
2. Describe how the R-MMIS will convert x-rays and other radiological films to digital images of a quality usable by the Department for medical review.

Prior Approvals - Electronic Proposal Requirements

1. Describe how the R-MMIS will support a process allowing Local Department of Social Services (LDSS) and other authorized entities to submit prior approval requests electronically in proprietary formats; and,
2. Describe how the Workflow Management System would be used for routing and tracking electronic prior approvals.

Prior Approvals - Web-Based Application Proposal Requirement

1. Describe how the web-based application will allow users to perform prior approval functions including: entering prior approvals, reviewing and making determinations; accessing prior approvals and all supporting materials; inquiring on and updating existing prior approvals; and entering and maintaining text notes associated with the prior approval. Particular attention should be focused on the application's ease of use and support for the medical, dental and pharmacy review.

Prior Approvals - Provider Area of Web Portal Proposal Requirements

1. Describe how the provider area of the web portal will:
    a. provide the capability for providers to enter and submit prior approvals;
    b. support the uploading of documents in industry standard formats;
    c. allow prior approval information and supporting materials to be modified, saved and deleted prior to submission;
    d. allow prior approval information and supporting materials to be reviewed and printed.
2. Describe the method to be used for developing and maintaining the business rules to enforce the required edits including the role of the business rules engine. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change.
3. Describe how prior approvals will be routed and tracked using the Workflow Management System.
4. Describe how the R-MMIS will electronically associate prior approvals and all supporting materials. In particular, describe how supporting materials received prior to or after the original prior approval will be associated.

Prior Approval Notifications Proposal Requirements

1. Describe how the R-MMIS will produce notifications to providers and members regarding: finalized prior approvals; missing information on prior approvals; and pending prior approvals; and,
2. Describe how the R-MMIS will produce notifications on demand to providers and members regarding prior approval information.

J.1.4.1.2 Prior Authorization

Prior Authorization processing is used when the determination regarding specific services can be made automatically by the application of a set of business rules. These rules are based upon information contained in the transaction, member information, medical history and other criteria. The specific services involved and the business rules are subject to frequent change that must be quickly accommodated within the R-MMIS. If the Prior Authorization is approved based on the business rules, a Prior Authorization Number is issued and must be included by servicing providers on the claim(s).

Prior Authorizations - Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will:
    a. accept and process real time prior authorization requests received from the IVR;
    b. assign a unique PA number to each prior authorization and use that number for tracking and monitoring purposes;
    c. automatically enforce Department defined business rules to make determinations on prior authorization requests; and,
    d. provide the flexible capability to modify, add and delete criteria used for prior authorization request.

Prior Authorizations - Provider Area of Web Portal - Proposal Requirements

1. Describe how the provider area of the web portal will:
    a. allow providers to enter prior authorization requests and cancel prior authorization requests;
    b. allow prior authorization information and supporting materials to be modified, saved and deleted prior to submission; and,
    c. allow prior authorization information and supporting materials to be reviewed and printed.
2. Describe the method to be used for developing and maintaining the business rules to enforce the required edits including the role of the business rules engine. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change.

Prior Authorizations - Web-Based Application Proposal Requirement

1. Describe how the web-based application will support searching, inquiring on, entering, and updating prior authorization information.

J.1.4.1.3 Service Authorization

Service Authorization processing is part of the management of each member's utilization of Medicaid services. Members are assigned utilization levels for different types of services (e.g., pharmacy, lab, and physician) based on the Member's Clinical Risk Group (CRG). Ordering provider service authorizations verify that sufficient utilization levels are available for ordered services and reserve the service units. Dispensing/servicing provider service authorizations check to determine whether the service has been reserved by the ordering provider and, if no service has been reserved, verify that sufficient utilization levels are available for service and reserve the service units.

Service Authorizations are used for the Post & Clear and Card Swipe Fraud avoidance processes. Posting providers are required to obtain service authorizations for specific ordered services that must then be cleared by the dispensing/servicing provider. Mandatory Card Swipe providers are required to obtain service authorizations using POS devices supplied by the Office of the Medicaid Inspector General (OMIG) to swipe the member's card at the time service is provided. Providers may be Post & Clear, Card Swipe or both.

Service Authorization Proposal Requirements

Offerors must meet the following proposal requirements:

Service Authorization - Systems Requirements Proposal Requirement

1. Describe how the R-MMIS will assign a unique SA number to each service authorization request and use that number for tracking and monitoring purposes.

Service Authorizations - Provider Area of Web Portal Proposal Requirements

1. Describe how the provider area of the web portal will:
    a. allow providers to enter service authorization requests and cancel service authorization requests after submission;
    b. allow service authorization information to be modified, saved and deleted prior to submission; and,
    c. allow service authorization information to be reviewed and printed prior to and after submission.
2. Describe the method to be used for developing and maintaining the business rules to enforce the required edits including the role of the business rules engine. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change.

Service Authorizations - Web-Based Application Proposal Requirements

1. Describe how the web-based application will support the capability for users to search, inquire on, add and cancel service authorizations.

Utilization Threshold - Proposal Requirements

1. Describe the process the R-MMIS will provide the capability to:

a. determine Utilization Threshold applicability;
b. replenish UT limits when a service authorization is cancelled or a claim is voided/adjusted;

2. Describe how the web-based application will provide the capability to inquire on and update UT information; and,
3. Describe how the R-MMIS will produce notifications to members regarding Utilization Threshold Information.

Threshold Override Application - Proposal Requirements

1. Describe how the R-MMIS will:
   a. provide and integrate the imaging, OCR, data entry, editing and verification of TOAs;
   b. automatically approve or reject TOA applications based on Department defined business rules;
   c. assign a unique TOA number to each threshold override application and use that number for tracking and monitoring purposes; and,
   d. provide routing and tracking of TOAs using the Workflow Management System.
2. Describe how the R-MMIS will electronically associate TOA applications and all supporting materials. In particular, describe how supporting materials received prior to or after the original TOA application will be associated.
3. Describe how the R-MMIS will produce notifications to members and providers regarding TOA information.
4. Describe how the web-based application will:
   a. provide the capability to perform TOA functions; and,
   b. allow users to search, inquire on and update TOA information.
5. Describe how the provider area of the web portal will allow providers to:
   a. enter TOA applications and cancel TOA applications; and,
   b. search, inquire on and view TOA application information.

Post and Clear - Proposal Requirements

1. Describe how the R-MMIS will support a Post/Clear and Card Swipe process. Specifically address Post Only, Post and Card Swipe and Card Swipe; and,
2. Describe how the web-based application will provide the capability to inquire on posted member services.

J.1.4.2 Payment Management

The Payment Management sub-business area is further broken down into three sub-business areas including: the Claims/Encounter Adjudication, Payment and Reporting; and Capitation and Premium Payments. This sub-business area contains the core business processes responsible for processing claims/encounters for Medicaid services and payments to providers and health insurance plans.

J.1.4.2.1 Claims/Encounter Adjudication Requirements

In the Claims Adjudication sub-business area, the R-MMIS will support the Edit Claim/Encounter, Price Claim, Apply Claim Attachment and Apply Mass Adjustment business processes. These business processes encompass all the claims and encounter processing.

A key requirement is the use of Rate Codes for processing and pricing institutional claims. The rate code and service location zip plus 4 submitted on the claim are used to retrieve the correct reimbursement amount.

Claims processing is performed at the document level rather than the line level. In document level processing, all lines of a multi-line claim must be adjudicated (either paid or denied) for the claim to finish adjudication. If any lines are pended, the entire claim is pended.

Claims/Encounter Adjudication Proposal Requirements

Offerors must meet the following proposal requirements:

Claims/Encounter Adjudication General Proposal Requirements

1. Describe the process for accepting:
    a. claims transactions through each channel;
    b. encounter transactions through each channel;
2. Describe how the R-MMIS will capture claims/encounters adjudication information. Specifically address the maintenance of adjudication related information;
3. Describe how the R-MMIS will store adjudicated claim/encounter transactions based on the Department requirements. Specifically address the method for retrieving archived transactions required for processing adjustments, voids, and other transactions (including retroactive-rate adjustments);
4. Describe how the R-MMIS will assign a unique control number to each claim/encounter and use that number for tracking and monitoring purposes;
5. Describe how the R-MMIS will:
    a. maintain the member's Utilization Threshold information for both claimed service units used and those returned by a void or adjustment;
    b. maintain the member's Co-Pay information for claims, adjustments and voids; and,
    c. update Prior Approval, Prior Authorization, and Service Authorization information upon final adjudication of the claim including recording both service units used and those returned by a void or adjustment;
6. Describe how the R-MMIS will process ordered ambulatory claims submitted in the 837I Institutional claim format as a Professional claims;
7. Describe how the web-based application will support inquiry and review of the claim/encounter and adjudication information (including images for paper claims and attachments); adjustment and void information; provider information (e.g., billing provider, servicing provider, ordering provider, and referring provider); and member information. Specifically describe the search capabilities and method for accessing

related provider and member information not included on the claim/encounter (e.g., provider contact information; and member eligibility information);
8. Describe the tools and methodology proposed for retrieving and producing claims information.

Electronic Claims Proposal Requirements

1. Describe how the R-MMIS will accept, process, respond to and capture information from HIPAA standard electronic claims transactions;
2. Describe how the R-MMIS will process electronic encounter transactions received in a proprietary format; and,
3. Describe how the R-MMIS will provide the capability to process and respond to all electronic claim transactions in real time using HIPAA standard formats based on industry standards and Department requirements.

Pharmacy Benefit Management - NCPDP Claims Proposal Requirements

1. Describe how the R-MMIS will process NCPDP claims from providers participating in special New York State medication coverage programs where the providers are enrolled only with a proprietary Provider Identifier;
2. Describe how the R-MMIS will issue rejections or warnings for conflicts detected by ProDUR edits;
3. Identify and describe the current participating pharmacy available overrides used by its pharmacy claims adjudication system and how overrides from participating pharmacies and messaging to participating pharmacies would be tracked, monitored and reported to the Department;
4. Describe how the R-MMIS will reject pharmacy claims exceeding limits;
5. Describe how the R-MMIS will perform interactive messaging and use text messages in free text format and override codes as defined by NCPDP standards;
6. Describe how the R-MMIS claims processing will facilitate consistent and accurate application of the Program's mandatory generic substitution provisions;
7. Detail how the R-MMIS will distinguish between A-rated generic drugs and authorized generic drugs requiring generic substitution, A-rated generics not requiring substitution including, but not limited to NTI drugs and non-A-rated generic drugs. Describe the capability the R-MMIS to appropriately price, but not enforce generic substitution for non-A-rated generic drugs, NTI drugs, or for available A rated generic drugs that the Department has directed the contractor not to enforce the Program's mandatory generic substitution requirement; and,
8. Describe how the R-MMIS will provide medical limit and step therapy editing for pharmacy claims with prescriptions falling outside the approved parameters automatically identified as requiring prior approval (PA). Describe how the proposed solution, including the use of commercially available packages, will easily adapt to changing edit requirements and is designed to enforce edits based on a variety of combinations of parameters including but not limited to: frequency, quantity and duration of therapy for selected drugs or drug classes; and diagnostic, medical and member data.

Provider Area of the Web Portal Proposal Requirements

1. Describe the web portal user interface proposed for providers to process claims and uploading supporting materials. Address the way in which the user interface will return and identify errors; and,
2. Describe the method to be used for developing, maintaining and changing the business rules to enforce the required edits including the role of the business rules engine. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change.

Paper Claims Proposal Requirements

1. Describe how the R-MMIS will:
    a. provide and integrate the imaging, OCR, data entry, editing and verification of paper claims;
    b. accept, process and capture information from paper claim forms; and,
    c. electronically associate images of paper claims with electronic claim information.

Adjustment and Void Processing Proposal Requirements

1. Describe how the R-MMIS will:
    a. perform adjustments or voids on previously adjudicated claims/encounters;
    b. adjust the claim/encounter document including all line items; and,
    c. process adjustments to reflect all claim information.
2. Describe how the R-MMIS will process payments sent in by a provider to refund amounts for claims that should not have been paid and create void/adjustment claims without affecting provider payment.

J.1.4.2.1.1 Edit Claim/Encounter

The R-MMIS must perform a variety of complex claims editing including data validity; member, provider, reference, duplication, Utilization Review, and ProDUR edits. The R-MMIS must support a complex pend resolution process that involves a variety of staff from different Department Divisions, the Fiscal Agent, and the Office of the Medicaid Inspector General.

Edit Claim/Encounter Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will:
    a. perform document level processing with a disposition determination for every line;
    b. reject transactions that do not meet minimum standards;
    c. process a claim/encounter transaction which meets the minimum standards through all applicable edits; and
    d. derive the payment status for each edit failure.
2. Describe how the R-MMIS will provide the capability to selectively apply edits based on Department business rules. Specifically address the method to be used for developing

and maintaining the business rules to enforce the required edits including the role of the business rules engine.
3. Describe how the R-MMIS will derive the claim/encounter type and assign the appropriate claim type, category of service and specialty code.
4. Describe how the R-MMIS will confirm that a prior approval for claimed services exists when required by Department business rules.

Claim/Encounter Edits Proposal Requirements

1. Describe how the R-MMIS will edit claim/encounter transactions. Specifically address the method to be used for developing and maintaining the business rules to enforce the required edits including the role of the business rules engine.

Pend Resolution Proposal Requirements

1. Describe how the R-MMIS will route claims pending for edit failures via the Workflow Management System for resolution;
2. Describe the method to be used to reprocess resolved pended claims through all edits for adjudication;
3. Describe how the web-based application will support processing pended claims and the integration with the Workflow Management System. Specifically identify all the features, the incorporation of supporting documentation, and availability of information regarding the providers, member, and previously adjudicated claims. Particular attention should be focused on the application's ease of use and support for the medical and dental review;
4. Describe how the web-based application will provide the capability to enter and maintain text notes associated with resolution of the pended claim; and,
5. Describe how the web-based application will support the review and mass release of pended claims based on criteria specified by the Department.

J.1.4.2.1.2 Price Claim/Encounter

The R-MMIS prices professional, dental, institutional and pharmacy claims using a variety of Fee Schedules, Groupers, and other pricing methodologies with adjustments for wide variety of reasons. New pricing methodologies are being adopted with increasing frequency to accommodate changes required by State law and regulation. The R-MMIS also supports manual pricing of claims that are identified by Department business rules during the editing process and pended for pricing.

Rate Codes are submitted on institutional claims to facilitate the claims pricing. The combination of the provider, rate code and service location zip plus 4 submitted on the claim is the key to correctly determining the payment amount. In cases where the provider, rate code and zip plus 4 combinations are not found, additional processing is required and the payment amount is based on the lowest active amount for the provider's rate code.

While encounters are edited, they are not currently priced. The Department is interested in considering methodologies for pricing encounters in the R-MMIS. The offeror must propose

methodologies for encounter pricing that can be considered for adoption during requirements validation.

The Medicaid Pharmacy Program benefit structure and reimbursement methodology is outlined below.

Pharmacy Reimbursement: Medicaid pharmacy reimbursement for prescription drugs is established in Section 367-a of the NYS Social Services Law. Effective July 1, 2008, reimbursement for brand name drugs is Average Wholesale Price (AWP) minus16.25%. Also effective July 1, 2008, reimbursement for generic drugs is the lower of AWP minus 25% or FUL or SMAC or Usual and Customary. The Department pays a $3.50 pharmacy dispensing fee for brand name drugs and $4.50 pharmacy dispensing fee for generic drugs.

Amount and Duration of Pharmacy Benefit: The NYS Medicaid program provides coverage for an original prescription and multiple refills. Multiple refills cannot exceed six (6) months from the date the original prescription is written or five (5) refills, whichever comes first. Quantity limits usually consist of a 30 day supply, unless otherwise specified by the NYS Medicaid Program.

Price Claim Proposal Requirements

Offerors must meet the following proposal requirements:

Price Claim General Requirements Proposal Requirements

1. Describe how the R-MMIS will price claims:
    a. based on pricing information and reimbursement methodologies applicable for the claim's date of service; and,
    b. at both the document and line levels;
2. Describe how the R-MMIS will determine pricing based on Department business rules using the rate code submitted on the claim and accounting for: Medicaid copayment reductions; Third Party reductions; Medicare/Medicaid maximization rules; and patient responsibility minimization rules. Specifically address the method to be used for developing and maintaining the business rules for rate based pricing including the role of the business rules engine;
3. Describe how the R-MMIS will accommodate variable pricing methodologies for identical procedure codes based on member benefit plan and provider specific data;
4. Describe how the R-MMIS will adjust payments based on various pricing factors;
5. Describe how the R-MMIS will provide the capability to add premium, bonus and incentive payments based on Department business rules. Specifically address the method to be used for developing and maintaining the business rules for pricing including the role of the business rules engine;
6. Describe how the R-MMIS will provide the capability to adjust pricing based on Department business rules for the grouping of procedures performed;
7. Describe how the R-MMIS will pay only the designated Federal share for specific claims based on Department business rules. Specifically address the method to be used for developing and maintaining the business rules for pricing including the role of the business rules engine; and,

8. Describe how the web-based application will provide the capability to manually price pended claims routed through the Workflow Management System based on business rules defined by the Department. Specifically identify all the features, the incorporation of supporting documentation, and availability of information regarding the providers, member, and previously adjudicated claims.

Professional and Dental Claims Proposal Requirements

1. Describe how the R-MMIS will determine the price for professional and dental claims with the capability to adjust the price as specified by Department business rules. Specifically address the method to be used for developing and maintaining the business rules for pricing including the role of the business rules engine;
2. Describe the process for adding new professional and dental reimbursement methodologies and their impact on the R-MMIS;
3. Describe how the web-based application will provide the capability to adjust the claim payment for Prior Approval/Prior Authorization pricing. Specifically identify all the features, the incorporation of supporting materials, and availability of information regarding the providers, member, and previously adjudicated claims; and,
4. Describe how the web-based application will provide the capability to adjust the claim payment during the Utilization Review (UR) process and integrate with the Workflow Management System. Specifically identify all the features, the incorporation of supporting material, and availability of information regarding the providers, member, and previously adjudicated claims.

Institutional Claims Proposal Requirements

1. Describe how the R-MMIS will use the rate code and zip plus 4 information from the claim to derive the correct reimbursement amount; and,
2. Describe how the R-MMIS will use the Net Available Monthly Income (NAMI) amount to reduce the payment based on Department business rules for Inpatient and Nursing Home pricing.

Inpatient Claims Proposal Requirements

1. Describe how the R-MMIS will provide inpatient pricing reimbursement methodologies. Describe the process for adding new reimbursement methodologies and their impact on the R-MMIS; and,
2. Describe how the R-MMIS will provide the ability to submit the entire stay in a single claim.

Non-Inpatient Institutional Claims Proposal Requirements

1. Describe how the R-MMIS will provide non-inpatient reimbursement methodologies; and,
2. Describe the process for adding new reimbursement methodologies and their impact on the R-MMIS.

Pharmacy Benefit Management Pricing Proposal Requirements

1. Describe how the R-MMIS will adjust pricing based upon Department business rules including but not limited to discount rates or markup rates;

2. Describe how the R-MMIS will use and apply pricing methodologies for Over the Counter (OTC) drugs based on Department business rules; and,
3. Describe how the web-based application will provide the capability to adjust the claim payment based on prior authorization/service authorization pricing for claims routed through the Workflow Management System. Specifically identify all the features, the incorporation of supporting material, and availability of information regarding the providers, member, and previously adjudicated claims.

Drug Pricing Proposal Requirements

1. Describe how the R-MMIS will implement the variety of drug pricing methodologies and provide the flexibility to reimburse pharmacies at different rates or pricing methodologies based on Department business rules; and,
2. Describe how the R-MMIS will use a variety of pricing factors within Department approved drug pricing methodologies. Describe the process for adding new pricing factors and their impact on the R-MMIS.

Supply Pricing Proposal Requirements

1. Describe how the R-MMIS will determine the price for pharmacy supply claims based on the procedure code and the General Fee schedule.
2. Describe how the R-MMIS will apply a variety of claims pricing methodologies to pharmacy supply claims. Describe the process for adding new pricing factors and their impact on the R-MMIS; and,
3. Describe the process for adding new pharmacy supply reimbursement methodologies and their impact on the R-MMIS.

Price Encounter Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the methodology that the R-MMIS would use to price encounters based on information applicable for the encounter's date of service.

J.1.4.2.1.3 Apply Claim Attachment

The R-MMIS must support the acceptance and processing of claims attachments that support the adjudication process.

Apply Claim Attachments Proposal Requirements

Offerors must meet the following proposal requirements:

Apply Claim Attachments General Proposal Requirements

1. Describe the process for accepting claims attachments through each channel;
2. Describe how the R-MMIS will
    a. accept or reject claim attachments;

b. provide the capability to electronically associate claim attachments received to the appropriate claim; and,
c. provide the capability to route the claim attachments through the Workflow Management System.

Hard Copy Claim Attachments Proposal Requirement

1. Describe how the R-MMIS will provide and integrate the imaging, OCR, data entry, editing and verification of claim attachments.

Provider Area of the Web Portal Claim Attachments Proposal Requirements

1. Describe how the provider area of the Web Portal will:
    a. support the uploading of claim attachments in industry standard formats approved by the Department;
    b. allow claim attachments to be retrieved, viewed and printed; and,
2. Describe the method that will be used to generate receipt notices for claims attachments and propose information to be included in the notice. Specifically address the process for handling email delivery failures.

Electronic Claims Attachments Proposal Requirements

1. Describe how the R-MMIS will:
    a. accept electronic attachments in Industry Standard format or as mandated by HIPAA (i.e., X12 275); and,
    b. generate electronic transaction acknowledgment in Industry Standard format or as mandated by HIPAA (i.e., X12 275).

J.1.4.2.1.4 Apply Mass Adjustment

The R-MMIS must support three types of adjustments: mass adjustments, special inputs and retroactive rate adjustments.

The mass adjustment process provides the capability to select previously adjudicated claim(s) to be reprocessed, adjusted, or voided based on Department specified factors and claim information. Selected claims are displayed for review with the ability to select or deselect chosen claims for continued adjustment processing.

The special inputs adjustment process is reserved for claims that require special processing based on program or policy determinations or reprocess after a system issue has been resolved. Special input processing also occurs at the request of the OMIG and the Office of the State Comptroller based on the review or audit of claims.

The retroactive rate adjustment process automatically generates adjustment transactions when provider rate modifications result in a change to the reimbursement amounts for previously adjudicated claims. Retroactive rate adjustments can affect claims from 1978 forward.

Mass Adjustment/Special Inputs & Retroactive Rate Adjustment Proposal Requirements

Offerors must meet the following proposal requirements:

Mass Adjustment Proposal Requirement

1. Describe how the web-based application will allow the user to select previously adjudicated claim(s) to be reprocessed, adjusted, or voided. Specifically address how the selected claims will be displayed for review before processing.

Special Inputs Proposal Requirements

1. Describe how the R-MMIS will accept and process files in proprietary formats containing adjustments and voids; and,
2. Describe how the R-MMIS will apply alternate edit statuses for edits failed during the special input process.

Retroactive Rate Adjustment Proposal Requirements

1. Describe how the R-MMIS will provide a retroactive rate adjustment process to automatically generate adjustment transactions when provider rate modifications result in a change to the reimbursement amounts for previously adjudicated claims; and,
2. Describe how the R-MMIS will provide the capacity to manage the retroactive rate adjustment process so that other R-MMIS processing is not impacted by high volumes of retroactive rate adjustments.

J.1.4.2.2 Payment and Reporting Requirements

In the Payment and Reporting sub-business area, the R-MMIS must support the Prepare Remittance Advice, Prepare EOB, and Prepare Provider EFT/Check business processes. These business processes cover: producing provider EFT or checks; prepare remittance advices; payment and reporting activities that create the balancing report and payment file for the payment cycle; and the preparation of Explanation of Benefits (EOB) statements for members.

J.1.4.2.2.1Prepare Remittance Advice

The R-MMIS must generate remittance advices (RA) and transmit to providers in either electronic or hard copy form as requested by the provider using HIPAA compliant RA codes and messages that must be used for suspended, denied, and paid claims. Remittance advices are produced by provider and Electronic Transmitter Identification Number (ETIN). This will result in multiple remittance advice statements for providers with multiple ETINs.

The R-MMIS must produce encounter reports for all MCO's submitting encounters in the Department’s proprietary format.

Prepare Remittance Advice Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will generate and transmit remittance advices (RA) and split the RA based on standard transaction size limitations using HIPAA compliant RA codes and messages must be used for denied and paid claims. Describe how the R-MMIS will produce hard copy RA's in a proprietary format;
2. Describe how the R-MMIS will:
    a. support the transmission of remittance advices (RA) and Health Care Claim Status Notification transactions;
    b. generate X12 277 Health Care Claim Status Notification transactions for all pended claims;
    c. generate remittance advices by provider and Electronic Transmitter Identification Number (ETIN);
    d. provide the capability to include broadcast messages on paper remittance statements
3. Describe how the R-MMIS will provide options for the provider's RA;
4. Describe how the R-MMIS will produce encounter reports for MCO's submitting encounters in the proprietary format.

J.1.4.2.2.2 Prepare HCBS Payment

The R-MMIS must produce HCBS Payments based on claims received in the institutional claims format. Pricing is based on the rate code and locator code included on the claim. Payments and remittance advices are produced in the same manner as any claim.

Prepare HCBS Payment Proposal Requirement

Offerors must meet the following proposal requirement:

1. Describe how the R-MMIS will accept, process and respond to claims for HCBS services.

J.1.4.2.2.3 Prepare EOB

The R-MMIS must produce EOBs based on a variety of criteria including: a random sample of members who received services; specific members; members who received services from a specified provider; members who received specific services; members who received specific services from a specified provider; members receiving services related to a specified procedure or formulary code; and members based on specific demographic information.

Prepare EOBs Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the web-based application will provide the capability to inquire on, add and change EOB text by EOB code;
2. Describe how the R-MMIS will produce EOBs based on criteria selected by the Department; and,

3. Describe how the R-MMIS will produce a file containing EOB information for the Department.

J.1.4.2.2.4 Prepare Provider EFT/Check

The R-MMIS must calculate the payment amount for the provider during the payment cycle and apply payments to the accounts receivable balances based on Department business rules. EFT/checks are produced by provider and Electronic Transmitter Identification Number (ETIN). The R-MMIS will have the capability to hold payments, suspend payments, split payments and produce interim/emergency payments based on the Department's business rules. If checks are adjusted then the remittance advices for those payments must also reflect the adjustments.

Prepare Provider EFT/Check Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will maintain payment data.
2. Describe how the R-MMIS will:
    a. produce at least one payment cycle per week with the capability to process extra payment cycles;
    b. generate EFT/checks;
    c. calculate the payment amount for the provider and apply payments to the accounts receivable balances; and,
    d. balance the remittance advice (RA) payment amount to the check/EFT amount and reflect any and all adjustments.
3. Describe how the R-MMIS will provide the capability to:
    a. lag EFT/check release;
    b. release the EFT /check for specific providers bypassing the lag period based on Department business rules;
    c. pay specific exempt providers as a separate payment cycle when normal payments are suspended or otherwise not processed; and,
    d. pay, adjust or suspend claims payments for all categories of providers.
4. Describe how the R-MMIS will provide an automated payment calculation process capable of determining interim or emergency payments.
5. Describe the tools and methodology proposed for retrieving and batching payment information.
6. Describe how the web-based application will provide the capability to:
    a. hold payment for individual claims, all claims processed, or all claims for a particular provider;
    b. review check/EFT balancing information (including shares information) for the payment period; and,
    c. generate manual checks or split existing checks and EFTs.

Check Processes

1. Describe how the R-MMIS will produce hard copy checks for providers requesting that option;

2. Describe how the R-MMIS will provide the capability to manage provider pickup for checks and their associated remittances;
3. Describe how the R-MMIS will provide the capability to reconcile accounts with the designated financial institution based on the exchange of files containing information related to the status of checks;
4. Describe how the R-MMIS will:
    a. automatically generate letters to providers for checks that have not cleared within a period established by the Department; and,
    b. automatically generate stop payment orders for checks that have not cleared within a period established by the Department.
5. Describe how the web-based application will provide the capability to create the following transactions: Stop Check Transaction; Void Check Transaction; Stop & Reissue Check Transaction; and Void & Reissue Check Transaction

EFT Processes

1. Describe how the R-MMIS will produce an EFT payment file for each payment cycle and transmit payment authorizations to the designated financial institution for payment processing;
2. Describe how the R-MMIS will provide the capability to:
    a. create Hold / Release EFT Transactions; Stop EFT Transactions; and Debit EFT Transactions; and,
    b. track and correct any unsuccessful or incorrect EFT payments.

J.1.4.2.3 Capitation and Premium Payment Requirements

In the Capitation and Premium Preparation sub-business area, the R-MMIS must support the Prepare Medicare Premium Payment and Prepare Capitation Premium Payment business processes.

Capitation and Premium Payment Proposal General Requirement

Offerors must meet the following proposal requirement:

1. Describe how the R-MMIS will maintain all data required to support capitation and premium payment processing, including Medicare and Managed Care data.

J.1.4.2.3.1 Prepare Capitation Premium Payment

The R-MMIS must processes capitation payments by automatically generating premium payments monthly through X-12 820 transaction for each recipient billed and paid.

Capitation Premium Payment Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will:

a. automatically generate premium payment transactions monthly for each member enrolled in a MCO as of the first of the month. Payments via EFT or check will be produced and reported on the X12 820 (versions 4010 & 5010); and,
b. automatically generate adjustment and void transactions for each member whose enrollment in a MCO was retroactively modified; and,

2. Describe how the R-MMIS will provide the capability to add premium, bonus and incentive payments based on Department business rules. Specifically address the method to be used for developing and maintaining the business rules for pricing including the role of the business rules engine.

J.1.4.2.3.2 Prepare Medicare Premium Payment

The R-MMIS must process the Medicare Premium files from CMS and produce and transmit the Medicare Buy-In Premium Billing file to the Department of Health (DOH) Fiscal Management Group (FMG).

Medicare Premium Payment Proposal Requirement

Offerors must meet the following proposal requirement:

1. Describe how the R-MMIS will produce and transmit the Medicare Buy-In Premium Billing File to the Department's Fiscal Management Group (FMG).

J.1.4.3 Payment Information Management Requirements

In the Payment Information Management sub-business area, the R-MMIS must support both the Manage Payment Information and Inquire Payment Information business processes.

J.1.4.3.1 Inquire Payment Information

For provider payment inquiry, the R-MMIS will accept and process X-12 276 Claim Status Request responding with the X-12 277 Claim Status Response and provide the capability for providers to inquire on the last payment amount.

For Department and other authorized staff, the R-MMIS must provide the capability through a variety of channels including the web-based application, to view payment information including: adjudicated claims information; payment amounts, dates, cycle, method; Remittance Advice information; imaged copies of all paper claims or RA's; capitation payments; and other payment information.

Inquire Payment Status Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will:
    a. support claims inquiry transactions through all channels; and,

   b. provide the capability for providers to inquire on the last payment amount.
2. Describe how the R-MMIS will accept and process X12 276 Claim Status Request responding with the X12 277 Claim Status Response;
3. Describe how the web-based application will provide the capability to review payment information. Specifically identify all the features, search capabilities, the incorporation of supporting documentation, and availability of information regarding the providers, member, and previously adjudicated claims.

J.1.4.3.2 Manage Payment Information

The R-MMIS must maintain all information related to payments including: provider; member information; service information; adjudication information; and adjustment and void transaction information.

The R-MMIS must provide the capability to view, enter and update information related to the Federal allotment for the QI-1 program and monitor spending against the QI-1 program allotment for each Federal fiscal year.

The R-MMIS must provide the capability to produce the Methadone Maintenance Treatment Program (MMTP) Claims extract file for the Human Resources Administration (HRA) in NYC based on specific rate and procedure codes.

Manage Payment Information Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will maintain payment related information.
2. Describe how the R-MMIS will produce and transmit the MMTP extract file.
3. Describe how the web-based application will provide the capability to:
   a. view, enter and update information related to the Federal allotment for the QI-1 program; and,
   b. monitor spending against the QI-1 program allotment.
4. Describe how the provider area of the web portal will provide the capability for portal users to inquire on information related to payments, remittance advices and retroactive rate processing.

J.1.4.4 Cost Recoveries Requirements

In the Cost Recoveries sub-business area, the R-MMIS must support the Manage Recoupment, Manage TPL Recovery, and Manage Drug Rebate business processes.

J.1.4.4.1 Manage Recoupment

Recoupment is managed through Accounts receivable functions that are a complex combination both manual and automated processes. Accounts receivable can be created automatically through negative claim adjustments/voids or negative retroactive rate adjustments.

They can also be created manually by contractor staff or Department staff and their agents based on audits or other recovery activity. Accounts receivables are managed at the Taxpayer, entity or provider level and must accommodate lien information for processing payments to lien holders.

Cost Recoveries Proposal Requirements

Offerors must meet the following proposal requirements:

Manage Recoupment (Accounts Receivable) General Proposal Requirement

1. Describe how the R-MMIS will maintain the data required to support recoupments; and,
2. Describe how the R-MMIS will accept and process accounts receivable files from the Department's FMG.

Recoupment Accounts Receivable Proposal Requirements

1. Describe how the R-MMIS will:
    a. establish accounts receivable balances at the Taxpayer, Entity or Provider level;
    b. automatically establish accounts receivable balances based on claim transaction processing;
    c. assign a unique control number to each recoupment and payment;
    d. automatically apply claims payment amounts to outstanding accounts receivable balances;
    e. support multiple payment adjustments for a given provider including a prioritization of accounts receivables to satisfy outstanding balances and controls to prevent duplicate recoveries;
    f. calculate simple or compound interest with different interest rates with the flexibility to waive interest on a case by case basis; and,
    g. generate notices to providers for accounts receivable amounts due.
2. Describe how the web-based application will:
    a. establish accounts receivable balances for recoupments;
    b. maintain lien information for recoupments;
    c. enter and maintain text notes associated with recoupments; and,
    d. apply payments received from providers to the outstanding accounts receivable balances.
3. Describe how the provider area of the web portal will allow providers to view accounts receivable information.

Recoupment Payment and Associated Document Processing Proposal Requirements

1. Describe how the R-MMIS will provide the capability to:
    a. accept and process provider payments;
    b. image and index recoupment payments and associated documents received from providers; and,
    c. electronically associate payments and other documents with the appropriate recoupment.

2. Describe how the web-based applications will provide the capability to:
    a. enter payment information; and,
    b. enter and maintain text notes associated with recoupment payments.
3. Describe how the R-MMIS will provide the capability to generate a check to the provider when the payment received exceeds the accounts receivable balance.

Recoupment Information Management Proposal Requirement

1. Describe how the web-based application will provide the capability to review all information related to recoupments.

J.1.4.4.2 Manage TPL Recovery

Third Party Liability recovery activities are performed by a Third Party contractor. The R-MMIS must support these activities by generating and transmitting files with the required member and claims information. The R-MMIS must also have the capability to process files from the Third Party contractor in a proprietary format as special inputs for adjustments and voids to claims.

TPL Recovery Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will produce and transmit files for the TPC to support TPL Recovery and data matching activities; and,
2. Describe how the R-MMIS will provide the capability to process files in Department specified proprietary formats as special inputs for adjustments and voids to claims identified by the Third Party contractor.

J.1.4.4.3 Manage Drug Rebate

The Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations (CMSO). The Supplemental Drug Rebate and Supply Rebate programs are based on agreements between manufacturers and New York State. These rebate programs represent significant savings for the NYS Medicaid program and the management of these programs is requires a complex set of tasks that are critical for its success

Manage Drug Rebate Proposal Requirements

Offerors must meet the following proposal requirements:

OBRA, Supplemental and Supply Rebate Requirements

1. Describe how the R-MMIS will provide the flexibility to expand rebate programs to include a variety of different types of rebates or add new rebate programs; and,
2. Describe how the R-MMIS will maintain current and historic information used in the Drug Rebate process.

Rebate Labeler Information Management

1. Describe how the R-MMIS will maintain rebate labeler information.
2. Describe how the R-MMIS will provide the capability to add, update and terminate rebate labelers through a batch process based on the:
    a. CMS listing of labelers;
    b. Supplemental Rebate listing of labelers; and,
    c. Supply Rebate listing of labelers.
3. Describe how the web-based application will provide the capability to search, view, add, update and terminate rebate labeler information as required by the Department.
4. Describe how the rebate labeler area of the web portal will provide the capability for rebate labelers:
    a. view their account information; and,
    b. view the status of invoice disputes.

Rebate Labeler Communication Management

1. Describe how the R-MMIS will provide the capability to:
    a. image and electronically associate all correspondence to and from rebate labelers; and,
    b. route correspondence through the Workflow Management System based on Department business rules; and,
2. Describe how the R-MMIS will automatically generate letters and/or electronic notifications to rebate labelers.

Quarterly Invoice Process Proposal Requirements

Offerors must meet the following proposal requirements:

Pre-Processing

1. Describe how the R-MMIS will:
    a. calculate quarterly rebate amounts due based on number of units per NDC/HCPCS/UPN from applicable claims/encounters and applicable unit rebate amounts for OBRA, Supplemental and Supply rebates; and,
    b. use the most current CMS, Supplemental or Department determined rebate per unit.
2. Describe how the R-MMIS will perform analysis to identify outlier claims and other issues with the quarterly rebate amounts for review by the Department.
3. Describe how the R-MMIS will provide the capability to:
    a. exclude from drug rebate invoices those units paid to public health service entities that have separate agreements with rebate labelers under the Veterans Health Care Act of 1992 and subsequent amendments, with effective dates; and,

   b. exclude or include from drug rebate invoices any units based on factors mandated by Federal or State Laws and Regulations or as directed by the Department.
4. Describe how the web-based application will provide the capability to adjust the OBRA, Supplemental and Supply rebate units for specific NDC/HCPCS/UPN codes.

Invoice Generation

1. Describe how the R-MMIS will maintain:
   a. invoice information; and,
   b. information that identifies all claims included on each invoice.
2. Describe how the R-MMIS will generate labeler invoices on a quarterly basis meeting CMS and Department format standards.
3. Describe how the R-MMIS will provide the capability to:
   a. generate rebate labeler specific invoice and claims level data extracts;
   b. distribute rebate labeler invoices in hard copy and electronic formats as requested by the rebate labeler; and,
   c. create electronic copies of the invoices for the Department in industry standard formats.
4. Describe how the web-based application will provide the capability to review the OBRA, Supplemental and Supply rebate invoice amounts for rebate labelers prior to invoice release.

Payment Receipt & Account Management Process Proposal Requirements

1. Describe how the R-MMIS will maintain information on the rebate accounts receivable by product code; and,
2. Describe how the web-based application will provide the capability to search and review payment and account information for rebate labelers.

EFT Account Management

1. Describe how the R-MMIS will provide the capability to:
   a. manage rebate labeler EFT account information; and,
   b. reconcile accounts with the designated financial institution based on the exchange of files.

Electronic Reconciliation of State Invoice (ROSI)

1. Describe how a labeler area of the Web Portal will provide the capability for rebate labelers to: view their quarterly invoice information; enter payment information related to the invoice; dispute specific lines of the invoice; enter text notes for lines in dispute; and upload supporting materials. Route transactions through the Workflow Management System based on Department business rules; and,
2. Describe how the Web Portal will edit ROSI information based on Department business rules for data presence, validity, inter-field relationships, and completeness. Errors returned must be clearly identified to facilitate correction by user.

Hard-Copy Reconciliation of State Invoice (ROSI)

1. Describe how the R-MMIS will provide the capability to log, image, electronically associate, OCR and/or data enter, and verify hard copy ROSI information and supporting

materials received as directed by Department. Route transactions through the Workflow Management System based on Department business rules; and,
2. Describe how the R-MMIS will provide the ability to automatically compare hard copy ROSI information to invoice information and flag any discrepancies by NDC/HCPCS/UPN code.

EFT Invoice Payments

1. Describe how the R-MMIS will provide the capability to receive EFT invoice payments and reconcile those payments to invoices and accounts receivable.

Check Invoice Payments

1. Describe how the R-MMIS will process batches of rebate payments and reconcile batch totals and other information based on Department business rules (checks are received, logged, copied, and deposited by the Fiscal Management Group prior to being batched for processing); and,
2. Describe how the R-MMIS will provide the capability to log, image, electronically associate to the invoice and route through the Workflow Management System checks received for invoice payments and reconcile those payments to invoices as specified by the Department.

Accounts Receivable Process Proposal Requirements

1. Describe how the R-MMIS will apply payments received to accounts receivable balances.
2. Describe how the R-MMIS will provide the capability to identify and process transactions for payments inappropriately deposited as drug rebate payments.

General Ledger Process

1. Describe how the R-MMIS will provide the capability to automatically balance quarterly invoicing and payments.

Accounts Payable Process

1. Describe how rebate labeler credits in either OBRA or Supplemental programs will be applied to outstanding accounts receivables balances for OBRA and Supplemental programs via the web-based application.; and,
2. Describe how the R-MMIS will provide the capability to process accounts payable transactions to resolve outstanding credit balances as required by the Department.

Outstanding Accounts Receivable Collection Process Proposal Requirements

1. Describe how the R-MMIS will provide the capability to:
    a. automatically generate notices to rebate labelers regarding outstanding accounts receivable balances based on Department business rules taking into account dispute status;
    b. automatically generate notices through the Workflow Management System regarding accounts receivable balances based on Department business rules taking into account dispute status; and,
    c. retrieve and batch accounts receivable information in an industry standard file format accessible through the web-based application.

2. Describe how the web-based application will provide the capability to enter information related to the write-off of accounts receivable.
3. Describe how the R-MMIS will maintain a process to calculate and apply interest to accounts receivable balances.

Dispute Resolution Process Proposal Requirements

Dispute Review Process

1. Describe how the web-based application will provide the capability to:
    a. search and review invoice and dispute information for rebate labelers;
    b. retrieve and review claims included on the invoice for the NDC/HCPCS/UPN code being disputed; and,
    c. review the disputed NDC/HCPCS/UPN code information, note review comments, send email or letter requesting information to the labeler, set dispute determination status, generate dispute resolution proposals, and record the revised quantity for substantiated disputes.
2. Describe how the R-MMIS will provide the capability to:
    a. analyze utilization data to assist in the dispute resolution process;
    b. recalculate the amount due from the rebate labeler if the disputed information is substantiated while maintaining the original invoice information;
    c. synchronize substantiated OBRA dispute information or CMS information with the Supplemental Rebate process; and,
    d. maintain the final dispute resolution agreement on unit quantity amounts;
3. Describe how the R-MMIS will provide the capability to:
    a. log, image, electronically associate, dispute resolution agreements received as directed by Department. Route transactions through the Workflow Management System based on Department business rules; and,
    b. track dispute resolution contacts including but not limited to: rebate labelers, pharmacies, and other billing providers.
4. Describe how the R-MMIS will provide an R-MMIS Dashboard for monitoring, tracking and reporting on dispute resolution activity.

Rebate Reference Information Management Process Proposal Requirements

1. Describe how the R-MMIS will maintain OBRA, Supplemental and Supply rebate reference information and multiple effective date spans on the drug labeler information;
2. Describe how the R-MMIS will provide flexibility to use NCPDP rebate standard or other similar national standards for rebate program.
3. Describe how the R-MMIS will:
    a. process the CMS drug rebate file or other rebate files on a quarterly basis, as well as on any other dates set by CMS;
    b. accept and process CMS's listings of rebate labelers with rebate agreements as required by the Department; and,
    c. acquire and process the drug rebate information related to rebate labelers with Supplemental rebate agreements.
4. Describe how the R-MMIS will:

a. provide the capability to include unit type conversion factors for drug unit type mismatches between the pharmacy claim unit types paid, and the drug labeler unit rebate amount types on the CMS rebate list;
b. maintain the crosswalk(s) between the physician administered drugs and NDC codes as directed by the Department;
c. provide the capability to exclude specified drugs from drug rebate information processing based on Department criteria.

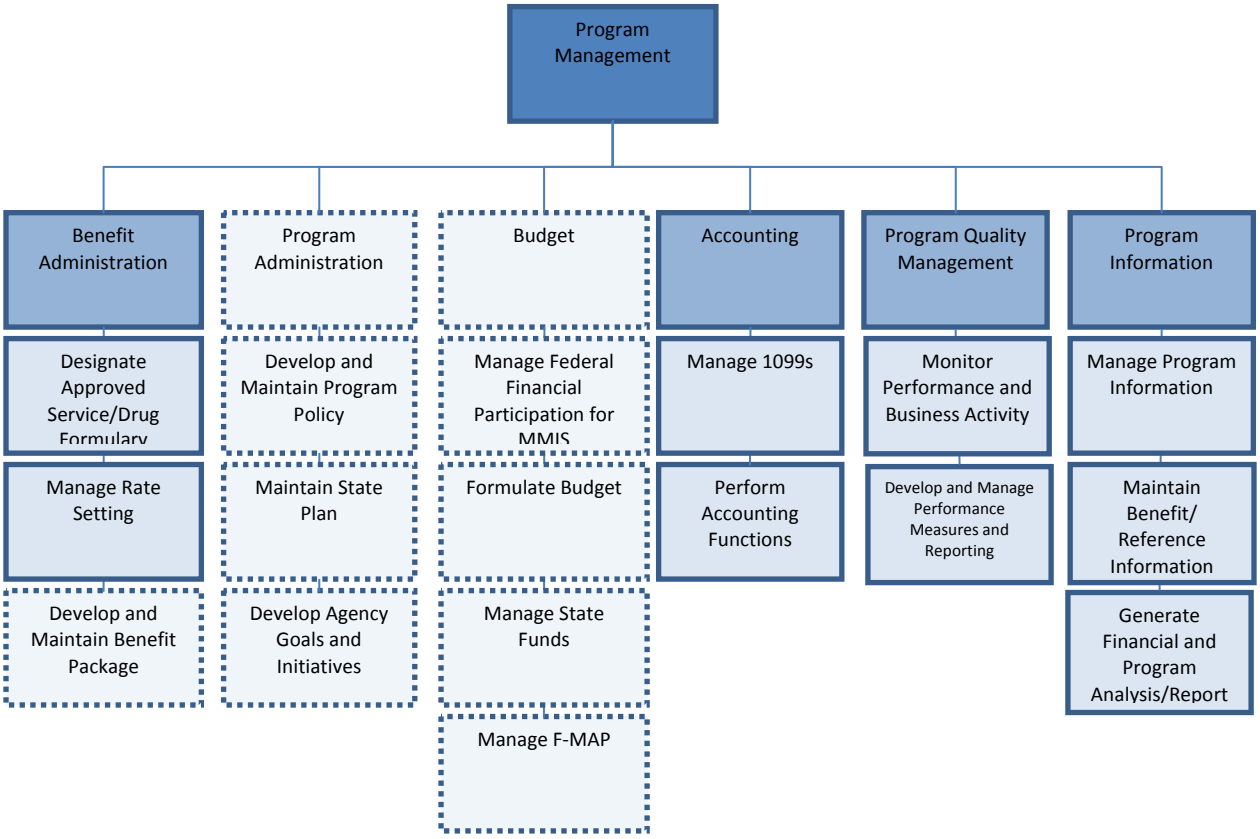
5. Describe how the web-based application will provide the capability to automatically identify inconsistencies in measurement units between CMS and the R-MMIS drug reference data and provide the capability to review and approve automated conversions.

J.1.5 PROGRAM MANAGEMENT

The Program Management business area that focuses on the strategic planning, policymaking, monitoring, and oversight activities of the agency is comprised of six sub-business areas: Benefit Administration; Program Administration; Budget; Accounting; Program Quality Management; and Program Information. The R-MMIS will support four business processes in all sub-business areas except Program Administration and Budget.

These are the core business oversight and monitoring processes supported by the R-MMIS that range from insuring that the code sets are maintained to performing accounting functions to monitoring performance and business activity. They are organized based on MITA business areas illustrated in the exhibit below.

Exhibit III-5 R-MMIS MITA Program Management Business Area



Functional requirements are presented only for those business processes for which there are R-MMIS and contractor requirements (shown by solid borders in this Exhibit).

J.1.5.1 Benefit Administration

In the Benefit Administration sub-business area, the R-MMIS will support the Manage Rate Setting business process. This business process supports the maintenance of Rate Codes which are used for processing and pricing institutional claims.

J.1.5.1.1 Manage Rate Setting

Provider rates for institutional and waiver services are set by a variety of NYS agencies including but not limited to the Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Office of Children and Family Services and the Office of Alcoholism and Substance Abuse Services. The rates are maintained based on rate codes unique to NYS and are specific to service locations. The R-MMIS will receive and processes rate files from these sources and allows for the entry and updating of provider rate information through the web-based application.

Manage Rate Setting Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the process for accepting provider rate setting transactions through each channel;
2. Describe how the R-MMIS will maintain provider rate setting data;
3. Describe how the R-MMIS will:
    a. accept and process provider rate setting transactions;
    b. process provider rate transactions batches received from rate setting agencies;
    c. route and track provider rate transaction batches through all the steps in the process
4. Describe how the web-based application will provide the capability to:
    a. review batches and delete, modify, approve or reject individual records;
    b. search, view, enter and update provider rate information;
5. Describe how the R-MMIS will produce hard copy and/or electronic notice of rate code changes for providers; and,
6. Describe how the provider area of the Web Portal will allow users to view provider rate information.
7. Describe how the R-MMIS will provide the capability to manage various rate based reimbursement methodologies. Specifically address the process that would be used to establish new rate based reimbursement methodologies and the impact on the R-MMIS;

J.1.5.2 Accounting

The Accounting business sub-area contains two business processes: Manage 1099s and Perform Accounting Functions.

J.1.5.2.1 Manage 1099s

The Manage 1099 business process produces and distributes hard copy and electronic 1099 statements to providers, the IRS and NYS Department of Taxation and Finance. The R-MMIS will calculate payment amount and produce a single 1099 for each taxpayer identification number while factoring in payment lag periods between check/EFT production and payment release. 1099's will be produced in accordance with Federal and State guidelines.

Manage 1099 Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will maintain all information required to create provider specific 1099 statements;
2. Describe how the R-MMIS will calculate payment amounts and produce a single 1099 for each taxpayer identification number factoring in payment lag periods between check/EFT production and payment release and make accommodations when tax payer ID ownership changes occurred during the tax year;
3. Describe how the R-MMIS will produce hard copy 1099 forms and distribute to providers in accordance with Federal and State regulations;
4. Describe how the R-MMIS will:

a. track all requests for replacement or corrected 1099s through the Workflow Management System;
b. provide the capability to produce replacement or corrected 1099s; and view 1099 information via the web-based application;
c. provide the capability to retrieve 1099 information and create a copy of any prior year 1099 in an industry standard file format accessible through the web-based application;

5. Describe how the R-MMIS will produce and transmit original and corrected 1099 files for: the IRS; the NYS Department of Taxation and Finance; and the Department's Fiscal Management Group; and,
6. Describe how the web-based application will provide the capability to view and update the status of taxpayers exempt from the 1099 reporting process.

J.1.5.2.2 Perform Accounting Functions

The Perform Accounting Functions business process encompasses the functions related to accounts payable, accounts receivable, and general ledger. In addition to processing financial information related to the claims payment process and weekly funding reports, the R-MMIS must support the processing of information related to the Public Goods Pool and Shares Funding (Federal, State and Local Government). Financial transactions including recoupment, funds received, lump sum payments and cash advances are created and processed by the R-MMIS.

Perform Accounting Functions Proposal Requirements

Offerors must meet the following proposal requirements:

Perform Accounting Functions General Proposal Requirements

1. Describe how the R-MMIS will:
   a. maintain accounting information;
   b. track financial transactions by source;
   c. generate a Financial Control Number (FCN) for every approved fiscal transaction; and,
   d. capture and maintain on all adjudicated claims the Federal, State and Local Government shares funding;
2. Describe how the R-MMIS will maintain controls to track each financial transaction, balance batches, and maintain appropriate audit trails on the claim and payment history files;
3. Describe how the R-MMIS will:
   a. provide the files and reports necessary to compute the weekly funding;
   b. provide the capability to assign weekly payment cycle funding information by various State agency appropriation pursuant to Department accounting rules;
4. Describe how the web-based application will provide the capability to:
   a. create financial transactions; and, enter and maintain text notes associated with financial transactions;
   b. view accounting information;

c. view, add and update date specific shares funding information based on member aid category, charge indicator, services indicator as required by the Department; and,
d. view and update a Public Goods Pool file which contains percentages and fixed dollar amounts used to calculate the NYS Medicaid Program's contribution to the Public Goods Pool.

Accounts Receivable Proposal Requirements

1. Describe how the R-MMIS will provide the capability to process accounts receivable transactions;
2. Describe how the web-based application will provide the capability to:
    a. set the percentage on recoupment transactions to recoup each payment cycle or use the system defaults; and,
    b. process funds received transactions that may create history only voids/adjustments for payments sent in by a provider to refund amounts for claims.

Accounts Payable Proposal Requirements

1. Describe how the R-MMIS will provide the capability to process accounts payable transactions;
2. Describe how the R-MMIS will update claim history and financial files with the check number, date of payment, and amount paid;
3. Describe how the R-MMIS will provide the capability to process:
    a. Lump Sum Payment transactions for payments to a provider that are not related to a specific claim;
    b. Cash Advance transactions that generate both an accounts payable and accounts receivable transaction for the payment to be recouped; and,
4. Describe how the R-MMIS will maintain lien information to be used in directing or splitting payments to the provider and lien holder.

General Ledger Proposal Requirements

1. Describe how the web-based application will provide the capability to view and update general ledger codes based on Major Program Code, Claim Type, Provider Type and additional criteria required by the Department;
2. Describe how the R-MMIS will assign a general ledger code to every claim. General Ledger Codes are assigned based on Major Program Code, Claim Type, Provider Type and additional criteria required by the Department; and,
3. Describe how the R-MMIS will reconcile accounts with the designated Financial Institution.

J.1.5.3 Program Quality Management

In the Program Quality Management sub-business area, the R-MMIS must support the Develop and Manage Performance Measures and Reporting business process and the Maintain Benefit/Reference Information business process.

J.1.5.3.1 Monitor Performance and Business Activities

The R-MMIS must support the monitoring of performance and business activities through reports and an R-MMIS Dashboard interface for information that is not available in a timely manner through the MDW. Both will supply information necessary to perform, manage, and control all functions of the R-MMIS; support fiscal agent processes; and monitor Service Level Agreements (SLAs).

Monitor Performance and Business Activity Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the COTS reporting tool will be used to develop the required reports including the ability to select different sort orders and limit reporting to sub-sets of data at run time. Specifically address how modifications to the report content and format will be flexible; and,
2. Describe how the features and information proposed for the R-MMIS Dashboard interface. Specifically address how the drill-down capability will be implemented and the information that it would be most appropriate.

Reporting Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the R-MMIS will generate Federally mandated reports;
2. Describe how the R-MMIS will produce all reports and/or files required to meet Federal CMS-64 reporting requirements;
3. Describe how the R-MMIS will produce all reports necessary to perform, manage, and control the drug rebate process as required by the Department using the COTS reporting tool; and,
4. Describe how the R-MMIS will generate a quarterly file of all invoices including prior period adjustments resulting from dispute resolution for CMS.

J.1.5.3.2 Develop and Manage Performance Measures and Reporting

In NYS, the Develop and Manage Performance Measures and Reporting business process is supported by the Medicaid Data Warehouse (MDW). The R-MMIS will support the MDW by performing extract activities of the data that forms the foundation of the MDW.

Develop and Manage Performance Measures & Reporting Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the data extracts from the R-MMIS will be performed. Specifically address how increasing the frequency of the data extracts from daily to hourly would impact the extract process;

2. Describe how the extract process will identify, correct, report, and monitor data quality/defect issues and monitor data quality;
3. Describe how the tool based repository will be implemented to perform the data extraction operations. Specifically address how requests to add or delete data and add new extracts will be accommodated;
4. Describe how the R-MMIS will:
    a. produce extract files in a variety of formats;
    b. provide the capability to publish ("push") the data to a destination; and,
    c. trace and monitor the extract processes. Specifically address the audit and control, error/exception handling, balancing, and operational statistics;
5. Describe how the R-MMIS will maintain extract files online and the process for archiving and retrieving the archived extract files; and,
6. Describe how the R-MMIS will provide the capability to export drug rebate information to the Medicaid Data Warehouse based on Department standards.

J.1.5.4 Program Information

The Program Information business process is responsible for managing all the operational aspects of the Program Information data store and is the source of comprehensive program information used by all business areas. In NYS, the majority of the analysis and reporting capabilities are supported by the Medicaid Data Warehouse (MDW). However, operational performance and business activities monitoring that is not available in a timely manner are supported by the R-MMIS.

J.1.5.4.1 Maintain Benefit/Reference Information

The Maintain Benefit/Reference Information business processes encompasses the activities that are required to maintain information used by other business processes to edit, verify and process transactions including various code sets and grouper software. NYS is unique in its implementation of the 3M Ambulatory Patient Grouper (APG) for pricing selected institutional claims.

The implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding must be accomplished on the compliance date set.

Maintain Reference Data Proposal Requirements

Offerors must meet the following proposal requirements:

Maintain Reference Data General Proposal Requirement

1. Describe how current and historical reference information will be maintained in the Reference registry.

ICD9 Proposal Requirements

1. Describe how the R-MMIS will:
    a. accept and process the ICD-9 Diagnosis file from CMS; and,
    b. accept and process the ICD-9 Procedure update file from CMS.
2. Describe how the web-based application will provide the capability to inquire on, add and change diagnosis and procedure code information.

Groupers Proposal Requirements

1. Describe how the R-MMIS will:
    a. maintain the grouper processes to support claims processing and pricing;
    b. accept and process the DRG Code Interface files;
    c. obtain and process the E-APG grouper updates; and,
    d. accept or obtain and process all other grouper interface files.
2. Describe how the web-based application will provide the capability to inquire on, add, delete and change all grouper information.

Prescription Pad Proposal Requirements

1. Describe how the R-MMIS will accept and process the Bureau of Narcotics Enforcement (BNE) Prescription Serial Number Interface File; and,
2. Describe how the web-based application will provide the capability to inquire on, add, and change Prescription Serial Number information.

HCPCS/CPT Procedure Code Updates Proposal Requirements

1. Describe how the R-MMIS will:
    a. accept and process the quarterly and annual HCPCS Update files received from CMS; and,
    b. accept and process the CMS Mandate Lab Update File; and,
2. Describe in detail how the web-based application will provide the capability to:
    a. inquire on, add, and change procedure code information; and,
    b. inquire on, add, delete and change procedure pricing information.

Health Professional Shortage Areas (HPSA) Proposal Requirements

1. Describe how the R-MMIS will accept and process the Health Professional Shortage Areas (HPSA) File; and,
2. Describe how the web-based application will provide the capability to inquire on, add and change HPSA information.

Revenue Code Proposal Requirement

1. Describe how the R-MMIS will accept and process revenue code information from the National Uniform Billing Committee (NUBC);
2. Describe how the web-based application will provide the capability to:
    a. inquire on, add and change revenue code information; and,
    b. inquire on, add, delete and change revenue code pricing information.

Text Update Proposal Requirement

1. Describe how the web-based application will provide the capability to inquire on, add, delete and change Remittance Text Messages.

Claims Edit Status Proposal Requirements

1. Describe how the web-based application will provide the capability to inquire on, add and change Claim Edit Status information; and
2. Describe how the R-MMIS will provide the capability to enter and maintain text notes associated with Claim Edit Status information.

ProDUR/Medical Limit/Step Therapy Edit Status Proposal Requirements

1. Describe how the R-MMIS will:
    a. update ProDUR with the most current parameters used in patient drug therapy safety edits (ProDUR edits) as updates for these parameters become available; and,
    b. develop new ProDUR edits and modify existing vendor-supplied ProDUR edits based on user-defined configurable criteria; and,
2. Describe how the solution for providing medical limit and step therapy editing for pharmacy claims (including commercially available packages) will facilitate changes to the edit parameters including: frequency, quantity and duration of therapy for selected drugs or drug classes; and diagnostic, medical and member data. Specifically describe how changes to the parameters can be made through the web-based application and how the history of edit parameters will be maintained.

PA Edit Status Proposal Requirements

1. Describe how the web-based application will provide the capability to inquire on, add, delete and change PA Edit Status information;
2. Describe how the R-MMIS will:
    a. establish PAs at all levels contained in the drug formulary file;
    b. specify the reasons that a PA is required for a particular drug including but not limited to program association or age/gender edit override; and
    c. provide the capability to enter and maintain text notes associated with PA edit status information.

Pharmacy Benefit Management Proposal Requirements

1. Describe how the R-MMIS will:
    a. maintain a drug formulary, to support pharmacy drug claim adjudication, pricing and other R-MMIS functions;
    b. update the drug formulary on a Department approved schedule that ensures pharmacy claims are paid according to the most current drug data available;
    c. maintain drug formulary data necessary to support Department pricing methodologies;
    d. maintain drug formulary data necessary to identify reused NDCs and provide historical access to their former formulas, characteristics and pricing; and,
    e. maintain unlimited historical pricing segments, unrestricted by the limitations of the pricing data source.

2. Describe how the R-MMIS will:
    a. identify brand and generic drugs;
    b. apply and maintain indicators and their effective dates to identify drug attributes; and,
    c. maintain drug coverage and/or limitations specified at various levels that may vary by population or plan and their effective dates.
3. Describe how the R-MMIS will accept and process drug data from multiple vendors.
4. Describe how the R-MMIS will process the State Maximum Allowable Cost (SMAC) update files.
5. Describe how the R-MMIS will:
    a. create and maintain listings of drugs specific to pharmacy management programs and make lists available to the public via the web portal; and,
    b. publish current formulary information via the web portal.
6. Describe how the web-based application will provide:
    a. capability to inquire on and change drug formulary information; and,
    b. capability to search and inquire on historical and date/time-sensitive drug formulary information.

ICD-10 Implementation

ICD-10-CM and ICD-10 Procedure Classification System (PCS) will increase the number, granularity, length, complexity (including alpha-numeric) and organization format of diagnosis and procedure codes. It is anticipated that this implementation will have far reaching effects on both systems and operations. This will require a detailed analysis of the R-MMIS and all operations and training programs.

The ICD-10 code set is intended to entirely replace the ICD-9 code set for claims submission over time. A cross-walk will be needed to support data retrieval and historical audits, including history of onetime procedures. It is anticipated that there will be a need to process claims with procedure and diagnosis codes that have not yet been addressed by the crosswalk or do not map one-to-one. These instances may require manual review or other processing. A method for dealing with situations in which all care providers do not use the same ICD version (i.e., physician rendering service bills ICD-9 and hospital bills ICD-10 for the same procedure) will be required.

Training will be an important component of the transition to ICD-10-CM and ICD-10 Procedure Classification System (PCS). Training programs for provider, Department and other NYS staff will be required to insure a successful implementation and insure program integrity. Training should include: web-based and in-person education in various settings including provider association meeting, on-site, and advanced (scheduled) training sessions. The education and training shall be driven by results from outreach efforts with stakeholders to gauge input regarding readiness and capability/willingness to cooperate with the upgrade efforts.

The transition to ICD-10 codes will increase the ability to link procedure codes in more structured coding data from provider billing. The contractor must propose analysis tools and

processes to take advantage of this additional information for improving quality of care. These must be able to support the following activities:

1. Review and analyze reclassification of diseases (to reflect current medical knowledge) and make recommendations to the Department regarding implementation;
2. Updating coverage determinations based on detailed coding (limited aid codes);
3. Improved/modified authorization processes;
4. Refining of edits and audits to take advantage of more specific coding;
5. Modification/refinement of provider payments based on new information such as associated morbidities;
6. Providing ongoing recommendations to improve quality of care parameters; and,
7. Information exchange with other entities and agencies.

ICD-10 Implementation Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe their approach to the implementation of ICD-10 diagnosis and procedure codes including the required crosswalk to the current coding standard;
2. Describe their approach to the impact analysis;
3. Describe their previous experience in designing and supporting coding crosswalks and identify any unique aspects of the ICD-10 conversion;
4. Describe their approach to the business process change for providers, Department and other stakeholders affected by the code conversion;
5. Describe how they would use the additional information in supporting operational and quality improvements;
6. Describe the health care professional expertise that will be provided to support the policy decision making process; and,
7. Provide a training plan for provider, Department and other NYS staff.

J.1.5.4.2 Generate Financial and Program Analysis/Report

The R-MMIS generates financial and program reports that are critical to financial integrity and processing. These include the key reports required to compute the weekly funding (Weekly Computation of Federal, State, and County Share; Retroactive Adjustment County Report and Summary of Accounts Receivable by Reason Code).

Generate Financial and Program Analysis-Report Proposal Requirement

Offerors must meet the following proposal requirement:

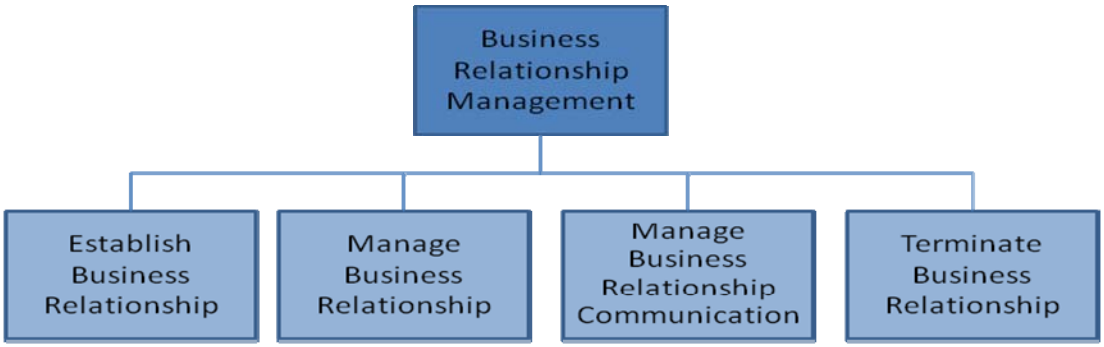
1. Describe how the COTS reporting tool will be used to develop the required reports including the ability to select different sort orders and limit reporting to sub-sets of data at run time. Specifically address how the COTS reporting tool will facilitate modifications to the report content and format.

J.1.6 BUSINESS RELATIONSHIP MANAGEMENT

The Business Relationship Management business area includes the four business processes necessary for establishing and maintaining business relationships for the purpose of exchanging data in accordance with the interoperability standards defined by the agency.

These business processes of the R-MMIS will enforce NYS policy related to the submission and processing of business transactions. Requirements are included for four types of business relationships: Trading Partner and Security Agreements; Electronic Transmitter Identification Numbers (ETIN); User Access to the Web Portal; and Electronic Funds Transfers (EFTs). The requirements for each business process represented are organized based on MITA business area illustrated in the exhibit below.

Exhibit III-6: R-MMIS MITA Business Relationship Management Business Area



J.1.6.1 Establish Business Relationship

The Establish Business Relationship business process covers all activities required to enter into business partner relationships with providers for the purpose of exchanging data.

Establish Business Relationship Proposal Requirements

Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the process for accepting Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT applications through each channel;
2. Describe how information related to a Trading Partner and Security Agreements, ETIN, Web Portal user, and EFT applications will be maintained;
3. Describe how the R-MMIS will:

   a. image, index and associate Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT applications;
   b. route applications for processing; and,
   c. track Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT applications through all steps in the process;
4. Describe how the web-based application will:
   a. support the review and approval of Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT applications; and,
   b. provide the capability to view, add and update Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT information;
5. Describe how the web portal application will provide the capability for users to:
   a. enter Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT applications (specifically address the method for minimizing the maintenance effort);
   b. modify, save and delete applications prior to submission;
   c. review and print applications; and,
   d. check the status of application processing;
6. Describe how the web portal application will:
   a. route applications through the Workflow Management System;
   b. generate receipt notices for application transactions and propose information to be included in the notice (specifically address the process for handling email delivery failures);
7. Describe the method to be used for developing and maintaining the business rules to enforce the required edits. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change. Address the way in which the user interface will return and identify errors; and,
8. Describe how the R-MMIS will transmit a test EFT to the designated Financial Institution and verify that the EFT transaction was processed in accordance with Department policies and procedures.

J.1.6.2 Manage Business Relationship

The Manage Business Relationship business process covers all activities required to maintain and re-certify agreements. This includes routine changes to required information such as authorized signers, addresses, terms of agreement, and data exchange standards.

Manage Business Relationship Proposal Requirements

Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the process for accepting Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT maintenance requests through each channel;

2. Describe how information related to a Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT will be maintained;
3. Describe how the R-MMIS will provide the capability to:
    a. image, index and associate hard copy and fax Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT maintenance requests;
    b. route for processing via the Workflow Management System; and,
    c. track maintenance requests through all steps in the maintenance process;
4. Describe how the web-based application will:
    a. support the review and update of Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT maintenance requests; and,
    b. provide the capability to view, add and update Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT information;
5. Describe how the web portal application will provide the capability for users to:
    a. enter Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT applications (specifically address the method for minimizing the maintenance effort);
    b. modify, save and delete applications prior to submission;
    c. review and print applications; and,
    d. check the status of application processing;
6. Describe how the web portal application will:
    a. route maintenance requests through the Workflow Management System; and,
    b. generate receipt notices for maintenance requests and propose information to be included in the notice (specifically address the process for handling email delivery failures);
7. Describe the method to be used for developing and maintaining the business rules to enforce the required edits. Identify the approach to managing business rule changes to minimize the maintenance effort required as business rules change. Address the way in which the web portal user interface will return and identify errors;
8. Describe how the R-MMIS will provide the capability to perform mass updates to Trading Partner and Security Agreement, ETIN, Web Portal user, and EFT information as requested by the Department;
9. Describe how the R-MMIS will support the annual ETIN re-certification process; and,
10. Describe how the R-MMIS will automatically grant a grace period as specified by the Department before terminating an ETIN.

J.1.6.3 Manage Business Relationship Communication

The Manage Business Relationship Communication business process includes formal, routine, and ad hoc communications between the Department and its business partners.

Trading Partner and Security Agreement, ETIN, Web Portal User, and EFT Manage Business Relationship Communication Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe how the web portal will provide all Trading Partner and Security Agreement, ETIN, Web Portal User, and EFT applications, instructions and related materials;
2. Describe how the R-MMIS will automatically generate letters and/or electronic notifications to providers with all Trading Partner and Security Agreements, active ETINs, Web Portal User accounts, and active EFTs agreement;
3. Describe how the R-MMIS will produce information packets when Trading Partner and Security Agreement, ETIN, and Web Portal User applications are approved;
4. Describe how the R-MMIS will automatically send letters/notices to providers with Trading Partner and Security Agreements, ETINs, Web Portal User accounts, and EFT agreements informing them when the related agreement/account is terminated;
5. Describe how the R-MMIS will provide the capability to generate annual ETIN recertification notices; and,
6. Describe how the R-MMIS will automatically:
    a. Identify ETINs that are expiring and notify the providers; and,
    b. Send letters/notices to providers whose ETIN is expiring within a time frame set by the Department informing them of their responsibilities.

J.1.6.4 Terminate Business Relationship

The Terminate Business Relationship business process formally closes the agreement between the Department and the business partner.

Terminate Business Relationship Proposal Requirements

Terminate Trading Partner and Security Agreement, ETIN, Web Portal User account, and Electronic Funds Transfer (EFT) Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the process for accepting Trading Partner and Security Agreement, ETIN, Web Portal User account, and EFT termination requests through each channel;
2. Describe how the R-MMIS will:
    a. maintain the data associated with a terminated Trading Partner and Security Agreement, ETIN, Web Portal User account, and EFT;
    b. image and index hard copy termination requests;
    c. route and track termination requests through all steps in the termination process;
    d. automatically end date information related to the terminated Trading Partner and Security Agreement, ETIN, Web Portal User account, and EFT; and,
    e. automatically terminate groups of Trading Partner and Security Agreements, ETINs, Web Portal User accounts, and EFTs;
3. Describe how the web portal application will:
    a. provide the capability for users to enter Trading Partner and Security Agreement, ETIN, Web Portal User account, and EFT termination requests;
    b. route termination requests for processing; and,
    c. allow providers to check the status of termination request processing; and,
4. Describe how the web-based application will:

a. process Trading Partner and Security Agreement, ETIN, Web Portal User account, and EFT termination requests received from a provider; and,
b. provide the capability to view, add, change, and terminate Trading Partner and Security Agreements, ETINs, Web Portal User accounts, and EFTs.

J.2 FUNCTIONAL PHASE II REQUIREMENTS

J.2.1 OVERVIEW

Functional Phase II includes the implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding; and the implementation of a COTS Financial Management System.

J.2.2 R-MMIS Financial Management System (R-MMIS FMS)

Currently, the Department utilizes both the Financial System provided by the fiscal agent and the New York State Central Accounting System (CAS) to process, record and report financial transactions. To address the inefficiencies of the current approach, the Department seeks to implement software which will improve operations and reengineer processes using an available COTS Financial Management System (FMS) solution. The Department envisions this as a separate phase, but is open to considering early adoption.

The Department's desire is to make use of standard functionality within a COTS solution to address all or the majority of the financial business processes. However, the complexities involved in the wide variety of financial transactions required to support the NYS Medicaid Program which are based on Federal and State laws and regulations may require functionality that is not available in a standard FMS. If required functionality is identified that is not available in the standard FMS, the contractor must provide an integrated solution that is acceptable to the Department.

The R-MMIS Financial Management System (R-MMIS FMS) must provide financial management functions and information for the NYS Medicaid Program and an interface to the New York State Central Accounting System (CAS). Standard financial reports and an ad hoc reporting capability are expected as part of the proposed solution.

The core financial management functions that are envisioned for the R-MMIS Financial Management System include:

1. General Ledger (GL);
2. Accounts Payable (AP);
3. Accounts Receivable (AR); and,
4. Contracts Management (CO).

J.2.2.1 General Ledger

The General Ledger serves as a central repository for all financial transactions and represents the accounting structure of the organization. It is critical to the Department's ability to provide financial reporting on the NYS Medicaid Program at the level required to efficiently manage its operations. The general ledger will reflect the accounting impact of all R-MMIS FMS

transactions and support cash-basis and GAAP-basis accounting. Most of the transactions posted or updated within the general ledger will originate in other modules within the R-MMIS FMS, although some transactions will be generated by legacy systems outside of the R-MMIS FMS, and the Central Accounting System.

In addition, transactions will originate within the general ledger and be used to correct, accrue, record, or redistribute the categorization of transactions. Two core functions that would be performed within the general ledger are journal vouchers (JV) and cost allocations. The processing of JVs (i.e., a Journal Entry), is a mechanism utilized to move spending or revenue between object codes, programs or other areas within an agency, or among agencies. While the amounts contained in the JV can originate in another process, another system, or within General Ledger, the resulting financial transaction will be posted in the General Ledger, and validated by the CAS. Cost allocation, or a stable method to re-distribute expenditures, through the R-MMIS FMS general ledger, will be based on identification of direct and indirect costs that can be distributed both inter- and intra-agency as determined by established and approved algorithms, based upon consistent factors such as fixed percentages or posted statistical units.

J.2.2.2 Accounts Payable

The Accounts Payable process encompasses the procedure for processing payments, from the receipt of claim, invoice or other financial transaction to the payment. The interface between any components of the R-MMIS and the R-MMIS FMS must be fully automated. The R-MMIS FMS must be capable of making payments to a variety of organizations and individuals including, but not limited to: service providers, members, Managed Care plans, the Federal government and other State agencies. These payments are the result of a variety of transactions. For example, the payment may be the result of claims, Managed Care premiums, Medicare Buy-In premiums, financial transactions for special payments to providers (i.e., incentive payments), and HIPP premium payments transactions. Transactions related to the accounts payable must be transmitted to and received from the CAS using an automated interface.

J.2.2.3 Accounts Receivable

The Accounts Receivable process encompasses the procedure for bill processing, from the creation of invoices to the collection and recording of receipts. The R-MMIS FMS or another system generates an invoice as required and a receivable is created. Interfaces between the R-MMIS or other systems and the R-MMIS FMS must be fully automated. Once the Department receives the payment, it is verified for accuracy, and the receipt is recorded. In case of non-receipt after a few attempts, the Department may exercise the right to apply interest charges against the account or determine that the account is uncollectable. Billing functionality could also support the interagency billing for reimbursement of services provided from one agency to another. There are a variety of sources for accounts receivable transactions, including but not limited to: Drug Rebate processing; audit recoveries and settlements; negative retroactive rate transactions; claims adjustments or voids that create negative claim balances; tax liens and court orders. Transactions related to the accounts receivable must be transmitted to and received from the CAS using an automated interface.

J.2.2.4 Contract Management

The Contract Management process outlines the steps involved in initiating and managing Department's contracts with vendors. The process begins when the Department identifies a need, develops a bid outlining the terms and conditions of the services/goods that must be rendered, and distributes it to the vendor community. The Department then receives bids from the vendors, evaluates the responses, and selects a vendor. Once a vendor has been selected, the Department negotiates the terms and conditions with the vendor(s), drafts the contract, and receives final approval from the vendor(s), all internal parties, and the State's control agencies. After the Contract is executed, the Department manages the delivery of the goods and services to ensure that it meets the terms and conditions of the Contract. At the end of the original Contract term, the Department may amend or renew, as appropriate.

J.2.2.5 Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe their approach to integrating the R-MMIS with the proposed COTS Financial Management System;
2. Describe their approach to the implementation of the Financial Management System;
3. Describe their previous experience in implementing COTS Financial Management Systems;
4. Describe their approach to the business process change for Department staff, Department contractor staff and other stakeholders affected by the implementation;
5. Describe their approach to the interface with the NYS Central Accounting System;
6. Describe the standard and ad hoc reporting capabilities; and,
7. Provide plans for implementation and continuing training for Department staff, Department contractor staff and other stakeholders.

J.3 FUNCTIONAL PHASE III REQUIREMENTS

J.3.1 Overview

Functional Phase III includes the implementation of capabilities that broaden the application of information technology and system interoperability within the R-MMIS and with associated systems. At this time, the goal of the Department is to transition to a MITA maturity level 3 for most business processes. MITA maturity level 3 capabilities focus on: the adoption and use of national standards; reusable business services; data sharing; collaboration and coordination of health care service delivery; use of State/regional information exchanges; and access to health care information. The capabilities for many of the MITA business areas are still being developed, but it is anticipated that they will be available at the beginning of this phase in order to provide a comprehensive framework for specifying the requirements.

The following table contains the Level 3 capability standards for the MITA goals and provides a high level overview of the types of capabilities that will be required in each MITA business area.

Exhibit III-7: MITA Goals and Level 3 Capability Standards

MITA Goals	Level 3
Develop seamless and integrated systems that effectively communicate to achieve common Medicaid goals through interoperability and common standards.	At Level 3, agencies share business services and adopt use of national standards. Statewide or regional data exchanges facilitate communications. Intrastate agencies coordinate and collaborate on common benefit plans and business services, i.e., "Enroll Member".
Promote an environment which supports flexibility and adaptability and rapid response to changes in programs and technologies	Agencies improve on flexibility and adaptability through implementation of shared and extensible business services, adoption of national standards, increased collaboration among intra-state agencies, and use of State/ regional information exchange.
Promote an enterprise view that supports enabling technologies that are aligned with Medicaid business processes and technologies	The agency adopts an EA and plans its transition to MITA compliance.
Provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for health care management and program administration	Data standards are adopted nationally. Shared repositories of data improve efficiency of access. This results in improvements in accessibility and accuracy of data used in program administration.
Provide performance measurement for accountability and planning	With more standards in place and the ability to share business services, agencies make broader use of performance measurements. Information exchange hubs provide better support for accountability and planning. However, performance measurement continues to rely on administrative data.
Coordinate with Public Health and other partners, and integrate health outcomes within the Medicaid community	States adopt common standards for shared business services and enter into Service Agreements for data sharing.
Provide a beneficiary centric focus	Applicants and members have direct access to information about program benefits, enrollment procedures, and personal health information. Intra-state agency cooperation reduces stove pipes and establishes a single point of entry. Shared member business services and national data standards increase beneficiary focus.

Source: Centers for Medicare and Medicaid, MITA Framework 2.0, Part I - Business Architecture, Appendix B - Maturity Model Details, pp. 10-12.

The Department is currently involved in several Health Information Technology and Electronic Health Record initiatives. Given the Department's commitment to HIT and EHR initiatives, it is anticipated that by the beginning of this phase the capability requirements for MITA maturity level 4 may be more appropriate for some business processes than the Level 3 capability requirements. To accommodate this, the initial planning for this phase will include a gap analysis to identify the appropriate MITA maturity level for each business area and determine the scope of work required to advance to that level.

J.3.2 Proposal Requirements

Offerors must meet the following proposal requirements:

1. Describe the method to be used to specify the functional and operational capabilities that would be necessary meet the MITA maturity level business capability standards and the associated measures for the timeliness of the process; data access and accuracy; effort to perform or efficiency; cost effectiveness; accuracy of process results; and utility or value to stakeholders;
2. Describe the approach to the gap analysis that will identify the appropriate MITA maturity level for each business area and determine the scope of work for each business process; and,
3. Describe the approach to incorporating improvements currently identified by the Department as enhancements that would meet MITA maturity level 3.

K. FACILITY REQUIREMENTS

K.1 OVERVIEW

The contractor must establish a primary facility in a location approved by the Department. All work specified in this RFP (including but not limited to receipt of paper claims, generation of checks and Call Center Operations) is required to be performed in this facility. Exempt from this requirement are the activities performed in the New York City Office (defined below) and the actual computer operations and the required back-up and recovery facility. However, the primary facility may be combined with the computer facility as long as the computer facility is physically secured as required in this RFP.

The primary facility must be within ten (10) miles of the New York State Capitol building in Albany, New York. All other facilities must be within the continental United States. When selecting the location of the primary, computer and disaster recovery sites, the offeror must take into consideration Service Level Agreements described in section III.O Contractor Performance.

In addition, upon implementation of the R-MMIS the contractor must maintain an office in New York City. The purpose of this office shall be to provide on-site assistance to providers. In addition, the contractor must use the New York City office to receive paper claims forms, and distribute checks to New York City providers.

The contractor must identify and provide suitable location(s) where cooperative R-MMIS and contractor service functions will be performed. Proposals must include an open floor plan at the primary location where contractor and Department staff (including Department contractor staff) can be intermingled based on functional areas. This will facilitate and encourage a strong working relationship between them. When proposing space the contractor should look to increase efficiencies of the program and minimize overall administrative and program costs. In addition, proposals must include strategies to rapidly procure adequate space for key and core State and contractor staff during the initial phases of project development. The Department reserves the right to inspect all facilities at any time.

The contractor must prepare a Facility Management Plan at the onset of the Project and submit it to the Department for approval.

The contractor's primary facility must be large enough to house its own entire staff, the training and meeting rooms defined in Attachment J and the following one hundred fourteen (114) State, contractor and Federal staff:

1. 70 State and contractor staff attached to the Office of Health Insurance Programs Division of Systems;
2. 41 State and contractor staff attached to the OSC; and,
3. 3 Federal staff.

The contractor is responsible for all costs related to securing and maintaining the contractor's primary project site and any other of its locations for the life of the project. The contractor is also responsible for providing all office equipment and supplies including but not limited to: desktop PCs, LAN and network printers, faxes, copiers, paper, file folders and associated software for all staff assigned to the Department and contract staff for project activities performed at the primary and computer facility sites. The contractor must replace the PCs, PC software and network printers every three (3) years with the most current technology available unless otherwise directed by the Department.

The contractor must house all facilities in a secure area, protected by a defined security perimeter, with appropriate security barriers and entry controls.

The computer facility and the back-up and recovery facility shall meet, at a minimum, the specifications of a Tier III Data Center Infrastructure as defined by the Uptime Institute.

K.2 PROPOSAL REQUIREMENTS

The offeror must describe how the facility requirements specified in this RFP will be supported. The offeror should describe in detail the processes and procedures necessary to secure and operate the facilities defined in the RFP.

At a minimum, the offeror must provide a detailed description of the following:

1. Location of all facilities, including the single location of the primary facility;

2. Capacity of facilities including but not limited to: floor layout, utilities, parking;
3. General layout of facilities showing the open floor plan at the primary location that must intermingle contractor staff and Department staff (including Department contractor staff) and all other space necessary to fulfill the requirements of this RFP;
4. All redundant utilities;
5. Security of all facilities;
6. Approach to continuous availability of all facilities; and,
7. Services at each facility including but not limited to: janitorial, cafeteria, etc.

L. BUSINESS CONTINUITY AND DISASTER RECOVERY REQUIREMENTS

L.1 OVERVIEW

The contractor's approach to the operation of the R-MMIS must incorporate a comprehensive business continuity and disaster recovery methodology that will protect valuable information assets of the R-MMIS and allow continuous availability of all applications.

System availability is of the utmost importance and whether it is a natural disaster or other event that interrupts operations, the proposed business continuity solution must provide the ability to recover quickly with minimal impact to ongoing R-MMIS operations.

The R-MMIS Business Continuity requirements are categorized in the following three (3) areas:

1. Backup/Recovery;
2. Failover; and,
3. Disaster Recovery.

Within thirty (30) calendar days of contract signing, the contractor must submit to the Department for approval a Business Continuity Plan that is based upon the contractor's business continuity and disaster recovery methodology and addresses the three (3) categories above.

The R-MMIS environments must be designed for 24 hours a day, 7 days a week availability.

L.2 R-MMIS BUSINESS CONTINUITY BACKUP/RECOVERY

All elements of the contractor's proposed backup/restore solution should be high-speed, high-capacity, enterprise-class components. Incremental and full system backups should be automated and conducted on each of the environments.

L.3 R-MMIS BUSINESS CONTINUITY FAILOVER

The proposed R-MMIS failover solution must provide for continued operation in the event of a failure in any of the environments. This solution should include but not be limited to redundancy in:

1. Data center power and air conditioning;
2. Network infrastructure components;
3. Server level components;
4. Database component; and,
5. Disk level components.

Together, these components should provide for a complete and robust failover capability that will switch from the current environment to a full-service alternate environment in the event of disruptions such as a failed disk or failed server.

L.4 R-MMIS BUSINESS CONTINUITY & DISASTER RECOVERY

In the event that the failover solution cannot be successfully executed, the contractor must develop a Disaster Recovery Plan which will ensure the R-MMIS is operational at a second computer site within twenty-four (24) hours. The second site must also meet the Tier III requirements published by the Uptime Institute.

The contractor is also required to ensure that the Disaster Recovery Plan addresses Call Center Operations, all other operational functions discussed in this RFP and office space availability in the event that the primary site becomes unavailable.

The contractor must execute annually a disaster recovery test as outlined in the approved Disaster Recovery Plan.

L.5 PROPOSAL REQUIREMENTS

The offeror must describe in detail its proposed Business Continuity and Disaster Recovery Methodology and how it will fulfill the Department's objective to protect valuable information assets of the R-MMIS and allow continuous availability of business-critical applications. This Business Continuity and Disaster Recovery Methodology should have a set of defined processes that are designed to work together in the event of a disruption or disaster.

At a minimum, the offeror must provide a detailed description of the following:

1. Business processes, methodologies and procedures for back-up and recovery including but not limited to:
    a. Appropriate storage media for back-up copies;
    b. Retention approach for on-site back-up copies and off-site back-up copies;
    c. Back-up and recovery software tools and utilities used; and

   d. Off-site storage location for back-up data copies;
2. Business processes, methodologies and procedures for failover including but not limited to;
   a. How the proposed production configuration(s) will ensure failover and redundancy to meet the system availability requirements outlined in this RFP in an event such as power shutdown or power interruption, failure in the telecommunications equipment, hardware failure (processor, disk storage, memory, I/O subsystem), etc;
   b. Redundant or fail-over strategies associated with all storage device;
   c. Redundant or fail-over strategies with all network hardware; and
   d. Redundant or fail-over strategies with all databases;
3. Business processes, methodologies and procedures for disaster recovery including but not limited to:
   a. The description of the disaster recovery site, including hardware, software, network and disk storage;
   b. If a shared site, the assurances that the R-MMIS will be a priority if the site is necessary;
4. Any tools or COTS products (such as an automated scheduler) used within the business continuity plan;
5. Approach to continuous availability of business-critical applications; and,
6. Approach to the recovery of Call Center Operations, all other operational functions and office space in the event of a disaster.

M. ORGANIZATION AND STAFFING REQUIREMENTS

M.1 OVERVIEW

The successful implementation, operation and maintenance of the R-MMIS relies on an effective organization structure and a highly productive, motivated, and qualified workforce. The contractor must provide a highly skilled technical staff with a breadth and depth of Medicaid knowledge, a proven management team, and a management structure that supports all aspects of the project.

The R-MMIS encompasses a large variety of roles. Many of these roles involve an individual working within multiple phases of the project or have overlapping roles. The offeror is required to provide in its proposal a Staffing and Organization Plan that will list the proposed staffing pattern by each phase of the project. This plan will be used to ensure that the offeror has a clear understanding of the magnitude and complexity of the project.

The offeror must show how the Department's required seventy (70) base staff, which is comprised of twenty-one (21) key and forty-nine (49) core staff, fit within the offeror's overall Staffing and Organization Plan. These key and core staff will provide the base of the contractor's management team and continuity for the Department. The general responsibilities of the key and core staff as well as the minimum qualifications are defined in Attachment O.

Other than the key and core staff this RFP does not define the offeror's staffing requirements. The Department is relying upon the experience and expertise of the offeror to

propose and provide an adequate number of qualified staff to satisfy the requirements in this RFP.

The contractor's staff will work closely with the Department in all phases of the R-MMIS contract and under the direction of designated Department staff and/or Department contractor staff. The contractor's staff will provide knowledge transfer to the Department's technical and programmatic staff throughout the life of the contract. The Department requires that designated key and core staffs are full time, work at the primary project site and are intermingled with Department staff and Department contractor staff as defined in RFP section III.K Facility Requirements. This will enable direct interaction with Department staff.

The staffing requirements in this RFP have been developed to ensure that all offeror understand the Department's expectations for the R-MMIS staff in terms of qualifications, roles and responsibilities, staffing contract constraints and payment mechanisms. Minimum key staffing requirements are described in this RFP. The offeror should describe in its staffing plan any additional key staff they need to accomplish the work proposed.

M.2 CLASSIFICATIONS OF CONTRACTOR STAFF

Key staff consists of the project's senior leadership, technical architects, PBM management, and the management staff assigned to System Operational Enhancements. These resources are responsible for providing the overall leadership and management, obtaining necessary corporate resources, and creating standards and processes required for the successful implementation, operation and maintenance of the R-MMIS. Key staff also provides the technical leadership, direction and management responsible for the oversight of construction, implementation, operation, performance, maintenance and enhancement of the R-MMIS. All key staff positions must be full-time roles filled by a single, dedicated person who is assigned to work at the contractor's primary site. The offeror must name Key staff in its proposal and provide a detailed resume for each. All proposed key staff must be available on the contract start date.

Core staff is key staff that does not need to be named in the offeror's proposal. Core staff consists of some project management staff, team leadership and other staffs who, once assigned to the project, are expected to remain on the project throughout the remainder of the contract to ensure continuity within the System Operational Enhancement and PBM tasks. The offeror is required to propose forty-nine (49) core staff (from the titles defined in Attachment O) to fill out the base staff of seventy (70). These forty-nine staff must be shown in the Staffing and Organization Plan submitted with the proposal. The quantity of each title and their organizational placement will be left up to the offeror based upon its experience and expertise. This will assist the Department in ensuring that the offeror has a comprehensive understanding of the scope of this RFP.

Supplemental staff are staff that the Department, from time-to-time, may ask the contractor to provide over the life of the contract. These staff will be governed by Attachment O of this RFP. The offeror is to bid an hourly rate for these types of staff. Upon receipt of an order

to supply the staff the contractor must supply the staff as quickly as possible based upon the qualifications / experience defined in Attachment O.

The key and core staff requirements do not include the staff the contractor must assigned to the maintenance function described in section III E.2 of this RFP.

The contractor may assign a staff resource to cover several roles if those roles are deemed to be part-time in nature. When the offeror proposes to have one individual fill more than one role, a rationale for the dual assignment must be provided within the staffing plan. However, none of the key staff positions may be shared across multiple assignments; all key staff positions must be a full-time role filled by a single, dedicated person. The Department reserves the right to approve or disapprove the contractor's proposed staffing. The contractor must fill each R-MMIS key, core or supplemental role with individuals having at least the minimum skills and experience as provided in Attachment O Staffing Requirements.

All staff must have a direct reporting line to the Account Executive.

M.3 STAFFING PLAN

Other than base key and core staff, this RFP does not define contractor staffing requirements. As part of its proposal the offeror must provide a detailed Staffing and Organizational Plan discussing each phase of the project, including:

1. Project Planning Phase;
2. Certification Phase;
3. Implementation Phase;
4. System and Operational Enhancements Phase;
5. Operations Phase; and,
6. Turnover Phase.

These staffing plans must include an organizational chart for each stage of the project depicting the key and core staff and showing all other proposed staff by title, minimum qualifications for that title and number of positions being proposed. This plan must be detailed and will be used to determine if the offeror has a comprehensive understanding of the breadth and depth of this RFP and the associated SLAs. The Department will require that the contractor update the Staffing and Organization Plan annually.

The contractor may not transfer, reassign or replace a key or core staff person who is proposed or defined in the annual staffing plan without the written approval of the Department, which shall not be unreasonably withheld. If the Department gives written approval of the transfer, reassignment or replacement of key or core staff such personnel will remain assigned to the performance of duties under this contract until replacement personnel, approved by the Department, are in place performing the key or core staff functions

M.4 PROPOSAL REQUIREMENTS

Offerors must meet the following proposal requirements:

1. Provide a Staffing and Organization Plan, for each phase of the project, detailing how the project staff is actually organized, where the staff is located and how communication is handled between remote sites and the project site. The Staffing and Organization Plan must:
    a. Include an organizational chart depicting key and core staff identified in Attachment O, as well as showing the proposed organizational structure and each organizational units staffing level by title and number of positions for each title being proposed;
    b. Include minimum qualifications for each title;
    c. Describe reporting relationships and responsibilities of each organizational unit depicted in the staffing plan; and,
    d. Describe how the account management team interfaces with the Department's senior management;
2. Provide a description of the offeror's approach to determining staffing levels for the project, including the criteria and process used to develop the staffing estimates;
3. Describe the proposed staffing plan for managing the staff to ensure that project deadlines are met;
4. Describe the proposed organizational structure and staffing levels for providing stakeholders with technical assistance;
5. Provide expected turnover rates based on its experience with similar projects and describe the efforts that will be taken to minimize key staff turnover; and,
6. Provide resumes and any other supporting documentation for the twenty-one (21) key staff positions identified in Attachment O, Staffing Requirements, showing the staff's relevant experience and/or justification that they possess the demonstrated knowledge, skills or ability.

N. TRAINING REQUIREMENTS

N.1 OVERVIEW

The training requirements for the R-MMIS are divided into two main sections: Initial Implementation Training and On-going Training.

Approaches to training must be based on a working partnership with the Department and result in a carefully orchestrated transfer of the knowledge and skills related to processes necessary to support implementation, operations and maintenance activities. The offeror must propose a Training Strategy that is the basis for the contractor's Training Plan. The Training Strategy must demonstrate that the contractor has a clear and comprehensive understanding of the Department's training requirements, the training-related tasks that are needed to support this project, and the contractor and Department roles in those tasks.

At a minimum the Training Strategy must address how the transfer of knowledge will occur between the contractor and project stakeholders including but not limited to:

1. OHIP/DOS staff;
2. Other Department and contractor staff (e.g., Managed Care, MDW, and QA);
3. Other State agencies (e.g., OMIG, OMH, OMR/DD, OASAS and OTDA);
4. Local Districts of Social Services staff (LDSS); and,
5. Providers.

Throughout this RFP, the Department has required the contractor to use COTS products. The contractor must be responsible for ensuring that Department staff has access to and is trained in those COTS products. Refresher COTS training will be required annually.

During parallel testing, the contractor must train all providers; authorized users in the Local Social Service Districts (LDSS) and Department authorized users in all aspects of the R-MMIS.

The contractor is also required to provide on-going training throughout the life of the contract. Subsequent to the R-MMIS implementation, the contractor must support providers, LDSS staff and Department staff with remedial training, training on new functionality and training for new employees and new providers. The contractor must have a regional presence throughout the State and will be required to provide "elbow-to-elbow" training by traveling to LDSS and provider sites.

Although the Department will require a certain amount of regional on-site, "elbow-to-elbow" training in the five regions of the state and the LDSS offices, the contractor is encouraged to propose other delivery mechanisms for training. Because of economic circumstances, fiscal constraints have been placed upon the state and LDSS staff restricting travel. These constraints will require innovative delivery mechanisms to minimize cost and travel.

N.2 PROPOSAL REQUIREMENTS

Offerors must meet the following proposal requirements:

1. Describe the proposed Training Strategy based on its understanding of Department's project goals, the contractor's proposed solution, and the contractor's own experience with comparable MMIS projects;
2. Describe the proposed methods to be used to develop and deliver training to all stakeholders of the R-MMIS;
3. Describe how the proposed Training Strategy will achieve the expected training outcomes detailed in this RFP;
4. Provide a recommended training course list and proposed content to support each stakeholder role;
5. Describe the organizational structure that will be used to ensure a regional presence and "elbow-to-elbow' training at provider and LDSS sites;
6. Describe the proposed approach to knowledge transfer and the training mechanisms that will be put into place to not only ensure but to measure the knowledge transferred;

7. Describe the proposed innovative delivery mechanisms that will be put into place to reduce the cost and travel associated with training; and,
8. Describe the training that will be available for each proposed COTS product.

O. CONTRACTOR PERFORMANCE REQUIREMENTS

The contractor must 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 Payment Error Rate Measurement (PERM), 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 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 must warrant that the R-MMIS must meet all requirements of this RFP, must be fully operational on the takeover date designated in Exhibit I-1 and must meet all CMS requirements, including certification requirements for the Department to claim the maximum allowable Federal Financial Participation (FFP) 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 must at all times operate the R-MMIS and perform its activities in conformity with the policies and procedures of the NYS Medicaid program. All requirements described in this 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.

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 the R-MMIS certification is lacking. Should Federal certification subsequently be granted retroactively, the Department shall reimburse the contractor for amounts withheld back to the date of Federal 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.

O.1 PERFORMANCE STANDARDS AND DAMAGES

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 must 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.

O.1.1 Loss or Reduction in Federal Financial Participation (FFP) for the New York State R-MMIS - Requirement

Section 1903(a) of Title XIX provides ninety percent (90%) FFP for development and seventy-five percent (75%) FFP for operation of mechanized claims payment and information retrieval systems approved by CMS. The contractor is responsible for all FFP penalties imposed on the State by CMS due to any action or inaction on the part of the contractor that delays or results in denial of approval by CMS of the R-MMIS.

Damages shall be assessed when incurred by the State if the R-MMIS is not certified by CMS retroactive to the beginning date of full operations. In addition, should decertification of the R-MMIS, or any component part of it, occur prior to termination of the contract or any subsequent extension thereof, the contractor will be liable for resulting damages to the State.

The contractor is responsible for maintaining the R-MMIS as well as the contract operations to the standards required to pass the periodic PERM reviews conducted by CMS or any subsequent review process established by CMS. The contractor must provide support to the Department during the PERM review 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 CMS inquiries. This level of support shall also be provided to all other State audit agencies or their designees.

O.1.1.1 Loss or Reduction in Federal Financial Participation (FFP) for the New York State R-MMIS - Damages

The contractor must be liable for the difference between the maximum allowable enhanced 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 PERM standards if attributable to the contractor. Damage assessments shall not be made until CMS has notified the State of its decision in writing.

O.1.2 Claims and Adjustment Processing Accuracy - Requirement

All payments, adjustments, and other financial transactions made through the R-MMIS for capitation payments, medical services, or insurance premiums (e.g., Buy-In or indemnity) must

be made on behalf of eligible members, to enrolled entities, for approved services, and in accordance with the payment methodology and other policies of the NYS Medicaid program. The contractor must notify the Department immediately upon discovery of any mispayments or duplicate payments, irrespective of cause.

O.1.2.1 Claims and Adjustment Processing Accuracy – Damages

The contractor must 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 must 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 must 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 must 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.

O.2 SERVICE LEVEL AGREEMENTS

Service Level Agreements (SLAs) play an important role in defining and managing the relationship between the contractor and the Department for the R-MMIS. SLAs define the Department's service requirements and expectations regarding how the contractor will meet these requirements. A successfully implemented service level management discipline ensures that information systems function smoothly while fulfilling the business needs of stakeholders.

This section presents the following project areas and their associated SLAs:

1. Performance;
2. Staffing;
3. Quality; and,
4. Business Continuity.

O.2.1 Performance

Sub-categories within performance include:

1. System Availability;
2. Processing Performance;
3. Customer Service Center; and,
4. Operational Reporting.

O.2.1.1 System Availability

R-MMIS Availability Schedule			
Requirements Category	Description	Specifications	Damages
Production Environment Hours of System Availability	The hours that the production environment needs to be operational and available. This SLA also applies to the failover and disaster recovery environments when they are used for production.	**Access Hours**: 24 hours/day, 7 days a week System availability requirement is one-hundred percent (100%).	$1000/minute penalty for any disruption in production environment
User Acceptance Test, ITF and CERT Environments Hours of System Availability	The hours that the environment needs to be operational and available.	**Access Hours**: 7 am – 7 pm ET, 6 days/week (Monday – Saturday) Monthly system availability requirement is a minimum of ninety-eight percent (98%) for each environment	$500/minute penalty for any disruption in User Acceptance Test, ITF and CERT environments
Provider Test	The hours that the environment needs to be operational and available.	**Access Hours**: 24 hours/day, 7 days a week Monthly system availability requirement is a minimum of ninety-eight percent (98%).	$500/minute penalty for any disruption in provider test environment
Production Environment R-MMIS Dashboard		**Access Hours**: Accessible by Department staff between 7 am – 7 pm ET, 5 days/week (Monday – Friday) Monthly system availability requirement is a minimum of ninety-eight percent (98%).	$500/minute penalty for any disruption in the production dashboard
Image Retrieval System		**Access Hours**: 24 hours/day, 7 days a week System availability requirement is one-hundred percent (100%).	$1,000 per hour or any portion thereof

O.2.1.2 Processing Performance

Processing Performance			
Requirements Category	Description	Specifications	Damages
Electronic Log Files		The contractor must maintain the necessary data in appropriate log files to measure its performance against the SLAs defined in this RFP. If the Department notifies the contractor that damages will be assessed because of nonconformance with an SLA and the log files are not maintained or are damaged in such a way that the contractor cannot substantiate its performance against an SLA it will be construed that the contractor did not meet the SLA in question.	The damages for the appropriate SLA will be assessed.
Electronic Claims Adjudication		Adjudicate a minimum of ninety-eight percent (98%) of all claims within one (1) calendar day of receipt. Time during which claims are under review by the Department will not count toward the adjudication standard.	$.25/claim for each claim that was not adjudicated within one (1) calendar day of receipt.
Electronic Claims Adjudication		Reprocess erroneously denied claims within three (3) business days of discovery of erroneous denial.	$.35/claim for each claim that was processed incorrectly
Claims Payment		Perform payment cycles as frequently as once a day on a schedule approved by the Department.	5% of total amount of paid claims in payment cycle
Non-Electronic Claims Adjudication		Pay, deny, or pend paper claims within seven (7) calendar days of receipt by the contractor.	$.75/claim for each claim that was not processed within the seven (7) calendar days
Drug Rebate (OBRA and Supplemental) Receipt Processing		Post Drug Rebate Invoice payments within forty-eight (48) hours of Contractor receipt.	$100 per payment not posted within forty-eight (48) hours of Contractor receipt.
Inbound Files		Process inbound files within 16 hours of receipt of the file.	One thousand dollars ($1,000) per file
Pricing Reference		Batch files containing reference	Amount of any

Processing Performance			
Requirements Category	Description	Specifications	Damages
Files		data required to price claims must be processed on the date specified by the Department.	overpayment or underpayment for claims processed using out-dated files plus ten percent (10%)
Outbound File to MDW		Process outbound files at a minimum daily to feed MDW.	$100,000 per file
All other Outbound Files		Process outbound files at a frequency as defined by the Department.	$1,000 per file
Notification of errors of inbound and outbound files reconciliation		Support and monitor the processing of transaction files and notify the Department of all transactions that have not been processed successfully. This notification must take place no later than one (1) business day of transaction processing date.	$5,000 for each occurrence of failure to notify the Department
Image Retrieval	The time it takes to get a viewable image to the user.	Have at a minimum ninety percent (90%) of document image retrieval response times during a given calendar day and be within 5 seconds. The remaining ten percent (10%) must not average more than twenty (20) seconds for a given calendar day.	$1,000 per day per occurrence
IVR &ARU Connections		Provide sufficient in-bound access so that Medicaid providers are connected with the IVR and ARU system(s) within two (2) telephone rings at least ninety-nine percent (99%) of the time; transaction response shall be within ten (10) seconds at a minimum ninety-nine percent (99%) of the time. The contractor must meet this SLA for both peak hours and non-peak hours.	$1,000 per day per occurrence

O.2.1.2.1 Batch Processing Performance

Batch Transaction Processing Performance			
Requirements Category	Description	Specifications	Damages
Batch Transactions Acknowledgement		Acknowledge the receipt of batch transaction files to the originator within 2 hours for at least ninety-five percent (95%) of the batches received on any calendar day and within at least 3 hours for ninety-eight (98%) of the batch files received on any calendar day. The remaining two percent (2%) must have an acknowledgment within ten (10) hours.	$1,000 per file not responded to within the appropriate time
Batch Transactions Response		At least ninety-five percent (95%) of all batch transactions files received on any one calendar day must have responses processed back to the originator within 4 hours of receipt of batch transactions. The remaining five percent (5%) for any one calendar day must be responded to within 6 hours. Response for this SLA is defined as the availability of the 999/997 transactions.	$1,000 per file not responded to within the appropriate time
Eligibility Transactions		At a minimum ninety-eight percent (98%) of the eligibility batch files received prior to 3 a.m. ET must be processed by 8 a.m. ET of the same day. The remaining two percent (2%) must be processed by the next business day.	$1,000 per eligibility file not processed within the appropriate time
All Other Batch Transactions		One hundred percent (100%) of all batch files containing provider initiated transactions must be processed within 24 hours of receipt of batch transactions.	$1,000 per eligibility file not processed within the appropriate time

O.2.1.2.2 Real-Time Transaction Performance

Real-Time Transaction Processing Performance			
Requirements Category	Description	Specifications	Damages
All Real-time Transactions including but not limited to: Web Portal, Web based applications, other real-time connections		Response time for users accessing the R-MMIS via real time transactions must not be greater than two (2) seconds for at least ninety percent (90%) of the transactions and no response time must be greater than five (5) seconds. The contractor must meet this SLA for each day during both peak hours and non-peak hours. The SLA is measured daily and reported monthly.	$5,000 per hour or any portion thereof that response time does not meet the times designated

O.2.1.3 Customer Service Center

Customer Service Center			
Requirements Category	Description	Specifications	Damages
Hours of Call Center Availability	The hours that the Call Center needs to be operational and available	**Access Hours**: 24 hours/day, 7 days a week	$5,000 per hour or any portion thereof that the call center is not available.
Call Center Responsiveness	**Average Speed to Answer** This service level measures the average speed in which agents answer calls. An answer is defined as an agent speaking to a caller. **Hold Time** The service level measures the total amount of time a customer spends on hold	**Average Speed to Answer** Calls must be answered within three (3) rings or fifteen (15) seconds. If an automatic voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. Total hold time for an operator shall be equal to no more than two (2) minutes for ninety-eight percent (98%) of the calls that are put on hold for the daily peak and non-peak times. **Hold Time** At least ninety-eight percent (98%) of the callers that are placed on hold for the daily average at peak time and non-peak time cannot remain on hold for more than thirty (30) seconds This SLA will be measured daily but reported out monthly.	$1,000 per hour or any portion thereof that the calls are not serviced as per the SLA $1,000 per hour or any portion thereof that the calls are not serviced as per the SLA
Call Center Responsiveness		**Telephone Abandonment Rate** The percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%), calculated for the daily peak and non-peak times. This SLA will be measured daily but reported out monthly.	$1,000 per hour or any portion thereof that the calls are not serviced as per the SLA

Customer Service Center			
Requirements Category	Description	Specifications	Damages
Call Center Responsiveness		Maintain a sufficient number of toll free telephone lines and personnel to staff the lines so that no more than two percent (2%) of incoming calls for the daily average at peak time and non-peak time ring busy.	$1,000 per hour or any portion thereof that the calls are not serviced as per the SLA
Call Center Responsiveness		Resolve all information 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 notify the Department within 24 hours of any delayed requests including the estimated response date. 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.	$500 dollars per occurrence
Provider Applications and Maintenance Requests		Process to completion ninety-eight percent (98%) of all clean provider applications and maintenance updates within two (2) business days of receipt. Process to completion the remaining two percent (2%) within five (5) business days of receipt. For “non-clean” applications (i.e., 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 must complete processing of “non-clean” applications within five (5) business days of receipt of the requested information. The contractor must maintain a log to support the monitoring of compliance with this standard and shall prepare and submit a	$500 dollars per application per day

Customer Service Center			
Requirements Category	Description	Specifications	Damages
		monthly report summarizing the information maintained on this log.	
Correspondence both hardcopy and electronic correspondence		Respond to at least ninety-eight percent (98%) of all written provider correspondence (inquiries) with a written response within at least ten (10) business days of receipt of the provider's correspondence by the contractor. Respond to the remaining two percent (2%) within at least fifteen (15) business days of receipt by the contractor. Responses are not complete until response is available to Department staff in the document repository.	$500 dollars per correspondence per day
Prior Approval		Process to completion ninety-five percent (95%) of Prior Approval Requests received by the Customer Service Center during the initial call. Process to completion one hundred percent (100%) of Prior Approval Requests received by the Customer Service Center within twenty-four (24) hours.	$1,000 per day that the Prior Approvals are not processed as per the SLA
Prior Approval paper requests and scanable supporting documents for Prior Approval (PA) requests that are delivered to the contractor's mail room		Scan documents, and associate them with the appropriate PA request and scanned artifact(s), within one (1) business day of receipt.	$500 dollars per document per day

O.2.1.4 Operational Reporting

Operational Reporting			
Requirements Category	Description	Specifications	Damages
EFT Registry		Produce and provide through electronic transmission a check register, EFT register, and all shares reports to the Department within 24 hours of completing the payment cycle.	$100,000 if a check register, EFT register, and all shares reports are not produced and distributed on-time
1099 Reporting		Produce and mail to providers 1099 earnings reports in accordance with Federal and State regulations.	$200,000 if 1099's are not accurate or produced and distributed on-time
1099 Reporting		Produce and transmit electronically original and corrected 1099 files for the IRS and NYS Department of Tax and Finance in accordance with Federal and State regulations.	$200,000 plus any penalties imposed on the Department by the IRS if 1099 files are not accurate or produced and distributed on-time
OBRA, Supplemental, and Supply Rebates	Generation and Transmittal of Drug Rebate Invoices	Generate and transmit Drug Rebate Invoices no later than 60 calendar days after the end of the quarterly rebate period.	For each quarter in which 100% of the invoices are not generated and transmitted no later than 60 calendar days after the end of each quarterly rebate period, contractor will pay $50,000 for each calendar day beyond the 60 days, up to and including the day that 100% of the quarterly invoices are generated and transmitted.
OBRA, Supplemental, and Supply Rebates	Accuracy of Drug Rebate Invoices	Produce invoices at a 98% accuracy rate. The accuracy measurement will take into account, but not be limited to, items such as: • Units • Unit Rebate Amounts • NDCs • Labelers • Reimbursement including 3rd Party • Summary amounts	For each quarter in which drug rebate invoices do not meet the 98% accuracy rate, contractor will pay $50,000 for each one (1) percent or fraction thereof in which the contractor's accuracy rate falls below 98% as measured by the contractor utilizing a statistically valid measurement methodology. Both the measurement

Operational Reporting			
Requirements Category	Description	Specifications	Damages
			methodology and measurement results must be approved in writing by DOH. All costs incurred for correcting and reissuing invoices found to contain material inaccuracies, as determined by DOH, will be the sole responsibility of the contractor. Maximum damages of $500,000 per quarter.
OBRA, Supplemental, and Supply Rebates	Maintain and Maximize Rate of Drug Rebate Accounts Receivable Collection within 45, 90, and 180 days of Invoicing.	Maintain and Maximize Accounts Receivable Collection rates at 45, 90, and 180 days from the date each quarterly invoice is transmitted. The minimum standard for accounts receivable collection rates are as follows: 45 days: 90% of Invoiced Amount Collected 90 days: 95% of Invoiced Amount Collected 180 days: 97% of Invoiced Amount Collected	The calculation of the percentage of total amount of rebates collected to total amount of rebates invoiced for each quarter is as follows: Total Rebates Received for the Invoiced Quarter divided by Total Rebates Invoiced for the Quarter For each quarter in which the percentage of total amount of rebates collected to total amount of rebates invoiced do not meet the minimum standard, the contractor will pay $20,000 for each one (1) percent or fraction thereof in which the collection rate falls below the standards as measured by the contractor and subject to review and approval by DOH. Maximum damages per quarter are $360,000 with individual limits as follows: 45 days: $200,000 90 days: $100,000 180 days: $60,000

Operational Reporting			
Requirements Category	Description	Specifications	Damages
OBRA, Supplemental, and Supply Rebates	Drug Rebate Receipt Processing	97% of rebate payments must be posted within two business days of receipt and 100% must be posted within 10 business days. For example, checks received on Monday and posted by Wednesday will have been posted in 2 business days. Checks received on Friday and posted on the following Wednesday will have been posted in 3 business days.	For each month in which 97% of rebate payments are not posted within two business days of receipt and 100% of rebate payments are not posted within 10 business days, contractor will pay damages of $5,000.
Supplemental Rebate	Maintain and Maximize Supplemental Rebate Revenue	Maintain and maximize the accrual and receipt of supplemental rebates through the NYS Medicaid Pharmacy Preferred Drug Program. The minimum standard shall be determined by calculating the percentage of Supplemental Rebate revenue received during the full 12 month period prior to the contract effective date of the total amount paid for prescription drugs for the same full 12 month period, rounded up to the second decimal point. For example, a result of 5.046 % would be rounded up to 5.05%.	The calculation of the percentage of supplemental rebate revenue to the total amount paid for Medicaid FFS prescription drugs is as follows: (Supplemental Rebate Revenue Received per Calendar Year) divided by (Total Amount Paid for Prescription Drugs per Calendar Year) At DOH's sole discretion, the contractor may be deemed financially responsible for any of or the entire amount determined by DOH to have fallen below the minimum standard.
OBRA, Supplemental, and Supply Rebate Reporting	Drug Rebate Reporting	Produce and provide to DOH accurate financial reporting under the timeframe(s) agreed to by the contractor.	The contractor will pay $250 per day for each business day for which accurate financial reporting has not been provided to DOH according to the timeframe(s) agreed to by the contractor.
Maintain and Maximize Cost Avoidance Attributable to State Maximum Allowable Cost (SMAC) Pricing		Maintain and maximize cost avoidance attributable to SMAC pricing. Cost avoidance is the difference between the actual cost for multi-source NYS Medicaid FFS drugs that	The calculation of the percentage of SMAC cost avoidance to the total amount paid for generic Medicaid FFS

Operational Reporting			
Requirements Category	Description	Specifications	Damages
		are paid at a SMAC price and the cost that would have been paid absent SMAC pricing. The minimum, standard for SMAC cost avoidance is 35 % of the total amount paid for generic Medicaid FFS prescription drugs in each calendar year.	prescription drugs is as follows: (SMAC Cost Avoidance Achieved per Calendar Year) divided by (Total Amount Paid for Generic Prescription Drugs per Calendar Year) At DOH's sole discretion, the contractor may be deemed financially responsible for any of or the entire amount determined by DOH to have fallen below the minimum standard.

O.2.2 Staffing

Staffing			
Requirements Category	Description	Specifications	Damages
Staffing Levels	Staffing levels are defined in the Staffing and Organization Plan and depict staffing per calendar month. Key staff roles are defined in Attachment O.	The contractor must meet the minimum staffing levels as stated in the Staffing and Organization Plan for each calendar month. The contractor must fill a vacant key staff position within thirty (30) calendar days.	$1,000 per day that minimum staffing levels are not met. One-tenth (.1%) of one percent of the fixed monthly administrative fee for each additional day beyond the initial thirty (30) calendar days the position remains vacant.

O.2.3 Quality

Quality			
Requirements Category	Description	Specifications	Damages
Data Quality Management	The contractor must notify appropriate Department staff when a data quality issue has been discovered or the contractor is notified of a data issue by the Department or another third party, describing the nature of the defect and the columns, tables and data elements impacted and the extent of the errors. At the direction of the Department, the contractor must notify affected users in accordance with procedures outlined in the Communication Plan.	The contractor must notify appropriate Department staff via the Department's formal notification process for each occurrence of a data quality defect within twenty-four (24) hours of discovery of occurrence or within twenty-four (24) hours of notification to the contractor of the occurrence. The contractor must notify affected users within twenty-four (24) hours.	$100,000 per each failure to provide notification of a data quality defect as defined in the Data Quality Audit SLA.
Data Quality Audit	On a quarterly basis, the R-MMIS tables and files will be assessed by an automated process to identify any existing data quality issues to determine what percentage of data elements is defect-free	First two years of operation: Requirement, ninety-eight percent (98%) defect-free per quarter. Each successive year of operations: Requirement, ninety-nine percent (99%) defect-free per quarter.	$100,000 per each occurrence for each quarter that the R-MMIS fails to meet the data defect percentage quality audit requirement for the applicable year as defined.

O.2.4 Business Continuity

Business Continuity			
Requirements Category	Description	Specifications	Damages
Backup and Recovery	Backups and must be executed as described in section III.L of Attachment J.	Daily and weekly backups must be executed and backups must be stored off-site. (See section III.L of Attachment J).	If backup/recovery strategy is not executed as defined, the Department may assess a penalty of $100,000 per occurrence.
Failover and Fallback	Failover and fallback is the capability to immediately switch operations from the production environment to the failover environment in the event technical problems incapacitate the production environment.	Failover and fallback processes must be executed per section III.L of Attachment J.	$100,000 if the failover does not successfully occur within five (5) minutes
Disaster Recovery	Disaster recovery refers to major disruptions to the production environment. Plans, procedures, and infrastructure need to be established to recover from a major disaster and resume daily operations with minimal downtime.	Disaster recovery processes and tests must be executed per section III.L of Attachment J.	$100,000 per occurrence, if the disaster recovery test is not executed as defined.

IV. PROPOSAL REQUIREMENTS

A. INTRODUCTION

These instructions prescribe the format and content of the offeror's proposal and are designed to facilitate the submission of a proposal that is easy to understand and evaluate. Failure to adhere to these instructions may result in the disqualification of the Proposal.

For the purposes of this section, the terms bidder, offeror and vendor may be used interchangeably and the terms bid, offer or proposal may be used interchangeably.

B. PROPOSAL REQUIREMENTS OVERVIEW

The following sections include requirements to be met by offerors in the submission of their Request for Proposal (RFP) responses. Other proposal requirements that are specific to business or other functional areas are identified independently as Proposal Requirements in Attachment P Proposal Requirements. Attachment J Bidder Requirements Traceability Matrix provides a comprehensive listing of all project requirements.

In submitting a response to this RFP, interested offerors should be aware that it is their sole responsibility to obtain any third party financing which may be necessary for the offeror to submit a proposal and, if an award is made, to provide the services being sought by the Department under the RFP. The State of New York or the Department will in no manner underwrite, guarantee, act as a signatory or co-signatory or in any manner participate in the securing of third party financing.

B.1 GENERAL REQUIREMENTS

1. By signing the "Bid Form" in Attachment D, each bidder attests to its express authority to sign on behalf of this company or other entity and acknowledges and accepts that:
    a. The RFP and all associated specifications, general and specific appendices, including Appendix A Standard Clauses for NYS Contracts and all schedules and forms included with such documents, as well as subsequently issued and agreed-upon work specifications issued pursuant to this Contract, will become part of any contract entered into, resulting from the RFP. Anything which is not expressly set forth in the above-referenced documents, but which is reasonable to be implied, shall be furnished and provided in the same manner as if specifically expressed.
    b. Each bidder is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality, and extent of work, products and services to be performed and the conditions under which the contract is to be executed.
2. The Department of Health will make no allowances or concession to an offeror for any alleged misunderstanding or deception related to quantity, quality, character, location or other conditions.
3. The proposal price must cover the cost of furnishing all of the said services, materials, equipment, and labor to the satisfaction of the Department of Health and the performance of

all work set forth in said specifications. Work to be provided by subcontractors must be documented in the RFP response.

4. If the use of subcontractors is proposed, the Proposal should explain how the work of subcontractors will be managed and controlled.

B.2 EXPERIENCE

1. The offeror shall submit documentation to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the services required including at least the following:
    a. The offeror must have a minimum of sixty (60) months of large scale, complex health care claim processing experience with Medicaid and/or health services organizations, or within other complex health care delivery systems such as managed care organizations; and,
    b. The offeror must have been the prime contractor for at least one (1) project that approximates the scope of this project and that includes system design, development, implementation, maintenance and operations and large, complex medical claims processing.

B.3 REFERENCES

1. The offeror should provide three (3) references external to the offeror or subcontractor organizations. The purpose is to provide the Department the ability to verify the claims made in the proposal by the offeror.
2. The references in total provided must meet all of the criteria below. The reference criteria are as follows:
    a. Every reference should be with regard to a project implemented within the past ten (10) years;
    b. The offeror should have been the prime contractor for at least one (1) of the contract(s) associated with any one of the three references;
    c. The services provided for each of the references should have included system design, development, implementation, maintenance and operations; and,
    d. At least one of the references should be for a health care claims processing system.

3. The Department reserves the right to contact additional references (i.e., those known to the Department as clients of the offeror but not listed by the offeror as a reference).

B.4 NON-COLLUSIVE BIDDING

By submission of this proposal, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its/his/her/their knowledge and belief:

1. The prices of this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;

2. Unless otherwise required by law, the prices that have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly to any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition; and
3. No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

NOTE: Chapter 675 of the Laws of New York for 1966 provides that every bid made to the State or any public department, agency or official thereof, where competitive bidding is required by statute, rule or regulation, for work or services performed or to be performed or goods sold or to be sold, shall contain the foregoing statement subscribed by the bidder and affirmed by such bidder as true under penalties of perjury.

A bid shall not be considered for award nor shall any award be made where (1), (2) and (3) above have not been complied with; provided however, that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefore. Where (1), (2) and (3) above have not been complied with, the bid shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the State, public department or agency to which the bid is made or its designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder has published price lists, rates, or tariffs covering items being procured, has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or has sold the same items to other customers at the same price being bid, does not constitute, without more, a disclosure within the meaning of the above quoted certification.

Any bid made to the State or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods, sold or to be sold, where competitive bidding is required by statute, rule or regulation and where such bid contains the certification set forth above shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation or other legal entity involved in the bid.

B.5 TECHNOLOGY PURCHASES NOTIFICATION POLICY

For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices; and

Any contract entered into pursuant to an award of this RFP shall contain a provision which extends the terms and conditions of such contract to any other State agency in New York. Incorporation of this RFP into the resulting contract also incorporates this provision in the contract.

B.6 MINORITY AND WOMEN OWNED BUSINESS POLICY STATEMENT

The New York State Department of Health recognizes the need to take affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department of Health's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy. It is the intention of the New York State Department of Health to fully execute the mandate of Executive Law, Article 15-A and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law. To implement this affirmative action policy statement, the contractor agrees to file with the Department of Health within ten (10) days of notice of award, a staffing plan of the anticipated work force to be utilized on this contract or, where required, information on the contractor's total work force, including apprentices and subcontractor staff, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing plan shall be supplied by the Department.

For purposes of this procurement and resulting Contract, the Department has established a goal of 15% for minority business enterprises (MBE) participation and 10% for women-owned business enterprises (WBE) participation, based on the total dollar value of the contract. As part of its proposal, and utilizing the forms as applicable in Attachment Q the Bidder is expected to document in detail and certify the good-faith efforts it will undertake to solicit the participation of such enterprises to meet these goals, and must provide an explanation acceptable to the Department in the event it cannot meet those goals.

After an award of this contract, the contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this contract, broken down by specified ethnic background, gender and Federal occupational categories or other appropriate categories specified by the Department. An updated version of such report shall be provided annually on the anniversary date of this contract. The contractor also agrees to submit, as part of its proposal and in updated form throughout the life of the contract, the additional forms provided as Attachment Q to this RFP.

Contractor must attempt to utilize, in good faith, any MWBE identified within its work force utilization report, during the performance of the contract. Requests for a partial or total waiver of established goal requirements may be made at any time during the term of the Contract to the Department, so long as such request is made as soon as possible and prior to the submission of a request for final payment on the contract.

B.7 CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in Federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for non procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the Federal government. A person who is debarred or suspended by a Federal agency is excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one Federal agency has government-wide effect. Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1. APPENDIX B TO PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS
2. Instructions for Certification:
    a. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below;
    b. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment;
    c. The prospective lower tier participant shall provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances;
    d. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations;
    e. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction,

unless authorized by the department or agency with which this transaction originated;

f. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions;
g. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of parties Excluded from Federal Procurement and Non procurement Programs;
h. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings; and
i. Except for transactions authorized under paragraph e of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions.
   a. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department agency; and
   b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

B.8 CONFLICT OF INTEREST

As part of its bid submission, the offeror (and /or any subcontractor(s) must comply with the following:

1) Disclose any potential or actual conflict of interest, including but not limited to, any relationship or interest, financial, business, beneficial or otherwise, which is in conflict with the proper discharge of their responsibilities under this RFP as the fiscal agent for the design, development, implementation, operation, processing, auditing and making of payments for the

New York State Medicaid Program. If there is no conflict(s) of interest, so indicate. In cases where such relationship (s) and/or interests exist, offeror must describe how a potential or actual conflict of interest and/or disclosure of confidential information relating to this contract will be avoided;

2) Guarantee knowledge and full compliance with the New York State Public Officers' Law (POL), as amended, including but not limited to Sections 73 and 74, as amended, with regard to ethical standards applicable to State employees;

3) Further, offeror acknowledges that State employees must not benefit from the awarding of the contract, subject to POL, Sections 73 and 74, which are referenced as the Code of Ethics and found at http://www.nyintegrity.org/law/ethc/POL74.html, and in particular, Section 74(2) entitled "Rule with respect to conflicts of interest", no officer or employee or a state agency should have any interest, financial or otherwise, direct or indirect, or engage in any business or transaction or professional activity or incur any obligation of any nature, which is in substantial conflict with the proper discharge of his duties in the public interest; and,

4) State that the offeror understands and acknowledges that subject to the State Finance Law, Section 163-a, if a vendor prepares and furnishes specifications for a state agency technology procurement proposal, to be used in a competitive acquisition, such vendor shall not be permitted to bid on such procurement either as a prime vendor or as a subcontractor.

The Department reserves the right to reject bids, at its sole discretion, based on any potential or actual Conflict of Interest. Failure to comply with these provisions may result in disqualification from the procurement process, withdrawal of a proposed contract award, and criminal proceedings as may be required by law.

C. PROPOSAL SUBMISSION INSTRUCTIONS

A Proposal consists of two distinct parts: (1) the Technical Proposal, and (2) the Price Proposal. The graphic below outlines the format and volume for submission of each part:

	DVD	Original	Copies
Technical Proposal	1 copy in Adobe PDF; 1 copy in MS Word 2003/XP; and 1 copy of all project plans in MS Project 2003/XP.	1 Original Hard Copy	40 Hard Copies
Price Proposal – excluding Company Financials	1 copy in Adobe PDF (complete); 1 MS Office copy consisting of: • Narrative in MS Word 2003/XP as needed; and • **Attachment M Worksheets in MS Excel 2003/XP- MANDATORY**	1 Original Hard Copy	12 Hard Copies
Price Proposal – Company Financials	N/A	1 Original Hard Copy	N/A

1. The proposal must be received by the Department in Albany, New York, no later than the time on the day specified on page i of this RFP and at the address specified in section V.E.1 Administrative Requirements Two-part Proposals of this RFP.
2. It is the bidders' responsibility to see that bids are delivered to the address specified in section V.E.1 Administrative Requirements Two-part Proposals of this RFP prior to the date and time of the bid due date. Late bids, for whatever reason, including delay by the carrier or not being received in the Department's mail room in time for transmission to the address specified in section V.E.1 Administrative Requirements Two-part Proposals of this RFP, will not be considered.
3. All proposal materials should be printed on 8.5” x 11” white paper (two-sided), be clearly page numbered on the bottom of each page with appropriate header and footer information. A type size of eleven (11) points or larger should be used. The Technical Proposal materials should be presented in D-ring binder(s) separate from the sealed Price Proposal and audited Company Financial Statements. The sealed Price Proposal, audited Company Financial Statements and Comprehensive Dunn & Bradstreet Reports should also be presented in separate D-ring binder(s);
4. Two (2) separate DVD(s) should accompany the hard copy proposals; one for the technical proposal and a separate DVD(s) for the Price Proposal. All files on the DVDs should be individually identified by Component Name, Offeror, proposal part, and version.

5. The proposal should be as specific as possible in its responses to provide the Department with an adequate understanding of the intent of the proposal; and,
6. The Department discourages overly lengthy proposals. Proposals should be self-contained. No models, videotapes, illustrations, brochures or Web site postings will be accepted.
7. In the event of any discrepancies between the original hard copies of the Technical Proposal and Price Proposal and the copies supplied on DVD, the hardcopy will prevail.

Any questions concerning this RFP contract procurement must be directed to the parties listed in page ii of this document.

D. TECHNICAL PROPOSAL CONTENTS

The Technical Proposal consists of the following sections separated by tabs. Documents and responses should be presented in this order:

Tab	Proposal Contents
1	Table of Contents
2	Transmittal Letter
3	Executive Summary and Introduction
4	Scope of Work
5	Contractor and Systems Requirements
6	Corporate Organization, Experience, and Qualifications

D.1 TABLE OF CONTENTS (TAB 1)

A Table of Contents of the Technical Proposal should be inserted in Tab 1. The Table of Contents should identify all sections (identified here as Tabs), all subsections contained therein, and the corresponding page numbers. The Table of Contents should include all sections and subsections present under Tabs 1 through 7. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Technical Proposal Table of Contents.

D.2 TRANSMITTAL LETTER (TAB 2)

Bidders should submit a Transmittal Letter(s), template provided in Attachment R, signed by an individual authorized to legally bind the offeror to the provisions of the RFP. The signature shall be hand written and the Transmittal Letter included in Tab 2. A photocopy of the Transmittal Letter should be included in each copy of the Technical Proposal. The Transmittal Letter(s) will be evaluated as part of the screening and should include:

1. The complete name and address of the company and the name, mailing address, email address, fax number and telephone number for both the authorized signer and the person the Department should contact regarding the proposal;
2. A statement that the offeror has the necessary qualifications and experience delineated in Section B.2 of this section of the RFP;

3. A statement that the primary facility will be located within ten (10) miles of the New York State Capitol building in Albany, New York and all other facilities will be located within the continental United States;
4. A statement indicating the legal structure of the entity submitting the offer;
5. A statement that the offeror accepts the contract terms and conditions contained in this RFP including attachments;
6. A statement confirming that the offeror has received and acknowledged all Department amendments to the RFP, as may be amended;
7. A statement confirming that the offeror is either registered to do business in New York State, or if formed or incorporated in another jurisdiction than New York State, can provide a Certificate of Good Standing from the applicable jurisdiction or provide an explanation, subject to the sole satisfaction of the Department, if a Certificate of Good Standing is not available;
8. A statement that the Offeror (i) does not qualify its proposal, or include any exceptions from the RFP and (ii) acknowledges that should any alternate proposals or extraneous terms be submitted with the proposal, such alternate proposals and extraneous terms will not be evaluated by the Department;
9. A statement that the proposal of the offeror will remain valid for a minimum of 365 calendar days from the closing date for submission of proposals;
10. A statement that the offeror agrees that it has the sole responsibility for obtaining any third party financing which may be necessary for the offeror to submit a proposal, and further that the offeror understands and agrees that should an award be made, the State of New York and the Department of Health will in no manner underwrite, act as a signatory or co-signatory, or in any manner guarantee participation in the securing of the offeror's financing;
11. A statement which complies with the four conflict of interest requirements set forth in RFP Section IV.B.8., Conflict of Interest. Where any potential or actual conflict is disclosed, a description should also be included as to how a potential or actual conflict and/or disclosure of confidential information relating to the contract will be avoided. If there is no conflict of interest a statement so indicating should be included;
12. If a proposal is submitted which proposes to utilize the services of a subcontractor(s), the offeror should provide, in an appendix to the Transmittal Letter, one subcontractor summary for each listed subcontractor. An individual authorized to legally bind the subcontractor should sign that subcontractor's summary document and certify that the information provided is complete and accurate. The summary document should contain the following information:
    a. Complete name of the subcontractor;
    b. Complete address of the subcontractor;
    c. Type of work the subcontractor will be performing;
    d. Percentage of work the subcontractor will be providing;
    e. Evidence that the subcontractor is (i) either registered to do business in New York State, or if formed or incorporated in another jurisdiction than New York State, can provide a Certificate of Good Standing from the applicable jurisdiction or provide an explanation, subject to the sole satisfaction of the Department, if a Certificate of Good Standing is not available;
    f. A general description of the scope of work to be performed by the subcontractor; and,

g. The subcontractor's assertion that it does not discriminate in its employment practices with regards to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin or handicap.

D.3 EXECUTIVE SUMMARY AND INTRODUCTION (TAB 3)

Tab 3 should be labeled Executive Summary and Introduction which contains a narrative prepared by the offeror that provides the Department with a collective understanding of the contents of the entire Proposal. The Executive Summary / Introduction should briefly summarize the strengths of the offeror and the key features of its proposed approach to meet the requirements of the RFP.

D.4 SCOPE OF WORK (TAB 4)

Tab 4 should be labeled Scope of Work. In this section, the offeror should document its approach to requirements described in section III R-MMIS Statement of Work by responding to each proposal requirement presented in that section and listed in Attachment P Proposal Requirements. The offeror should indicate in Attachment P the location of a response to a proposal requirement by filling in column F "Location of Response in Offeror's Proposal".

If the response to a requirement can be found in multiple locations then multiple entries should be made in column F. It is the offeror's responsibility to clearly identify where in the proposal an evaluator can find a response to a requirement.

Additionally, offerors should submit Attachment J Bidder Requirements Traceability Matrix.

Proposals should be fully responsive to the requirements; however offerors are given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures. Merely repeating a requirement statement does not demonstrate that the contractor understands the requirement and will result in a lower score in the technical evaluation.

D.4.1 Project Planning Phase

In this section the offeror must provide a detailed description of the methodologies that are being proposed for project management, quality management, scope management, requirements management, issues management, risk management, configuration management, performance management, communication management and the approach to data governance. A discussion of the EPMO and Project Plan must also be included. In addition all proposal requirements outlined in Section III.B of the RFP and Tab B of Attachment P must be addressed.

D.4.2 Implementation Phase

In this section the offeror must provide a detailed description of the methodologies being proposed for project initiation tasks, testing, organizational change management, data conversion, the proposed SDLC, and the approach to operational readiness and transition. In addition all

proposal requirements outlined in Section III.C of the RFP and Tab C of Attachment P must be addressed.

D.4.3 Certification Phase

In this section the offeror must provide a detailed description of the proposed strategy and approach to certification. In addition all proposal requirements outlined in Section III.D of the RFP and Tab D of Attachment P must be addressed.

D.4.4 System and Operational Enhancements Phase

In this section the offeror must provide a detailed description of the proposed strategy and approach to system and operational enhancements and maintenance. In addition all proposal requirements outlined in Section III.E of the RFP and Tab E of Attachment P must be addressed.

D.4.5 Operations Phase

D.4.5.1 Continuous Improvement and Business Reengineering Studies

In this section the offeror must provide a detailed description of the proposed strategy and approach to continuous improvements and business reengineering studies. In addition all proposal requirements outlined in Section III.F.1 and F.2 of the RFP and associated requirements in Tab F of Attachment P must be addressed.

D.4.5.2 General Operations

In this section the offeror must provide a detailed description of the proposed strategy and approach to general operations. In addition all proposal requirements outlined in Section III.F.3 of the RFP and associated requirements in Tab F of Attachment P must be addressed. This section of the proposal must have the following subsections.

D.4.5.2.1 Customer Service Center
D.4.5.2.2 Transaction Processing
D.4.5.2.3 Financial Services
D.4.5.2.4 Support Services
D.4.5.2.5 Expert and Consulting Services
D.4.5.2.6 Reporting
D.4.5.2.7 Archiving

D.4.6 Turnover Phase

In this section the offeror must provide a detailed description of the proposed methodology for turning the system over to a successor contractor or to the Department. In addition all proposal requirements outlined in Section III.G of the RFP and proposal requirements in Tab G of Attachment P must be addressed.

D.4.7 Technical and System Architecture

In this section the offeror must provide a detailed description of each of the proposed architectures and environments with ***detailed discussion and schematics***. A detailed discussion of each of the proposed COTS products and why they were chosen must be included. In addition all proposal requirements outlined in Section III.H of the RFP and proposal requirements in Tab H of Attachment P must be addressed. This section of the proposal must have the following subsections.

D.4.7.1 Environments
D.4.7.2 Technical, Application, Data and Network Architectures
D.4.7.3 WEB Portal
D.4.7.4 WEB Applications
D.4.7.5 Business Rules Engine
D.4.7.6 Document and Content Management
D.4.7.7 Workflow Management
D.4.7.8 Reporting
D.4.7.9 Automated Letter Generation
D.4.7.10 Contact Management
D.4.7.11 Data Receipt and Data Delivery Management
D.4.7.12 Metadata Management and Delivery
D.4.7.13 Data Management
D.4.7.14 Data Model

D.4.8 Security, Privacy and Confidentiality

In this section the offeror must provide a detailed description of the proposed approach to security, privacy and confidentiality. A detailed discussion of how the offeror will achieve Level 3 security must be included. In addition all proposal requirements outlined in Section III.I of the RFP and proposal requirements in Tab I of Attachment P must be addressed. This section of the proposal must have the following subsections.

D.4.8.1 HIPAA Security
D.4.8.2 HIPAA Privacy
D.4.8.3 Data Security
D.4.8.4 Network Security
D.4.8.5 Application Security
D.4.8.6 Physical Security
D.4.8.7 Role Based Security

D.4.9 Functional

In this section the offeror must provide a detailed description of the proposed approach to the Departments business requirements. In addition all proposal requirements outlined in Section III.J of the RFP and proposal requirements in Tab J of Attachment P must be addressed. This section of the proposal must have the following subsections.

D.4.9.1 Member Management
D.4.9.2 Provider Management
D.4.9.3 Operations Management
D.4.9.4 Program Management
D.4.9.5 Business Relationship Management
D.4.9.6 R-MMIS ICD-10 Implementation
D.4.9.7 R-MMIS Financial Management System
D.4.9.8 Phase III MITA Maturity Level Improvements

D.4.10 Facility

In this section the offeror must provide a detailed description of the proposed facilities to support the requirements in this RFP. In addition all proposal requirements outlined in Section III.K of the RFP and proposal requirements in Tab L of Attachment P must be addressed.

D.4.11 Business Continuity and Disaster Recovery

In this section the offeror must provide a detailed description of the proposed approach to business continuity and disaster recovery. In addition all proposal requirements outlined in Section III.L of the RFP and proposal requirements in Tab I of Attachment P must be addressed.

D.4.12 Organization and Staffing

In this section the offeror must provide a detailed description of the proposed staffing and organization plan for each phase of the project. This section should also include a discussion of key staff. In addition all proposal requirements outlined in Section III.M of the RFP and proposal requirements in Tab M of Attachment P must be addressed.

D.4.13 Training

In this section the offeror must provide a detailed description of the proposed approach to developing and delivering training. In addition all proposal requirements outlined in Section III.N of the RFP and proposal requirements in Tab N of Attachment P must be addressed.

D.4.14 Contractor Performance

In this section the offeror must provide a detailed description of how and why the proposed solution will satisfy the performance requirements of the RFP.

D.5 CONTRACTOR AND SYSTEMS REQUIREMENTS (TAB 5)

Tab 5 should be labeled Contractor and Systems Requirements. In this section, offerors will document their approach to meeting the contractor requirements described in section III R-MMIS Statement of Work of this RFP and provided in Attachment J Bidder Requirements Traceability Matrix.

The Department requires offerors to use where possible a one-to-one match between the numbering utilized for sections in the RFP and the numbering of their corresponding responses in Tab 5.

Proposals should be fully responsive to the requirements; however offerors are given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures. Repeating a requirement statement will be considered non-responsive and may disqualify the offeror.

D.6 CORPORATE ORGANIZATION, EXPERIENCE, AND QUALIFICATIONS (TAB 6)

Tab 6 should be labeled Corporate Organization, Experience, and Qualifications.

D.6.1 Corporate Organization

In this section the offeror should provide a corporate organization chart of its company that is submitted with the proposal. If the company is a subsidiary of a parent company, the organization chart should be that of the subsidiary company. The chart should display the company's structure and the organizational placement of the oversight for the Replacement MMIS project. The offeror should identify the level of the person who will be responsible for signing the contract and indicate the signing person's relationship with the company. The Proposal should document the legal structure of the company, including the date established and the state in which the company is registered, licensed, and incorporated, as applicable:

1. Describe the history of the company;
2. Provide a corporate organizational chart;
3. Describe the executive and management staff assigned to this project. Include the number of staff, their roles on this project, their expertise and experience in providing the services described in this RFP, and their tenure with the company;
4. Identify any contractual terminations for cause within the past five (5) years; and,
5. Describe resource availability for this project, given other projects currently undertaken by the offeror.

D.6.2 Letters of Reference

The offeror should provide Letters of Reference from three (3) previous customers and include a contact person, email address, and telephone and fax numbers for each reference. Letters of reference should meet the criteria outlined in section IV.B.3, above.

D.6.3 Experience

In this section the offeror must provide a detailed description of its relevant and extensive experience with:

1. A large scale complex health care claim processing Medicaid system and/or
2. Health Services organization and/or
3. Other complex health care delivery systems.

The offeror must also describe in detail its experience in managing a project of this size and scope as well as any and all MITA experience.

E. PRICE PROPOSAL CONTENTS

The Price Proposal is to be separately bound and sealed and contain the following tabs:

1. Table of Contents (see E.1, below);
2. Pricing Schedules (see E.2 below);
3. Minority and Women Owned Business Enterprise (M/WBE) Plan (see E.3, below);
4. Certifications and Guarantees (see E.4, below); and
5. Company Financials (see E.5, below).

E.1 TABLE OF CONTENTS (TAB 1)

A Table of Contents of the Price Proposal should be inserted at Tab 1. The Table of Contents should identify all sections (identified herein by Tabs), subsections contained therein, and corresponding page numbers. The Table of Contents should include all sections and subsections present under Tabs 1 through 4. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Price Proposal Table of Contents.

E.2 PRICING SCHEDULES (TAB 2)

Tab 2 shall contain a hardcopy of the pricing schedules described in Attachment M Pricing Schedules. Offerors must use the Microsoft Excel spreadsheet titled "Attachment M – Pricing Schedules MMIS RFP.xls" in the form and content provided with this RFP. **Deviations from this format are not permitted.** Offerors MUST also submit the Excel spreadsheet in electronic form in accordance with Section C, Proposal Submission Instructions. **Failure to submit in this required format will result in disqualification**.

The daily staffing rate is a fully loaded rate and includes all personnel, overhead, indirect, travel, profit, equipment usage and any other miscellaneous costs. These rates will be used in the event the Department determines the need to add additional staff as set forth under Attachment M.

E.3 MINORITY AND WOMEN OWNED BUSINESS ENTERPRISE (M/WBE) UTILIZATION PLAN (TAB 3)

As part of its proposal, utilizing all the forms in Attachment Q in accordance with guidelines set forth in section V.O Administrative Requirements M/WBE Utilization Plan for Subcontracting and Purchasing, the offeror is expected to document in detail and certify the good-faith efforts it will undertake to solicit the participation of such enterprises.

E.4 CERTIFICATIONS AND GUARANTEES BY THE OFFEROR (TAB 4)

New York State Department of Health Bid Form

The offeror should complete the Bid Form included as Attachment D Bid Form. The Bid Form should be filled out in its entirety. The responsible corporate officer for contract negotiation, consistent with the terms and conditions of the RFP, should be listed. This document should be signed by the responsible corporate officer.

Vendor Responsibility Attestation

New York State Procurement Law requires that state agencies award contracts only to responsible vendors. Vendors are invited to file the required Vendor Responsibility Questionnaire online via the New York State VendRep System or may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at https://portal.osc.state.ny.us. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us. Vendors opting to file a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Department of Health or the Office of the State Comptroller for a copy of the paper form. Offerors should also complete and submit Attachment S Vendor Responsibility Attestation and if the Vendor Responsibility Questionnaire has not been filed on-line include it with the proposal.

State Taxation and Finance, Contractor Certification Form ST-220-CA and Form ST-220-TD

The winning offeror must complete and submit the Contractor Certification to Covered Agency Form ST-220-CA (Attachment F of this RFP) that attests to the submission of the Form ST-220-TD (Attachment G of this RFP).

E.5 COMPANY FINANCIALS CONTENT (TAB 5)

The offeror should submit the following documents to be used in the evaluation of financial viability:

1. Audited financial statements (annual reports) for the last three (3) years;
2. Comprehensive Dunn & Bradstreet report;
3. Certificate of Incorporation, together with any and all amendments thereto; Partnership Agreement; or equivalent business organizational documents, as applicable.

The Company Financial Information should be submitted in a separate sealed envelope enclosed within Tab 5 and will be opened only for the Proposal that is selected as the apparent successful Proposal.

F. EVALUATION PROCESS

The State of New York will perform a fair and comprehensive evaluation of the proposals received in response to this RFP in accordance with the New York State procurement law, guidelines and procedures, as well as policies and procedures approved by the Department. This section of the RFP describes the evaluation process that will be used to determine which Proposal provides the best value to the Department.

The evaluation process will ensure the selection of the best overall solution for the New York State Medicaid program on a "best value" basis. Scoring will be split 75% for the Technical Evaluation and 25% for the Cost Evaluation.

F.1 REQUIREMENTS FOR PROPOSALS

The purpose of this phase is to determine if each Technical and Price Proposal is sufficiently responsive to the RFP to permit its complete evaluation. As part of its initial screening, a Compliance Assessment will be performed on all Proposals submitted in response to this RFP to assure that the mandatory requirements for proposals have been satisfied. Any one mandatory Compliance Assessment requirement that is not met may cause a proposal to be declared non-responsive.

The Compliance Assessment will have a pass/fail screening that includes the following requirements:.

1. The Technical Proposal was submitted by the proposal due date;

2. The Financial Proposal was submitted by the proposal due date in the form and content provided in Attachment M of this RFP.

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 the propriety and legality of the Department's use of outside consultant(s) and/or contractor(s) to assist the Department with this procurement.

F.2 SCORING OF OFFEROR TECHNICAL PROPOSALS (75%)

Evaluation Criteria and Assigned Point Totals

The evaluation of the offeror's technical approach will be based on the responses provided in the proposal. The highest scoring proposal will receive the full percentage. Information from the Price Proposal or the evaluation of the Price Proposal will not be available to the Technical Evaluation Committee during its evaluation.

The Technical Evaluation follows the Technical Proposal requirements; bidders are advised to submit proposals that are comprehensive and clearly reflect the technical proposal requirements. This includes, among other proposal requirements, contractor and staff background/Title XIX Medicaid experience, understanding of the scope of the project, responsiveness to specifications, a robust SDLC that includes adequate project and schedule controls, adequacy of staffing levels, etc.

Detailed evaluation criteria will not be disclosed to bidders.

The technical raw scores will be normalized as follows:

N = (A÷B) * 75% where:
A is the score being evaluated;
B is the highest technical score; and
N is the technical score.

F.3 SCORING OF OFFEROR PRICE PROPOSALS (25%)

A separate committee will review and score the Price Proposals from all offerors meeting the Compliance Assessment mandatory requirements.

Calculation of Scores

The Price Proposal Evaluation Committee will award the full percentage available to the bidder with the lowest overall cost.

The financial raw scores will be normalized as follows:

C = (A÷B) * 25%
A is Total Price of lowest Price Proposal;
B is Total Price of Price Proposal being scored; and,
C is the Price score.

F.4 TECHNICAL AND PRICE PROPOSALS COMBINED

Technical and Price Proposal scores will be combined to establish a score for each proposal. The proposals will then be ranked based on each offeror's combined score. The ranking will be in descending order. In the event of a tie, the determining factor(s) for award, in descending order of importance, will be:

- Lowest cost
- Minority/Women-owned Business Enterprise (MWBE) utilization
- Past experience
- References

F.5 NOTIFICATION OF STATUS OF PROPOSALS

At the end of the selection process, each offeror will be notified of the status of its proposal. Any award will be contingent upon execution of a written contract, approval of the New York State Attorney General and the New York State Office of the State Comptroller, as well as Federal approval.

F.6 FEDERAL APPROVALS

The contract award is subject to Federal approval in accordance with 45 CFR 95.611. The Department reserves the right to not award a contract if required external approvals are not obtained from CMS.

V. NEW YORK STATE ADMINISTRATIVE REQUIREMENTS

A. ISSUING AGENCY

This Request for Proposal (RFP) is a solicitation issued by the New York State Department of Health (the Department). The Department is responsible for the requirements specified herein and for the evaluation of all proposals.

B. 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 amended, as well as applicable procurement policies and procedures established by the State of New York, including relevant provisions of the New York State Finance Law.

C. INQUIRIES

All inquiries regarding this proposal must be submitted to the designated contacts listed on page ii of this document. Questions and answers, as well as any RFP updates and/or modifications, will be posted on the Department of Health's website at http://www.nyhealth.gov/funding/. Offerors wishing to receive these documents via mail must send a request, in writing, to the designated contacts listed on page ii of this document.

D. RFP ISSUANCE AND AMENDMENTS

Prior to its release, this RFP was reviewed and approved by the Office for Technology, the Department of Health and Region II of the Centers for Medicaid and Medicare Services. Its contents represent the best available statement of the requirements and needs of involved stakeholders.

The Department reserves the right, prior to the proposal due date, to amend the RFP specifications to correct errors or oversights or to supply additional information as it becomes available. All written addenda to the RFP, along with the RFP itself, will become part of the contract.

Both the RFP and any subsequent amendments will be posted on the Department's Web site. Offerors are responsible for checking for updates to information on the Web. Offerors should also visit http://www.nyhealth.gov/funding/ regularly to see if there are any changes.

D.1 QUESTIONS AND ANSWERS

Prospective offerors may submit questions concerning this RFP, in writing, to the permissible subject matter contact identified on page ii.

Questions received by the Department after the final due date specified on page i 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 received by electronic mail or delivered by the U.S. Postal Service, a commercial service, and/or in person by the date specified on page i. Requests for materials and information not in the Procurement Library should be sent as written questions to the contact specified on page ii.

Following receipt of the submitted questions, Department staff will prepare written responses to all questions received. These responses will be made available on the Department's Web site at http://www.nyhealth.gov/funding/. To the extent practicable, questions will remain as written. However, the Department may consolidate and paraphrase questions received.

Offerors should clearly understand that the only official answers or positions of the Department are those stated in writing and posted on the Department's website. 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.

D.2 PROCUREMENT LIBRARY

The Department will provide a Procurement Library. These materials will be made available on CD-ROM, upon offeror request to the subject matter expert designated for distribution on page iii of this RFP. Library documents are intended only as a resource and are not a guarantee of performance levels. They provide a window into current system functionality and Department operational needs and will require validation as part of the R-MMIS design, development and implementation effort that will result from this procurement.

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 either prior to or after contract award. All statistical information contained in the Procurement Library represents the best information available to the Department with regard to the current functioning 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.

D.3 OFFERORS' CONFERENCE

An Offerors' Conference will be held by the Department on the date and time specified on page i. While attendance at the Offerors' Conference is not required, it is strongly encouraged. The conference will be held in the following location:

Empire Plaza Convention Center

Meeting Room 1

The Offerors' Conference is intended to be an interactive exchange of information, and appropriate Department staff will attend to clarify RFP content.

Offerors are reminded that the official answers and positions of the Department will be those stated in writing and posted to the procurement website. Any verbal responses given at the Offerors' Conference are not binding on the Department.

Offerors are responsible for checking for updates to information on the procurement website as the Offerors' Conference date; time and location are subject to change.

D.4 USE OF FAX MACHINES AND ELECTRONIC MAIL

The Department will use the procurement website as the primary means of communication with offerors. However, where appropriate, 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 may also use the U.S. Postal 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 e-mail, the U.S. Postal Service, a commercial delivery service, or delivered in person) from the prospective offeror. The Department will not accept faxed or emailed proposals.

D.5 AGREEMENT TO ACCEPT AND ABIDE BY THE REQUEST FOR PROPOSAL AND REQUEST FOR PROPOSAL PROCESS

By 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 the terms of the RFP, including the requirements and procedures established accordingly. Alternate proposals or extraneous terms will not be evaluated.

E. SUBMISSION OF PROPOSALS

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

E.1 TWO-PART PROPOSALS

Proposals should be submitted in two (2) separate packages: a Technical Proposal and a Price Proposal, prepared in accordance with the requirements stated in this RFP.

Sealed proposals shall be delivered to the following address:

Joseph Zeccolo

New York State Department of Health

Corning Tower, Room 2019

The Governor Nelson A. Rockefeller Empire State Plaza

Albany, New York 12237

Proposals must be physically received at this location on or before the time and date specified on Page i of this document. Late proposals will not be evaluated.

Submitted proposals should conform to the proposal requirements specified in section IV Proposal Requirements.

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

New York State Department of Health

FAU #: 1002031048

Replacement MMIS (R-MMIS) Fiscal Agent Services Project – Technical Proposal

(Offeror Name)

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

New York State Department of Health

FAU #: 1002031048

Replacement MMIS (R-MMIS) Fiscal Agent Services Project – Price Proposal

(Offeror Name)

All proposals should 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.

E.2 PROPOSAL LIFE

All proposals should be fully responsive to this RFP in order to be considered for contract award. The proposal must remain valid for 365 calendar days from the proposal due date.

E.3 THE DEPARTMENT OF HEALTH RESERVES THE RIGHT TO:

1. Reject any or all proposals received in response to the RFP;
2. Withdraw the RFP at any time, at the agency's sole discretion;
3. Make an award under the RFP in whole or in part;
4. Disqualify any offeror whose conduct and/or proposal fails to conform to the requirements of the RFP;
5. Seek clarifications and revisions of proposals;
6. Use proposal information obtained through site visits, management interviews and the state's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFP;
7. Prior to the proposal due date, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;
8. Prior to the proposal due date, direct offerors to submit proposal modifications addressing subsequent RFP amendments;
9. Change any of the scheduled dates;
10. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective offerors;
11. Waive any requirements that are not material;
12. Negotiate with the successful offeror within the scope of the RFP in the best interests of the State;
13. Conduct contract negotiations with the next responsible offeror, should the agency be unsuccessful in negotiating with the selected offeror;
14. Utilize any and all ideas submitted in the proposals received;
15. Unless otherwise specified in the solicitation, every offer is firm and not revocable for a period of 365 calendar days from the proposal due date; and,

16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offeror's proposal and/or to determine an offeror's compliance with the requirements of the solicitation.

E.4 DEBRIEFING AND VENDOR PROTESTS

Once an award has been made, offerors may request a debriefing of their proposals in accordance with State Finance Law. Requests must be received no later than ten (10) business days from date of award or non-award announcement.

In the event unsuccessful offerors wish to protest the award resulting from this RFP, offerors should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found on the OSC website at: http://www.osc.state.ny.us/agencies/gbull/g_232.htm.

F. DEPARTMENT RESPONSIBILITIES

The following sections detail Department responsibilities, including:

1. Review and approval of all work products; and,
2. Providing direction and setting policy for all work accomplished.

F.1 REVIEW AND APPROVAL OF ALL WORK PRODUCTS

1. The Department reserves the right to review and approve all aspects of the contractor's work as it relates to this RFP;
2. The Department will determine that the contractor has addressed each requirement and will notify the contractor when it has been determined that an RFP requirement has been satisfied in each deliverable and project phase. The Department will use the requirements traceability matrix created and maintained by the contractor to assist in this process;
3. The Department reserves the right, at its sole discretion, to determine if the contractor has successfully met or completed all requirements for a project milestone or project phase; and the Department reserves the right, at its sole discretion, to withhold payments based on a deliverable, milestone or phase completion when the contractor has failed to meet all of the requirements;
4. The Department has sole responsibility of approving the addition of new System and Operational Enhancement projects and setting the priority of System and Operational Enhancement projects. When the Department submits a Change System Request (CSR), the contractor shall open the CSR in the tracking tool and assign a CSR number. The contractor shall begin work on the System Management project after receiving the Department's approval in writing; and,

5. The Department will conduct a timely review of all materials submitted to the Department by the contractor, returning comments within ten (10) business days unless otherwise agreed upon by the Department and the contractor.

F.2 PROVIDING DIRECTION AND SETTING POLICY FOR ALL WORK ACCOMPLISHED

1. The Department will provide policy and contract clarification as requested by the contractor;
2. The Department will notify the contractor regarding changes in Federal, State and Department requirements that affect the contractor's performance with regard to the requirements in this RFP;
3. The Department will establish policies and make administrative decisions concerning the requirements in this RFP; and,
4. The Department will identify all Federal and State mandated reports for the contractor's production and distribution including format, content, frequency of production, media, and distribution.

G. CONTRACTOR RESPONSIBILITIES

G.1 GENERAL CONTRACTOR REQUIREMENTS

1. All deliverables, materials or other submissions provided by the contractor must meet the form and content requirements specified by the Department. Such deliverables or other materials shall be subject to Department approval;
2. If the Department determines that a deliverable cannot be approved, the contractor will have a cure period beginning with notice from the Department that the deliverable is not approved. The cure period will last for ten (10) business days from the notice of deliverable rejection;
3. The contractor work plan also must provide sufficient time (a minimum of ten (10) business days) for Department review and approval of each deliverable based on the scope of the deliverable;
4. The contractor must deliver to the Department five (5) paper copies of all document deliverables and an electronic copy on the date specified in Department-approved plans. The electronic copy must be on a DVD or CD-ROM in Department-approved format;
5. The contractor must establish project management and reporting standards and communication protocols to be approved by the Department;
6. The contractor must maintain all approved project documentation in the R-MMIS metadata repository;
7. The contractor must use the project estimation methodology specified in its proposal for all project estimates provided to the Department. All artifacts and documents used to derive the estimation must be stored in both the R-MMIS metadata repository and the document repository; and,
8. Any tools used by the contractor and/or documents used to establish project estimates must be made available to the Department.

9. The contractor shall be responsible for full, current and detailed knowledge of, and compliance with, the requirements of New York State and Federal law and the pertinent regulations and guidelines promulgated thereunder. The contractor also shall be responsible for ascertaining all relevant requirements for R-MMIS operations and bring same to the attention of the Department.

H. VENDOR-TO-VENDOR RELATIONSHIPS

1. The contractor must participate in scheduled contract coordination meetings between the Department and the eMedNY contractor, the MDW contractor, the QA contractor and any other applicable contractors throughout the life of the R-MMIS contract;
2. The contractor must cooperate with the successor contractor while providing all required turnover services. This will include meeting with the successor and devising work schedules that are agreeable for both the Department and the successor contractor;
3. The contractor must participate in shared JAD sessions with the Department and the eMedNY contractor during development tasks and activities to establish specific areas that require contract coordination efforts to be established; and,
4. The contractor must participate in shared JAD sessions with the Department and the new MDW contractor during development tasks and activities to establish specific areas that require contract coordination efforts to be established.

I. PAYMENT

If awarded a contract, the contractor shall submit invoices and vouchers to:

Director of Operations
Office of Health Insurance Programs (OHIP)/
Division of Systems
New York State Department of Health (NYSDOH)
150 Broadway, Suite 480
Albany, New York 12204

Payment for invoices and/or vouchers submitted by the contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-474-4032. The contractor acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at http://www.osc.state.ny.us/epay.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

Payment of such invoices by the State shall be made in accordance with Article XI-A of the New York State Finance Law and in accordance with the schedules and methods defined in this section and Attachment M Pricing Schedules. Payment of such invoices by the State are exempt from late payment interest pursuant to the statutory exception for a contractor of third party payment agreements in accordance with New York State Finance Law Section 179-p.

No payment will be made until the Contract has received all required approvals. The Department is not responsible for and will not pay local, State, or Federal taxes. All costs associated with the contract must be stated in U.S. currency.

Contractor payments will be reduced by the amount of any actual or liquidated damages as determined by the Project Director in accordance with the provisions of the RFP. The allowed payment by phases is described below.

I.1 FUNCTIONAL PHASE I IMPLEMENTATION PHASE PAYMENTS

The contractor shall be paid the fixed price upon the Department's acceptance and approval of the completion of milestones as defined in this RFP. The distribution of payment is as follows:

- Project Plan (including business rules validation, requirements validation, and business process gap analysis) — Fifteen percent (15%)
- DDI Plans Development/ Project Plans Inventory — Three percent (3%)
- System Design — Seven percent (7%)
- Construction and Unit Testing/ System Test — Thirteen percent (13%)
- Data Conversion — Ten percent (10%)

- Replacement System Phase Training — Five percent (5%)
- User Acceptance Testing — Twelve percent (12%)
- Parallel Testing — Ten percent (10%)
- Operational Readiness Review/ Implementation and System Acceptance — Twenty percent (20%)
- Certification — Five percent (5%)

Reimbursement for the Certification Task shall be paid upon notification by CMS that the R-MMIS is certified. **Offerors should note that the total price proposed for the Functional Phase I Implementation Phase must not exceed twenty-five percent (25%) of the proposed total price for the contract.**

I.2 FUNCTIONAL PHASE II IMPLEMENTATION PHASE PAYMENTS

The contractor shall be paid the fixed price upon the Department's acceptance and approval of the completion of milestones as defined in this RFP for the design, development, and implementation of the COTS financial system. The distribution of payment is as follows:

- Project Plan (including business rules validation, requirements validation, and gap analysis) — Fifteen percent (15%)
- DDI Plans Development/ Project Plans Inventory — Three percent (3%)
- System Design — Seven percent (7%)
- Construction and Unit Testing/ System Test — Thirteen percent (13%)
- Data Conversion — Ten percent (10%)
- Replacement System Phase Training — Five percent (5%)
- User Acceptance Testing — Twelve percent (12%)
- Parallel Testing — Ten percent (10%)
- Operational Readiness Review/ Implementation/System Acceptance — Twenty-Five percent (25%)

I.3 OPERATIONS PHASE PAYMENTS

1. **Annual Administrative Fee**

The contractor shall be paid the annual 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 annual administrative fee will represent the fixed costs of the contractor for the following operations periods

- **Contract Years 1 Through 3 (Contract Start Date Through Month 36)**

  The first three contract years are expected to be devoted to design, development, and implementation; therefore, there will be no operations payments during these years.

- **Contract Years 4 Through 8 (Months 37 through 96)**

  The administrative fee includes the annual fixed amounts for operations, including systems maintenance, of all components of the Replacement MMIS.

  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.

2. **Cost Reimbursement**

The Department shall reimburse the contractor for the cost of postage directly and reasonably incurred by the contractor in carrying out the tasks required by the contract. Postage costs shall be reported separately and in a level of detail satisfactory to the Department. The contractor shall maintain as accounting records, subject to Department examination and audit, substantiating invoices, receipts and other evidence of expenses incurred. Postage costs shall not be subject to corporate allocation or markup. It is the responsibility of the contractor to perform in the most cost efficient manner, utilizing all discounts offered by the Postal Service for all mailings (e.g., zip+four, barcode, presort).

3. **Adjustment of Operations Payments**

There will be no adjustments of the operations payments on an annual or any other basis.

The contractor shall submit monthly income statements no later than fifteen days after the end of the month being reported which shall include all revenues and

expenses incurred during the term of the contract. The income statement shall be consistent with the format of Pricing Schedule D.

1. The fixed price payable to the contractor for operations performance requires the contractor to process all claims received. However, a contract operating year end settlement will be made if the total new claim volume received exceeds the base claim volume projections as set forth below. (Note: contract years 9 and 10 are optional extension years.)

Reporting Period	Base Claim Volume Projection
Contract Year 4	593,000,000
Contract Year 5	609,000,000
Contract Year 6	625,000,000
Contract Year 7	640,000,000
Contract Year 8	656,000,000
Contract Year 9	685,000,000
Contract Year 10	687,000,000

2. In the event the total volume of claims received exceeds the projections set forth in section V.I.3.3.1 for a contract year but do not exceed the upper threshold set forth below, the Department will pay the contractor the percentage increase identified on Pricing Schedule D. (Note: contract years 9 and 10 are optional extension years.)

Reporting Period	Base Claim Volume Projection
Contract Year 4	670,000,000
Contract Year 5	688,000,000
Contract Year 6	706,000,000
Contract Year 7	723,000,000
Contract Year 8	741,000,000
Contract Year 9	774,000,000
Contract Year 10	777,000,000

3. In the event the total volume of claims received exceeds the upper claim projections set forth in section V.I.3.3.2 above at the end of a contract year, the Department and the contractor shall enter into good-faith negotiations in order to reach agreement on the actions, if any, to be taken in order to achieve an equitable adjustment to the contract. Any modification or amendment to the contract will be pursued as set forth in section 22 Contract Amendment of Attachment I Contract Requirements.

4. The new claims entered figures found in the summary control report for weekly cycles, which is a weekly contract deliverable, shall be used in determining each contract year's total claim volume. Only the new claims submitted as paper, batch, POS or encounters will be factored into the calculation. In addition, the contractor shall present to the Department, within sixty calendar days of the end of each contract year, all supporting documentation used by the contractor to determine the additional cost or savings.

I.3.1 Supplemental Staff

The contractor shall be paid up to, but not in excess of, the Supplemental Staff price, as presented in Attachment M Pricing Schedules, Schedule F Supplemental Staff of the contractor's proposal. These monthly payments made by the Department will be variable and based on the actual hours spent by contractor system and operational enhancement staff working on completing Department-approved projects at the hourly rates in Pricing Schedule F appropriate to the staff and contract year.

1. The contractor shall maintain, as key staff, the Administrative, Technical, and PBM key staff defined in section III.M Organization and Staffing Requirements of this RFP and the staff required for the EPMO defined in Section III.M Organization and Staffing Requirements of this RFP. These personnel are funded by the fixed administrative fee.

2. The contractor shall support projects to change the system in each year of the contract through the annual provision of up to 200,000 hours of work performed by System Change Staff and also detailed in Attachment M Pricing Schedules. The annual System Change Staff pricing and budgets must be developed in these schedules using this 200,000 annual allotment of hours.

3. The allotment of 200,000 annual hours is to be used only for time the System Change Staff spend directly on Department approved projects. All other System Change Staff time (e.g., vacation, sick leave, training, etc.) shall not be applied against this allotment of hours.

4. Tracking and reporting of hours spent on individual system change projects by staff paid through the fixed administrative fees is mandatory. These hours are to be considered in each system change project's estimated and expended hours. However, these hours have no impact on monthly System Change Staff-priced payments based on Attachment M Pricing Schedules, Schedule F Supplemental Staff or meeting the 200,000 hours. The annual fixed administrative fee pricing and budgets must be developed in these schedules with this in mind.

5. Time spent on Department system change projects by staff categorized as System Change Staff must also be included in each project's estimated and expended hours. Time spent by these staff resources working on a system change project will be paid

upon Department-approved completion of that project based on the lesser of either the appropriate hourly rates from Attachment M Pricing Schedules or the actual cost to the contractor (see section V.I.3.1.8, below).

6. Some activities performed by contractor staff will be considered system maintenance (e.g., update version control management) and as such those activities are to be considered and budgeted as part of the annual fixed administrative fee regardless of whether the staff performing the task is budgeted under the fixed administration fee or the System Change Staff pricing.

7. If during the operations of the R-MMIS the Department determines that the system change workload and associated project deadlines necessitate additional contractor staff resources, the Department and the contractor may develop a contract amendment to acquire the additional staff. The daily rates (for Fixed Administrative Fee staff) and hourly rates (for System Change Staff) provided in Attachment M Pricing Schedules that are appropriate to the staff roles being requested and the contract year will be used for pricing the additional staffing component of the contract amendment.

8. Upon the successful completion of a project, or at another time as determined by the Department in its sole discretion, the Department will pay the contractor for the effort expended by the System Change Staff. Payment will be based upon the lesser of the either the rates proposed in Attachment M Pricing Schedules, Schedule F Supplemental Staff or the actual cost for each title used, including corporate allocation and markup, to the contractor. The contractor must certify that the rates used in the calculation of its billing reflect its actual cost. Corporate allocation and markup shall be applied in the same manner and at the same rates as in Attachment M Pricing Schedules, Schedule F Supplemental Staff of the contractor's proposal. The contractor shall receive no payment for System Change Staff in excess of the individual rates proposed in response to this RFP. In calculating the payment, corporate allocation and markup will not be applied to resources obtained through another corporate division. Upon any request, the contractor shall furnish to the Department all documentation, in a level of detail satisfactory to the Department, fully justifying the contractor's explanation of it calculation of its actual costs.

9. The total amount paid to the contractor for System Change Staff shall not exceed the total contract value, as may be amended. Any amounts not paid in any contract year will be available in subsequent years.

I.3.2 Optional Capability Increase

Any additional hardware or software acquired as the result of a system change project and the resultant need for increased capacity shall be supplied at prices equal to or less than with either pricing available through the lesser of the U.S. General Services Administration (GSA) or the New York State Office of General Services or their successor agencies. Line 6 System Change

Capacity on Pricing Schedule A in Attachment M Pricing Schedules includes a ten percent (10%) increase (based on the Operations – Annual Administrative Fee) to be used solely for this purpose.

I.3.3 Turnover

The Department will pay the contractor, in one lump sum, the amount contained in Pricing Schedule G upon completion, to the Department's satisfaction, of all tasks and deliverables required in the contractor's Department approved turnover plan. The Department, in its sole discretion, may also withhold the Operations annual administrative fee for the final month of the contract. This amount, minus any amounts owed the Department pursuant to Section III N Service Level Agreements, will be paid upon completion, to the Department's satisfaction, of all tasks and deliverables required in the contractor's Department approved turnover plan.

I.4 CONTRACT EXTENSION PRICING

Should the Department elect to extend the term of the contract, as set forth in this RFP, the pricing for each optional contract extension year will be subject to an annual price increase of the lesser of three percent (3%) or the percent increase in the National Consumer Price Index for All Urban Consumers (CPI-U) as published by the United States Bureau of Labor Statistics, Washington, D.C., 20212 for the twelve (12) month period ending three (3) calendar months prior to the end date of the last year of the contract, as may be amended

J. LOBBYING STATUTE

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, provides, among other things, the following as pertains to development of procurement contracts with governmental entities:

1. Makes the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;
2. Requires the above mentioned governmental entities to record all contacts made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;
3. Requires governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;
4. Authorizes the New York State Commission on Public Integrity to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;
5. Directs the Office of General Services to disclose and maintain a list of non-responsible offerors pursuant to this new law and those who have been debarred and publish such list on its website;

6. Requires the timely disclosure of accurate and complete information from offerors with respect to determinations of non-responsibility and debarment;
7. Expands the definition of lobbying to include attempts to influence gubernatorial or local Executive Orders, Tribal–State Agreements, and procurement contracts;
8. Modifies the governance of the New York State Commission on Public Integrity
9. Provides that opinions of the Commission shall be binding only on the person to whom such opinion is rendered;
10. Increases the monetary threshold which triggers a lobbyists obligations under the Lobbying Act from $2,000 to $5,000; and,
11. Establishes the Advisory Council on Procurement Lobbying.

Generally speaking, two related aspects of procurements were amended: (i) activities by the business and lobbying community seeking procurement contracts (through amendments to the Legislative Law) and (ii) activities involving governmental agencies establishing procurement contracts (through amendments to the State Finance Law).

Additionally, a new section 1-t was added to the Legislative Law establishing an Advisory Council on Procurement Lobbying (Advisory Council). This Advisory Council is authorized to establish the following model guidelines regarding the restrictions on contacts during the procurement process for use by governmental entities (see Legislative Law §1-t (e) and State Finance Law §139-j). In an effort to facilitate compliance by governmental entities, the Advisory Council has prepared model forms and language that can be used to meet the obligations imposed by State Finance Law §139-k, Disclosure of Contacts and Responsibility of Offerors. Sections 139-j and 139-k are collectively referred to as "new State Finance Law."

It should be noted that while this Advisory Council is charged with the responsibility of providing advice to the New York State Commission on Public Integrity regarding procurement lobbying, the Commission retains full responsibility for the interpretation, administration and enforcement of the Lobbying Act established by Article 1-A of the Legislative Law (see Legislative Law §1-t (c) and §1-d). Accordingly, questions regarding the registration and operation of the Lobbying Act should be directed to the New York State Commission on Public Integrity.

K. ACCESSIBILITY OF STATE AGENCY WEB-BASED INTRANET AND INTERNET INFORMATION AND APPLICATIONS

Any Web-based Intranet and Internet information and applications development, or programming delivered pursuant to the contract or procurement will comply with NYS Office for Technology Policy P04-002, "Accessibility of New York State Web-based Intranet and Internet Information and Applications", and NYS Mandatory Technology Standard S04-001, as such policy or standard may be amended, modified or superseded, which requires that state agency Web-based Intranet and Internet information and applications are accessible to persons with disabilities. Web content must conform to NYS Mandatory Technology Standard S04-00, as determined by quality assurance testing. Such quality assurance testing will be conducted by the Department, the contractor or other third party acceptable to the Department. The results of such testing must be satisfactory to the Department before Web content will be considered a qualified deliverable.

L. INFORMATION SECURITY BREACH AND NOTIFICATION ACT

Section 208 of the State Technology Law (STL) and Section 899-aa of the General Business Law (GBL) require that State entities and persons or businesses conducting business in New York who own or license computerized data which includes private information including an individual's unencrypted personal information plus one or more of the following: social security number, driver's license number or non-driver ID, account number, credit or debit card number plus security code, access code or password which permits access to an individual's financial account, must disclose to a New York resident when their private information was, or is reasonably believed to have been, acquired by a person without valid authorization. Notification of breach of that private information to all individuals affected or potentially affected must occur in the most expedient time possible without unreasonable delay, after measures are taken to determine the scope of the breach and to restore integrity; provided, however, that notification may be delayed if law enforcement determines that expedient notification would impede a criminal investigation. When notification is necessary, the State entity or person or business conducting business in New York must also notify the following New York State agencies: the Attorney General, the Office of Cyber Security & Critical Infrastructure Coordination (CSCIC) and the Consumer Protection Board (CPB). Information relative to the law and the notification process is available at: http://www.cscic.state.ny.us/security/securitybreach.

M. PUBLIC INFORMATION

Disclosure of information related to this procurement and the resulting contract shall be permitted consistent with the laws of the State of New York and specifically the Freedom of Information Law (FOIL) contained in Article 6 of the Public Officers Law. The State shall take reasonable steps to protect from public disclosure any of the records relating to this procurement that are exempt from disclosure. Information constituting trade secrets or critical infrastructure information for purposes of FOIL shall be clearly marked and identified as such by the contractor upon submission. Determinations as to whether the materials or information may be withheld from disclosure will be made in accordance with FOIL at the time a request for such information is received by the State.

N. NEW YORK STATE TAX LAW SECTION 5-A

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than $100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of $300,000 for the four (4) quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded $300,000 for the four (4) quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an Offeror meeting the registration requirements but who is not so registered in accordance with the law.

Contractor must complete and submit directly to the New York State Tax and Finance (DTF), Contractor Certification Form ST-220-TD (Attachment G of this RFP) attached hereto. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the contractor, its affiliate(s), or its subcontractor(s), a new form (ST-220-TD) must be filed with DTF.

Contractor must also complete and submit to the Department the form Contractor Certification to Covered Agency Form ST-220-CA (Attachment F of this RFP) attached hereto, certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an Offeror non-responsive and non-responsible. Offerors shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

O. M/WBE UTILIZATION PLAN FOR SUBCONTRACTING AND PURCHASING

The Department encourages the use of Minority and/or Women Owned Business Enterprises (M/WBE's) for any subcontracting or purchasing related to this contract. Offerors who are not currently a New York State certified M/WBE must define the portion of all consumable products and personnel required for this proposal that will be sourced from a M/WBE. The amount must be stated in total dollars and as a percent of the total cost necessary to fulfill the RFP requirement. Supportive documentation must include a detail description of work that is required including products and services.

The goal for usage of M/WBE's is at least 25% of monies used for contract activities (Minority-owned – 15%; Women-owned – 10%). In order to assure a good-faith effort to attain this

goal, the Department suggests that offerors complete the M/WBE Utilization Plan, found in Attachment Q M/WBE Forms, and submit this Plan with their price proposal.

Offerors that are New York State certified MBE's or WBE's are not required to complete this form. Instead, such offerors must simply provide evidence of their certified status.

Failure to submit the above referenced Plan (or evidence of certified M/WBE status) may result in disqualification of the vendor from consideration for award.

P. PIGGYBACKING

New York State Finance Law section 163(10)(e) (see also httrx//www.ogs.state.ny.us/procurecounc/pab~uidelines.asp) allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the contractor's consent.

Q. APPENDICES

The following will be incorporated as appendices into any contract resulting from this Request for Proposal. This Request for Proposal will, itself, be referenced as an appendix of the contract.

1. APPENDIX A - Standard Clauses for All New York State Contracts

2. APPENDIX B - Request for Proposal

3. APPENDIX C - Proposal

The bidder's proposal (if selected for award), including any Bid Forms and all proposal requirements.

4. APPENDIX I – Contract Requirements

5. APPENDIX E

Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:

Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:

- CE-200, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR

- C-105.2 – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the U-26.3; OR

- SI-12 – Certificate of Workers' Compensation Self-Insurance, OR GSI-105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance.

Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:

- CE-200, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR

- DB-120.1 – Certificate of Disability Benefits Insurance

- DB-155 – Certificate of Disability Benefits Self-Insurance

6. Appendix G - Notices

7. Appendix H - Health Insurance Portability and Accountability Act (HIPAA)

8. Appendix X – Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)

ATTACHMENT A

APPENDIX A STANDARD CLAUSES FOR NYS CONTRACTS

STANDARD CLAUSES FOR NYS 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 $50,000 (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. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law Section 163.6.a).

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. To the extent required by 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, sexual orientation, age, disability, genetic predisposition or carrier status, 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 CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms 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 Accounting Operations, Office of the State Comptroller, 110 State Street, 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 11-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
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
http://www.empire.state.ny.us

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
http://www.empire.state.ny.us

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 country, nation, province, state or political subdivision 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 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. PURCHASES OF APPAREL. In accordance with State Finance Law 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hours laws and workplace safety laws, and (ii) vendor will supply, with its bid (or, if not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized by the bidder.

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Glossary of Terms

AARA	American Recovery and Reinvestment Act of 2009
ADA	American Dental Association
APD	Advance Planning Document: A written plan of action which requests Federal Financial Participation in the cost of determining the need for, feasibility, and cost factors as well as acquisition of automated data processing equipment and services.
APG	Ambulatory Patient Groups: used as a basis for reimbursement
ATC	Alcohol Treatment Center; inpatient facility operated by NYS Office of Alcoholism and Substance Abuse Services (OASAS).
AWP	Average wholesale price used for drug pricing
BNE	NYS Department of Health, Bureau of Narcotics Enforcement Bureau is responsible for protecting the public health by combating the illegal use and trafficking of prescription controlled substances.
BPMS	Business Process Management System
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.
C/THP	Child/Teen Health Plan; New York State's EPDST program.
CAS	New York State Central Accounting System
CBIC	Common Benefit Identification Card
FCN	Financial control number; a control number assigned to uniquely identify financial transactions for recoupments, recoveries, funds received from providers, and lump sum payments.
CDRP	Clinical Drug Review Program: utilizes prior authorization to ensure specific medications are used in a medically appropriate manner.
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.
CLIA	Clinical Laboratory Improvement Amendments: system is a federally mandated set of certification criteria and data collection monitoring system designed to ensure the proper certification of clinical laboratories.
CMS	Centers for Medicare & Medicaid Services; the Federal agency that oversees the Medicaid and Medicare programs.
CMS-1500	CMS-approved standardized claim form used to bill professional services.
eMedNY-150002	NYS Department of Health proprietary version of the claim form used to bill professional services.
CMSO	Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations
COS	Categories of Service

COTS	Commercial-Off-The–Shelf products: For purposes of this RFP, COTS solutions are those products that can be licensed and utilized by multiple industries, are commercially available from a third party, and provide a common solution throughout the proposed R-MMIS application.
Covered Service	Mandatory medical services required by CMS and optional medical services approved by the State for which enrolled providers will be reimbursed for services provided to eligible Medicaid recipients.
CRG	Member's Clinical Risk Group (CRG)
DAMA	Data Management Association
DDI	Design, development and implementation
DEA	Drug Enforcement Agency. The DEA assigns a DEA 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.
DME	Durable medical equipment, such as wheelchairs, hospital beds, and other non-disposable medically necessary equipment.
DOH	New York State Department of Health, the Department responsible for the administration of the Medicaid program at the State level.
DQM	Data Quality Management involves instituting inspection and control processes to monitor conformance with defined data quality rules, as well as instituting data parsing, standardization, cleansing, and consolidation.
DRG	Diagnosis-related grouping; used as a basis for reimbursement.
Drug Rebate Program	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.
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.
EAC	Estimated acquisition cost for drugs; the Federal pricing requirements for drugs.
EAPG	3M Enhanced Ambulatory Patient Grouping System (3M Enhanced APGS), a proprietary product of 3M Health Information Systems.
EEDS	Electronic Eligibility Decision Support System
EFT	Electronic funds transfer; paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EHR	Electronic Health Records

eMedNY	New York State's Medicaid Management Information System.
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.
EPIC	Elderly Pharmaceutical Insurance Coverage; a New York State-funded program to cover prescriptions for the elderly population with limited income earnings.
EPMO	Enterprise Project Management Office (EPMO) that reports directly to the account executive.
EPSDT	Early and Periodic Screening and Diagnostic 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.
ETIN	Electronic Transmitter Identification Number
EVS	Eligibility Verification System; a system used by providers to verify recipient eligibility using a point-of-service device, online PC access, or an automated voice response system.
FDA	Federal Food and Drug Administration
FEIN	Federal employer identification number; a number assigned to businesses by the Federal government.
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 Publications
Fiscal Agent	A contractor who operates a claims processing system and pays providers on behalf of the State.
Fiscal Year - Federal	October 1 - September 30
Fiscal Year - State	April 1 - March 31
FMG	NYS DOH Fiscal Management Group
FMS	Financial Management System
FQHC	Federally Qualified Health Center
GSN	Generic Sequence Number uniquely identifies a product (i.e., it formulation) specific to its agent, dosage form, and strength, and route of administration.
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.
HCPCS	CMS Common Procedure Coding System; a uniform health care procedural coding system approved for use by CMS and all subsequent editions and revisions thereof.
HIC	Health insurance claim number; the number used to identify Medicare beneficiaries.
HIPAA	HIPAA The Health Insurance Portability and Accountability Act of 1996.
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payments
HIT	Health Information Technology
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Areas
HRA	New York City Human Resource Administration
HSEN	Human Services Enterprise Network
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification; ICD-10-CM codes are standardized diagnosis codes used on claims submitted by providers.
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.
IPRO	Island Peer Review Organization.
IRS	Federal Internal Revenue Service
ISO	International Standards Organization (ISO)
ITF	The Integrated Test Facility is an environment that will be used by Department staff and Department contractor staff to test system processing and ensure that quality control is maintained.
IVR	Interactive Voice Response systems
LDOH	Local Departments of Health; local district entities responsible for implementing health programs at the local level.
LDSS	Local Departments of Social Services; local district entities responsible for Medicaid eligibility determination and for performing a number of Medicaid functions. 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.
LOC	Level of care
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.

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
MDW	Medicaid Data Warehouse
MEDS	Medicaid Encounter Data System
MGDP	Mandatory Generic Drug Program
MITA	Medicaid Information Technology Architecture
MMA	Medicare Modernization Act
MME	Managed Metadata Environment
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.
MMTP	Methadone Maintenance Treatment Program
MOAS	Medicaid Override Application System
MEVS	Medicaid Eligibility Verification System
NAMI	Net Available Monthly Income amount to reduce the payment based on Department business rules for Inpatient and Nursing Home pricing.
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 Identifier.
NTI Drugs	Narrow Therapeutic Index drugs
NUBC	National Uniform Billing Committee (NUBC)
NYeNet	A statewide New York telecommunications network backbone.
OAG	Office of Attorney General
OASAS	Office of Alcoholism and Substance Abuse Services
OBRA	Omnibus Budget Reconciliation Act of 1990
OCFS	Office of Children and Family Services
OCR	Optical Character Recognition (OCR)
OHIP	Office of Health Insurance Programs within the New York State Department of Health.
OMH	Office of Mental Health
OMIG	Office of the Medicaid Inspector General
OMR/DD	Office Mental Retardation and Developmental Disabilities.
ORR	Operational Readiness Review is a formal inspection of the R-MMIS conducted to determine if the system is ready for release into production environment.
OSC	Office of the State Comptroller
OTC	Over the Counter drugs
OTDA	Office of Temporary and Disability Assistance is responsible for

	supervising programs that provide assistance and support to eligible families and individuals.
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.
PBM	Pharmacy Benefit Management programs
PCP	Managed Care Prepaid Capitation Plans
PDL	Preferred Drug List
PDP	Preferred Drug Program promotes the use of less expensive, equally effective prescription drugs when medically appropriate.
Peak Hours	10 am – 2 pm Monday through Friday excluding State holidays.
PERM	Payment Error Rate Measurement
PGP	Public Goods Pool
PHI	Protected Health Information
PMP	Project Management Plan that is based upon its proposed Project Management methodology and describes its overall plan and activities required to successfully complete this project within budget and on schedule.
POS	Point-of-service or place of service.
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.
Progressive Elaboration	The process whereby system requirements are refined and changes documented.
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.
QMM	Quality Management Methodology
QMP	Quality Management Plan
RA	Remittance advice; a summary of paid and denied claims produced by MMIS along with provider reimbursement; RAs are sent to providers along with checks or EFT.
RBRVS	Resource-based relative value scale; a reimbursement methodology used to calculate payment for physician, dental, and other practitioners.

Response Time	The elapsed time from when a real-time transaction enters the network demarcation point until the time the response leaves the network demarcation point.
RetroDUR	Retrospective Drug Utilization Review; a series of post-payment analytical reports which evaluate the use of drugs.
R-MMIS	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.
ROSI	Resolution of State Invoice
RRE	Member restrictions, exceptions and exemptions
SA	Service authorization
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
SIT	System Integration Testing is done when the system is handed over from the developers to the Testing Unit and tends to affirm the end-to-end quality of the entire system.
SLA	Service Level Agreements
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.
SMAC	State Maximum Allowable Cost
SMM	State Medicaid Manual
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.
SURS	Surveillance and Utilization Review Subsystem; refers to SURS functions and activities mandated by CMS necessary to maintain complete and continuous compliance with CMS regulatory requirements for SURS; SPR requirements for SURS 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.
TANF	Temporary Assistance for Needy Families, replacement program for Aid to Families with Dependent Children.
TOA	Threshold Override Applications (TOAs)
TPC	Third Party contractor
TPR	Third-party resource
UAT	User Acceptance Testing is done when the completed project is released from the Testing Unit to the Department. The purpose of UAT is for users to test the system in a pseudo environment to verify that the system is performing to specifications.
UB-04	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.
UR	Utilization Review
UT	Utilization Threshold
WBS	Work Breakdown Structures
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 breastfeeding 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.

Procurement Library Contents

The following list of materials will be made available on CD-ROM, upon offeror request to the subject matter expert designated for distribution on page iii of this RFP.

1. eMedNY As Is Business Process Models and Documentation
2. eMedNY Technical Design Documents (TDDs)
3. eMedNY Reports
4. Data Element Dictionary
5. Logical Data Models
6. Inbound and Outbound File Listings
7. Transaction Volume Listings
8. Provider Enrollment Hard Copy File Imaging Volumes
9. Claims Processing Manual
10. eMedNY Phase II User Manuals
11. Mobius Manual
12. Pharmacy Program Overview
13. Pharmacy Sample Reports
14. Data Governance Framework and Organizational Structure
15. MITA State Self-Assessment (SS-A)
16. eMedNY Glossary
17. eMedNY Quick Reference Guide

Additional materials, including Provider Manuals, Forms, Companion Guides, Edit/Error Knowledgebase and Provider Enrollment information, are available for review at the eMedNY website at http://www.emedny.org .

ATTACHMENT D

NEW YORK STATE
DEPARTMENT OF HEALTH

BID FORM

PROCUREMENT TITLE: _____FAU #_____

Bidder Name:
Bidder Address:

Bidder Fed ID No:

A. _____bids a total price of $_____
(Name of Offerer/Bidder)

B. Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller ("restricted period") to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document.* DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: http://www.ogs.state.ny.us/aboutOgs/regulations/defaultAdvisoryCouncil.html

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please circle):
   No Yes
   If yes, please answer the next questions:

   1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please circle):
   No Yes

   1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle):

No Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity:_____

Date of Finding of Non-responsibility: _____

Basis of Finding of Non-Responsibility:

_____
_____
_____
_____
_____
___

(Add additional pages as necessary)

2a. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle):

No Yes

2b. If yes, please provide details below.

Governmental Entity: _____

Date of Termination or Withholding of Contract: _____

Basis of Termination or Withholding:

_____
_____
_____
_____
_____
___

(Add additional pages as necessary)

C. Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.

_____ _____

(Officer Signature) (Date)

_____ _____

(Officer Title) (Telephone)

_____

(e-mail Address)

ATTACHMENT E

NEW YORK STATE
DEPARTMENT OF HEALTH

NO-BID FORM

PROCUREMENT TITLE: _____FAU #_____

Bidders choosing not to bid are requested to complete the portion of the form below:

- ☐ We do not provide the requested services. Please remove our firm from your mailing list
- ☐ We are unable to bid at this time because:

  _____

  _____

  _____

  _____

- ❑ Please retain our firm on your mailing list.

_____
(Firm Name)

_____ _____
(Officer Signature) (Date)

_____ _____
(Officer Title) (Telephone)

_____
(e-mail Address)

FAILURE TO RESPOND TO BID INVITATIONS MAY RESULT IN YOUR FIRM BEING REMOVED FROM OUR MAILING LIST FOR THIS SERVICE.

ATTACHMENT F

CONTRACTOR CERTIFICATION TO COVERED AGENCY (FORM ST-220-CA)

New York State Department of Taxation and Finance

Contractor Certification to Covered Agency

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-CA

(6/06)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a* (see *Need Help? on back*).

Contractor name				*For covered agency use only* *Contract number or description*
Contractor's principal place of business	City	State	ZIP code	
Contractor's mailing address *(if different than above)*				*Estimated contract value over the full term of contract (but not including renewals)* $
Contractor's federal employer identification number (EIN)	Contractor's sales tax ID number (if different from contractor's EIN)			
Contractor's telephone number	Covered agency name			
Covered agency address				*Covered agency telephone number*

I, _____ , hereby affirm, under penalty of perjury, that I am _____
(name) *(title)*

of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and I further certify that:

(Mark an **X** *in only one box)*

☐ The contractor has filed Form ST-220-TD with the Department of Taxation and Finance in connection with this contract and, to the best of contractor's knowledge, the information provided on the Form ST-220-TD, is correct and complete.

☐ The contractor has previously filed Form ST-220-TD with the Tax Department in connection with _____
(insert contract number or description)

and, to the best of the contractor's knowledge, the information provided on that previously filed Form ST-220-TD, is correct and complete as of the current date, and thus the contractor is not required to file a new Form ST-220-TD at this time.

Sworn to this ___ day of _____, 20 ____

_____ _____
(sign before a notary public) *(title)*

Instructions

General information

Tax Law section 5-a was amended, effective April 26, 2006. On or after that date, in all cases where a contract is subject to Tax Law section 5-a, a contractor must file (1) Form ST-220-CA, *Contractor Certification to Covered Agency,* with a covered agency, and (2) Form ST-220-TD with the Tax Department before a contract may take effect. The circumstances when a contract is subject to section 5-a are listed in Publication 223, Q&A 3. This publication is available on our Web site, by fax, or by mail. (See *Need help?* for more information on how to obtain this publication.) In addition, a contractor must file a new Form ST-220-CA with a covered agency before an existing contract with such agency may be renewed.

If you have questions, please call our information center at 1 800 698-2931.

Note: Form ST-220-CA must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 2 of this form must be completed before a notary public.

When to complete this form

As set forth in Publication 223, a contract is subject to section 5-a, and you must make the required certification(s), if:

i. The procuring entity is a *covered agency* within the meaning of the statute (see Publication 223, Q&A 5);

ii. The contractor is a *contractor* within the meaning of the statute (see Publication 223, Q&A 6); and

iii. The contract is a *contract* within the meaning of the statute. This is the case when it (a) has a value in excess of $100,000 and (b) is a contract for *commodities* or *services*, as such terms are defined for purposes of the statute (see Publication 223, Q&A 8 and 9).

Furthermore, the procuring entity must have begun the solicitation to purchase on or after January 1, 2005, and the resulting contract must have been awarded, amended, extended, renewed, or assigned *on or after April 26, 2006* (the effective date of the section 5-a amendments).

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ___ day of _____ in the year 20__ , before me personally appeared _____ ,

known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that

_he resides at _____ ,

Town of _____ ,

County of _____ ,

State of _____; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☐ (If a corporation): _he is the _____

of _____ , the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is a _____

of _____ , the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of _____ , LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

_____
Notary Public

Registration No. _____

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Need help?

Internet access: *www.nystax.gov* (for information, forms, and publications)

Fax-on-demand forms: 1 800 748-3676

Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday. 1 800 698-2931

To order forms and publications: 1 800 462-8100

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

ATTACHMENT G

CONTRACT CERTIFICATION

(ST-220-TD)

New York State Department of Taxation and Finance

Contractor Certification

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-TD

(5/07)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a (see Need help? below).*

Contractor name			
Contractor's principal place of business	City	State	ZIP code
Contractor's mailing address *(if different than above)*			
Contractor's federal employer identification number (EIN)	Contractor's sales tax ID number (if different from contractor's EIN)	Contractor's telephone number ( )	
Covered agency or state agency	Contract number or description	Estimated contract value over the full term of contract (but not including renewals) $	
Covered agency address		Covered agency telephone number	

General information

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded certain state contracts valued at more than $100,000 to certify to the Tax Department that they are registered to collect New York State and local sales and compensating use taxes, if they made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000, measured over a specified period. In addition, contractors must certify to the Tax Department that each affiliate and subcontractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. Contractors must also file a Form ST-220-CA, certifying to the procuring state entity that they filed Form ST-220-TD with the Tax Department and that the information contained on Form ST-220-TD is correct and complete as of the date they file Form ST-220-CA.

All sections must be completed including all fields on the top of this page, all sections on page 2, Schedule A on page 3, if applicable, and Individual, Corporation, Partnership, or LLC Acknowledgement on page 4. If you do not complete these areas, the form will be returned to you for completion.

For more detailed information regarding this form and section 5-a of the Tax Law, see Publication 223, *Questions and Answers Concerning Tax Law Section 5-a, (as amended, effective April 26, 2006)*, available at *www.nystax.gov*. Information is also available by calling the Tax Department's Contractor Information Center at 1 800 698-2931.

Note: Form ST-220-TD must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 4 of this form must be completed before a notary public.

Mail completed form to:

NYS TAX DEPARTMENT
DATA ENTRY SECTION
W A HARRIMAN CAMPUS
ALBANY NY 12227

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227.

Need help?

Internet access: *www.nystax.gov* (for information, forms, and publications)

Fax-on-demand forms: 1 800 748-3676

Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday.

To order forms and publications: 1 800 462-8100

Sales Tax Information Center: 1 800 698-2909

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

I, _____ , hereby affirm, under penalty of perjury, that I am _____
(name) *(title)*

of the above-named contractor, and that I am authorized to make this certification on behalf of such contractor.

Complete Sections 1, 2, and 3 below. Make **only one** entry in each section.

Section 1 — Contractor registration status

☐ The contractor has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made. The contractor is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law, and is listed on Schedule A of this certification.

☐ The contractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 2 — Affiliate registration status

☐ The contractor does not have any affiliates.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each affiliate exceeding the $300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each affiliate exceeding the $300,000 cumulative sales threshold during such quarters on Schedule A of this certification.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates, and each affiliate has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 3 — Subcontractor registration status

☐ The contractor does not have any subcontractors.

☐ To the best of the contractor's knowledge, the contractor has one or more subcontractors having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each subcontractor exceeding the $300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each subcontractor exceeding the $300,000 cumulative sales threshold during such quarters on Schedule A of this certification.

☐ To the best of the contractor's knowledge, the contractor has one or more subcontractors, and each subcontractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Sworn to this____ day of _____ , 20 ____

_____ _____
(sign before a notary public) *(title)*

Schedule A — Listing of each entity (contractor, affiliate, or subcontractor) exceeding $300,000 cumulative sales threshold

List the contractor, or affiliate, or subcontractor in Schedule A only if such entity exceeded the $300,000 cumulative sales threshold during the specified sales tax quarters. See directions below. For more information, see Publication 223.

A Relationship to Contractor	B Name	C Address	D Federal ID Number	E Sales Tax ID Number	F Registration in progress

Column A – Enter ***C*** in column A if the contractor; ***A*** if an affiliate of the contractor; or ***S*** if a subcontractor.

Column B – Name - If the entity is a corporation or limited liability company, enter the exact legal name as registered with the NY Department of State, if applicable. If the entity is a partnership or sole proprietor, enter the name of the partnership and each partner's given name, or the given name(s) of the owner(s), as applicable. If the entity has a different DBA (doing business as) name, enter that name as well.

Column C – Address - Enter the street address of the entity's principal place of business. Do not enter a PO box.

Column D – ID number - Enter the federal employer identification number (EIN) assigned to the entity. If the entity is an individual, enter the social security number of that person.

Column E – Sales tax ID number - Enter only if different from federal EIN in column D.

Column F – If applicable, enter an X if the entity has submitted Form DTF-17 to the Tax Department but has not received its certificate of authority as of the date of this certification.

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ___ day of _____ in the year 20___, before me personally appeared _____,
known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that
_he resides at _____,
Town of _____,
County of _____,
State of _____; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☐ (If a corporation): _he is the _____
of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is a _____
of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of _____
LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

_____
Notary Public

Registration No. _____

ATTACHMENT H

DOH APPENDIX H HIPAA

Appendix H

for CONTRACTOR that uses or discloses individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

I. Definitions. For purposes of this Appendix H of this AGREEMENT:

A. "Business Associate" shall mean CONTRACTOR.

B. "Covered Program" shall mean the STATE.

C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH") and implementing regulations, including those at 45 CFR Parts 160 and 164.

II. Obligations and Activities of Business Associate:

A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.

B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT.

C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.

D. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:

1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
5. Contact procedures for Covered Program to ask questions or learn additional information.

E. Business Associate agrees to ensure that any agent, including a subcontractor, to

whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Program agrees to the same restrictions and conditions that apply through this AGREEMENT to Business Associate with respect to such information.

F. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.

G. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply with 45 CFR § 164.526.

H. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.

I. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

J. Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.

K. Business Associate agrees to comply with the security standards for the protection of electronic protected health information in 45 CFR § 164.308, 45 CFR § 164.310, 45 CFR § 164.312 and 45 CFR § 164.316.

III. Permitted Uses and Disclosures by Business Associate

A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.

B. Business Associate may use Protected Health Information for the proper management and administration of Business Associate.

C. Business Associate may disclose Protected Health Information as Required By Law.

IV. Term and Termination

A. This AGREEMENT shall be effective for the term as specified on the cover page of this AGREEMENT, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by

Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program; provided that, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Appendix H of this AGREEMENT.

B. Termination for Cause. Upon Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for Business Associate to cure the breach and end the violation or may terminate this AGREEMENT if Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or Covered Program may immediately terminate this AGREEMENT if Business Associate has breached a material term of this AGREEMENT and cure is not possible.

C. Effect of Termination.

1. Except as provided in paragraph (c)(2) below, upon termination of this AGREEMENT, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Program, or created or received by Business Associate on behalf of Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
2. In the event that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of Business Associate and Covered Program that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this AGREEMENT to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

V. Violations

A. Any violation of this AGREEMENT may cause irreparable harm to the STATE. Therefore, the STATE may seek any legal remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.

B. Business Associate shall indemnify and hold the STATE harmless against all claims and costs resulting from acts/omissions of Business Associate in connection with Business Associate's obligations under this AGREEMENT. Business Associate shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the STATE from suits, actions, damages and costs, of every name and description relating to breach notification required by 45 CFR Part 164 Subpart D, or State Technology Law § 208, caused by any intentional act or negligence of Business Associate, its agents, employees, partners or subcontractors, without limitation; provided,

however, that Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the STATE.

VI. Miscellaneous

A. Regulatory References. A reference in this AGREEMENT to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.

B. Amendment. Business Associate and Covered Program agree to take such action as is necessary to amend this AGREEMENT from time to time as is necessary for Covered Program to comply with the requirements of HIPAA, HITECH and 45 CFR Parts 160 and 164.

C. Survival. The respective rights and obligations of Business Associate under (IV)(C) of this Appendix H of this AGREEMENT shall survive the termination of this AGREEMENT.

D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.

E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business Associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

Table of Contents

This Contract constitutes a fiscal agent agreement pursuant to Social Services Law Section 367-b (8) which authorizes the state to enter into agreements with fiscal agents for the design, development, implementation, operation, processing, auditing and making payments for medical assistance claims.

1. CONTRACT TERM

The terms of this contract are set forth in Section F, page I-7 of the RFP. With respect to extending this Contract as set forth in Section F, Page I-7, of the RFP, if the Department elects to exercise any of the one (1) year option periods, notice shall be sent to the Contractor 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 III.G. All Contract extensions shall be subject to approval by the Office of the State Comptroller (OSC) and by the Centers for Medicare and Medicaid Services (CMS).

2. TIME OF PERFORMANCE/SUSPENSION OF WORK

1. The work shall be commenced and shall be actually undertaken within such time as the Department may direct by notice, whether by mail, email, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end, and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.
2. The Department reserves the right to stop the work covered by this proposal and the Contract at any time that the Department deems the Contractor to be unable or incapable of performing the work to the satisfaction of the Department. In the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as the Department may deem advisable. If the cost thereof exceeds the amount of the proposal, the Contractor and its surety shall be liable to the State of New York for any excess cost on account thereof.
3. The Department, in its sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, in the best interests of the Department. In the event of such suspension, the Contractor will be given a formal written notice outlining the particulars of such suspension. Examples of the reason for such suspension include, but are not limited to, a budget freeze or reduction in State spending, declaration of emergency, contract compliance issues or other such circumstances. Upon issuance of such notice, the Contractor shall comply with the suspension order. Activity may resume at such time as the Department issues a formal written notice authorizing a resumption of performance under the Contract.

3. SUFFICIENCY OF PERSONNEL AND EQUIPMENT

1. The Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the

jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this Contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

2. All employees, subcontractors or agents performing work under the Contract must be trained staff or technicians who meet or exceed the professional, technical and training qualifications set forth in the RFP or Proposal, whichever is more restrictive, and must comply with all security and administrative requirements of the State, as well as those of the Department. The Department reserves the right to conduct a security background check or otherwise approve any employee, subcontractor or agent furnished by the Contractor and to refuse access to or require replacement of any personnel for cause based on, including but not limited to, professional, technical or training qualifications, quality of work or change in security status or non-compliance with the State's and the Department's security or other requirements. Such approval shall not relieve the Contractor of the obligation to perform all work in compliance with the Contract terms. The Department reserves the right to reject and/or bar from the facility for cause any employee, subcontractor, or agents of the Contractor.
3. If the Department is of the opinion that the services required cannot satisfactorily be performed because of insufficiency of personnel, the Department shall have the authority to require the Contractor to use such additional personnel, and to take steps to ensure satisfactory performance of services at no additional cost to the Department.
4. The Department has the right to approve or reject original and replacement project team members assigned by the Contractor to this project. The Contractor will not be allowed extra time or money to replace personnel. The replacement project team member must possess the same or a higher level of technical expertise and/or experience than the original staff person leaving the project. The Contractor must notify the Department Project Manager or designee of personnel vacancies and provide resumes of replacement staff as support for the Contractor’s compliance with this provision.
5. The Department also reserves the right to require the Contractor to remove specified employees from performance of any or all duties associated with the performance of this Contract. The Department will not exercise this right unreasonably. The Contractor agrees to replace any employees so removed with an employee of equal or better qualifications and acceptable to the Department. The Contractor will not be allowed extra time or money to replace personnel. The Department's exercise of this right shall be upon written notice to the Contractor setting forth the reasons for the requested action.

4. CONTRACTOR ROLE/INTERACTION WITH THIRD PARTIES

1. The Contractor will be responsible for compliance with all requirements set forth in the RFP, even if requirements are delegated to subcontractors. All Department policies, guidelines, and requirements apply to subcontractors.
2. The Department will consider the Contractor to be the sole point of contact with regard to contractual matters, payment of any and all charges resulting from the

outsource or purchase of the equipment and maintenance of the equipment for the term of the Contract.

3. The Contractor must serve as system integrator and must coordinate services with other entities, if necessary, for hardware and software testing, and the resolution of communications problems.
4. The Contractor shall have a representative to provide supervision of the work which Contractor employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department. The Department when so requested from the Contractor will give a confirmation in writing of such orders or directions.
5. It is understood and agreed that the legal status of the Contractor, its agents, officers and employees under this Contract is that of an independent contractor, and in no manner shall they be deemed employees of the Department, and therefore are not entitled to any of the benefits associated with such employment.
6. The Contractor agrees, during the term of this Contract, to maintain at the Contractor's expense those benefits to which its employees would otherwise be entitled by law, including health benefits, and all necessary insurance for its employees, including workers' compensation, disability and unemployment insurance, and to provide the Department with certification of such insurance upon request. The Contractor remains responsible for all applicable Federal, State and local taxes, and all FICA contributions.
7. The Contractor shall be responsible for fully cooperating with any third party, including but not limited to other contractors or subcontractors of the Department, as necessary to ensure delivery of product or coordination of performance of services. Additionally, the Contractor shall provide support to the Department during the System Performance Review (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 CMS inquiries. This level of support shall also be provided to all other State audit agencies or their designees.

5. SUBCONTRACTORS

1. Subcontracting or substitution of any subcontractor by the Contractor shall not be permitted except by prior written approval and knowledge of the Department. For any proposed replacement or substitution before or after the award, the Contractor must provide the Department with references, resumes, and financial documentation, in addition to meeting all other applicable requirements, and submission of all applicable forms, in this RFP.
2. All subcontracts shall contain provisions which include but are not limited to the following:
    a. That the work performed by the subcontractor must be in accordance with the terms of the Contract, and

b. That the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the Contract between the Department and the Contractor.

3. The Department shall have access to documentation and records of the subcontractor relevant to the performance of this Contract, consistent with section 10 of Attachment A attached hereto.

4. In the event of contract termination, the Department reserves the right to have the subcontract assigned to it on the same terms as between the Contractor and the subcontractor, to the extent consistent with New York law. The Department shall not be directly liable for payment to a subcontractor for products provided or services rendered under this Agreement unless the subcontract has been assigned as provided above.

6. CONTRACTOR RESPONSIBILITIES/CONFLICTS

1. The Contractor is responsible for the successful performance of this Contract, including the design, development, testing, implementation, and operation of all systems proposed or otherwise required under the Contract. Such work must be completed to the satisfaction of the Department in strict accordance with the specifications. The Contractor is also responsible for the successful performance of all subcontractors.

2. Consistent with the NYS Vendor Responsibility Questionnaire the Contractor may be required to update information at the request of the Department or OSC prior to the award and/or approval of a contract, or during the term of the contract.

3. The Contractor, its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this Contract, as confidential information to the extent required by State and Federal law.

4. The Contractor, and any of its subcontractors, shall use reasonable efforts to cooperate with all persons engaged in performing services for the Department, whether or not related to this Contract, including, without limitation, the Department officers and employees and third party vendors engaged by the Department.

5. The Contractor shall ensure that its officers, employees, agents, consultants and/or subcontractors comply with the requirements of the New York State Public Officers Law (“POL”), as amended, including but not limited to Sections 73 and 74, as amended, with regard to ethical standards applicable to State employees.

6. Further, Contractor acknowledges that, subject to the Public Officers’ Law, Section 74 (2) entitled “Rule with respect to conflicts of interest”, no officer or employee of a state agency should have any interest, financial or other wise, direct or indirect, or engage in any business or transaction or professional activity or incur any obligation of any nature, which is in substantial conflict with the proper discharge of his duties in the public interest.

7. If, during the term of the Contract, the Contractor becomes aware of a relationship or interest, actual or potential, which may be considered a violation of the POL, or which may otherwise be considered a conflict of interest, the Contractor shall notify the Department in writing immediately. Failure to comply with these provisions may result in termination or cancellation of the resulting contract and criminal proceedings as may be required by law.
8. In the event that a Contractor uses third party financing to finance any or all of the RFP services to be provided under the terms of the RFP, the Contractor understands and agrees that it has the sole responsibility for obtaining such financing and remains responsible to provide the services set forth in the RFP. Further the Contractor understands and agrees that the State of New York and the Department of Health will in no manner underwrite, act as signatory, co-sign, guarantee or in any way secure the Contractor's financing. Failure of the Contractor to secure necessary financing within fifteen (15) business days of OSC approval of the contract in order to provide the services may result in disqualification of the proposal or termination of the resulting contract.

7. CONTRACT INSURANCE REQUIREMENTS

1. A fidelity bond or other security shall be maintained by the Contractor in a form satisfactory to the Department and in the amount of five million ($5,000,000.00) dollars . The Contractor shall provide to the Department proof of the fidelity bond within ten (10) business days of notice from the Department of contract approval.
2. The Contractor must without expense to the State, procure and maintain, until final acceptance by the Department of the work covered by this proposal and the Contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under the Contract, whether performed by it or by subcontractors. Such insurance must be primary and non-contributing to any insurance or self insurance maintained by the Department or the State.
3. Before commencing the work, the Contractor shall furnish to the Department a certificate or certificates, in a form satisfactory to the Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty (30) calendar days written notice has been given to the Department. The kinds and amounts of required insurance are:
    a. A policy covering the obligations of the Contractor in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the Contract shall be void and of no effect unless the Contractor procures such policy and maintains it until acceptance of the work. Certificates of such coverage, with regards to Workers' Compensation and Disability Insurance coverage, must be provided and attached to the Contract as Appendices E-1 and E-2, respectively.
    b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than

$500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than $1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two (2) or more persons in any one occurrence, and not less than $500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than $1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.

i. Contractor's Liability Insurance issued to and covering the liability of the Contractor with respect to all work performed by it under this proposal and the Contract.

ii. Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this Contract, by the Contractor or by its subcontractors, including omissions and supervisory acts of the State.

iii. Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this Contract, by the Contractor or by its subcontractors, including omissions and supervisory acts of the State.

8. LETTER OF CREDIT

Without additional cost to the Department, and as a material condition of the Contract, the Contractor must furnish, for the duration of the contract term (including any extensions) plus one hundred eighty (180) calendar days thereafter, an irrevocable Standby Letter of Credit (SLOC) for the benefit of the Department in the amount of fifty million ($50,000,000) U.S. Dollars. The SLOC shall be issued by a financial institution ("Issuer") licensed to do business under the laws of the State of New York. The Issuer shall be subject to the approval of the Department. The form for the SLOC shall be subject to the approval of the Department. The Contractor must provide a draft SLOC to the Department within ten (10) business days of notice from the Department of contract approval. Failure to provide the draft SLOC to the Department within ten (10) business days of such notice will constitute grounds for termination for cause. The executed SLOC must be provided to the Department within ten (10) business days of the Department’s approval of the draft SLOC. The Department reserves the right to extend the due date for the executed SLOC based on circumstances the Department determines to be reasonable. Failure to provide the final SLOC to the Department within the date set will constitute grounds for termination for cause. The SLOC must contain provisions that satisfy the following requirements:

1. No Contingent Obligations:

   The obligations of Issuer under the SLOC shall in no way be contingent upon reimbursement by the Contractor.

2. Required Notices:

Issuer is required to provide the Department with written notice of: i) any failure by the Contractor to abide by its SLOC agreement with the issuer; ii) any failure of the Issuer to renew the SLOC. Such written notice shall be provided so that it is received by the Department within five (5) business days of each such event. As set forth in ii, should the Contractor fail to obtain an SLOC from another financial institution, the Department shall be entitled to draw the balance of the SLOC within one(1) business day of receipt of such notice.

3. The SLOC must provide funds to the Department for any liability, loss, damage, or expense as a result of the Contractor's failure to perform fully and completely all requirements of the Contract. Such requirements include, but are not limited to, the Contractor's obligation to pay liquidated damages, indemnify the Department under circumstances described in the Contract and the Contractor's obligation to perform the services required by the Contract throughout the entire term of the Contract.
4. The SLOC shall also provide that the bank where the drafts are drawn must be located within New York State.

9. DEPARTMENT OVERSIGHT

1. The Department shall designate a Contract Administrator or designee who shall be responsible for all matters related to this Contract.
2. 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.
3. 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.
4. 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.
5. 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.

6. The Project Manager or designee will chair weekly status meetings during the Implementation Phase and attend all formal project walk-throughs.
7. The Project Manager shall have direct oversight of the entire Replacement MMIS project and may request periodic presentations by the Contractor that demonstrate progress achieved during the project.
8. 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.

10. INSTALLATION

1. Where installation is required, the Contractor shall be responsible for placing and installing the product in the required locations. All materials used in the installation shall be of good quality and shall be free from any and all defects that would mar the appearance of the product or render it structurally unsound. Installation includes the furnishing of any equipment, rigging and materials required to install or place the product in the proper location.
2. The Contractor shall protect the site from damage for all its work and shall repair damages or injury of any kind caused by the Contractor, its employees, officers or agents. If any alteration, dismantling or excavation, etc., is required to effect installation, the Contractor shall thereafter promptly restore the structure or site. Work shall be performed to cause the least inconvenience to the Department and with proper consideration for the rights of other contractors or workers.
3. The Contractor shall promptly perform its work and shall coordinate its activities with those of other contractors. The Contractor shall clean up and remove all debris and rubbish from its work as required or directed. Upon completion of the work, the building and surrounding area of work shall be left clean and in a neat, unobstructed condition, and everything in satisfactory repair and order.

11. TOXIC SUBSTANCES

1. Each Contractor furnishing a toxic substance as defined by Section 875 of the Labor Law, shall provide the Department with not less than two (2) copies of a material safety data sheet, which sheet shall include for each such substance the information outlined in Section 876 of the Labor Law.
2. Before any chemical product is used or applied on or in any building, a copy of the product label and Material Safety Data Sheet must be provided to and approved by the Department.
3. All products supplied pursuant to this agreement shall meet local, State and Federal regulations, guidelines and action levels for lead, as they exist at the time of the State's acceptance of this contract.

12. OWNERSHIP RIGHTS

1. Title and ownership to Existing Software Product(s) delivered by the Contractor under the Contract that is normally commercially distributed on a license basis by

the Contractor or other independent software vendor proprietary owner ("Existing Licensed Product"), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall remain with the Contractor or the proprietary owner or other independent software vendor(s) (ISV). Effective upon acceptance, such Product shall be licensed to the Department in accordance with the Contractor's or ISV owner's standard license agreement, provided, however, that such standard license, must, at a minimum: (a) grant the Department a royalty-free, non-exclusive, perpetual license to use, execute, reproduce, display, perform, adapt and distribute Existing Licensed Product to the Department with all license rights necessary to fully effect the purpose(s) stated in the RFP and (b) recognize the State as the Licensee where the Department is a state agency. Where these rights are not otherwise covered by the ISV owner's standard license agreement, the Contractor shall be responsible for obtaining these rights at its sole cost and expense.

2. Consistent with 45 CFR Part 95.617, effective upon creation of Custom Products, the Contractor hereby conveys, assigns and transfers to the Department the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all trademark and copyrights. The Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Products are protected against unauthorized copying, reproduction and marketing by or through the Contractor, its agents, employees, or subcontractors. Nothing herein shall preclude the Contractor from otherwise using related or underlying general knowledge, skills, ideas, concepts, techniques and experience developed under this project in the course of the Contractor's business.
3. Any publishable or otherwise reproducible material developed under or in the course of performing this Contract, dealing with any aspect of performance under this Contract, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the State, and shall not be published or otherwise disseminated by the Contractor to any other party unless prior written approval is secured from the State. Any and all net proceeds obtained by the Contractor resulting from any such publication shall belong to and be paid over to the State. The State shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.
4. No report, document or other data produced in whole or in part with the funds provided under this Contract may be copyrighted by the Contractor or any of its employees, nor shall any notice of copyright be registered by the Contractor or any of its employees in connection with any report, document or other data developed pursuant to this Contract.
5. All reports, data sheets, documents, etc., generated under this Contract shall be the sole and exclusive property of the Department. Upon completion or termination of this Contract the Contractor shall deliver to the Department upon its demand all copies of materials relating to or pertaining to this Contract. The Contractor shall have no right to disclose or use any of such material and

documentation for any purpose whatsoever, without the prior written approval of the Department or its authorized agents.

6. All press releases, regarding this Contract, must be approved by the Department before being put on the Contractor's or the subcontractor's website or disseminated to the news media and the public.

13. SOFTWARE LICENSES

Where software and/or documentation is acquired on a licensed basis the following shall constitute the license grant:

1. The Contractor must pay all associated license, maintenance, and support fees throughout the Contract term for software (also referred to below as "product" or included in "Materials") proposed by the Contractor. The obligation to pay maintenance and support fees, as applicable, applies even where software or documentation is not acquired on a licensed basis.
2. The Existing Licensed Product of the Contractor and all subcontractors and suppliers proposed for installation must be available to the Department for its use for the entire Contract period, for any extensions the Department may choose to exercise and for any extended license terms the Department may choose to exercise after termination of the Contract.
3. The Department shall have a royalty free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use, software, modifications to software, and documentation that is designed, developed, installed or enhanced as a part of this RFP. No right or interest in any trademark, trade name, or service mark is granted hereunder.
4. As the Department's business operations may be altered, expanded or diminished, licenses granted hereunder may be transferred or combined for use at an alternative or consolidated site not originally specified in the license, including transfers between Agencies ("permitted license transfers"). The Department does not have to obtain the approval of the Contractor for permitted license transfers, but must give thirty (30) calendar days prior written notice to the Contractor of such move(s).
5. Outsourcers, facilities management or service bureaus retained by the Department shall have the right to use the product to maintain the Department's business operations, including data processing, for the time period that they are engaged in such activities, provided that: (i) the Department gives notice to the Contractor of such party, site of intended use of the product, and means of access; (ii) such party has executed, or agrees to execute, the product manufacturer's standard non-disclosure or restricted use agreement which executed agreement shall be accepted by the Contractor ("Non-Disclosure Agreement"); and (iii) if such party is engaged in the business of facility management, outsourcing, service bureau or other services, such third party will maintain a logical or physical partition within its computer system so as to restrict

use and access to the program to that portion solely dedicated to beneficial use for the Department. In no event shall the Department assume any liability for third party's compliance with the terms of the Non-Disclosure Agreement, nor shall the Non-Disclosure Agreement create or impose any liabilities on the Department.

6. Any third party with whom the Department has a relationship for a state function or business operation, shall have the temporary right to use the product (e.g., JAVA applets), provided that such use shall be limited to the time period during which the third party is using the product for the function or business activity.
7. If commercially available, the Department shall have the option to require the Contractor to deliver, at the Contractor's expense: (i) one (1) hard copy and one (1) master electronic copy of the software documentation in a mutually agreeable format; (ii) hard copy instructions for access by downloading from the Internet; and (iii) hard copies of the software documentation by type of license in the following amounts, unless otherwise mutually agreed:
    a. Individual/Named User License - one (1) copy per License;
    b. Concurrent Users - 10 copies per site; and
    c. Processing Capacity - 10 copies per site.
8. Software media must be in a format specified by the Department, without requiring any type of conversion.
9. The Department shall have a perpetual license right to make, reproduce (including downloading electronic copies of the documentation) and distribute, either electronically or otherwise, copies of the documentation as necessary to enjoy future use of the software in accordance with the terms of license;
10. The Department may, in perpetuity, use and copy the software and related documentation (collectively "product") in connection with: (i) reproducing a reasonable number of copies of the product for archival back-up and disaster recovery procedures in the event of destruction or corruption of the product or disasters or emergencies which require the Department to restore backup(s) or to initiate disaster recovery procedures for its platform or operating systems; (ii) reproducing a reasonable number of copies of the product and related documentation for cold site storage. "Cold Site" storage shall be defined as a restorable back-up copy of the product not to be installed until and after the declaration by the Department of a disaster; and (iii) reproducing a back-up copy of the product to run for a reasonable period of time in conjunction with a documented consolidation or transfer otherwise allowed herein. "Disaster Recovery" shall be defined as the installation and storage of the product in ready-to-execute, back-up computer systems prior to disaster or breakdown, which is not used for active production or development.
11. Except as expressly authorized by the terms of license, or otherwise authorized by the terms of this Contract or other expanded license rights granted to the State, the Department shall not:

1. Copy the Product;
2. Cause or permit reverse compilation or reverse assembly of all or any portion of the Product; or
3. Export the licensed software in violation of any U.S. Department of Commerce export administration regulations.

12. For all licenses and custom developed software, including any and all custom or modified transfer code, the Contractor must assign them per licensing agreement or place them in the public domain.

14. ESCROW

1. The Contractor shall either: (i) provide the Department with the source code for the product; or (ii) place the source code in a third party escrow arrangement with a designated escrow agent who shall be named and identified to, and acceptable to, the Department, and who shall be directed to release the deposited source code in accordance with a standard escrow agreement acceptable and approved by the Department. That agreement must, at minimum, provide for release of the source code to the Department a) when the owner of the software notifies the Department that support or maintenance of the Product are no longer available or b) if the Contractor fails to provide services pursuant to this Contract for a continuous period; or (iii) will certify to the Department that the product manufacturer/developer has named the Department as a named beneficiary of an established escrow arrangement with its designated escrow agent who shall be named and identified to the Department and who shall be directed to release the deposited source code in accordance with the terms of escrow. Source code, as well as any corrections or enhancements to such source code, shall be updated for each new release of the product in the same manner as provided above and such updating of escrow shall be certified to the Department in writing. The Contractor shall identify the escrow agent upon commencement of the Contract term and shall certify annually that the escrow remains in effect in compliance with the terms of this paragraph.
2. The Department may release the source code to those who have a) licensed the product or obtained services or b) who are otherwise authorized to use the product or related Materials, pursuant to this Contract or otherwise. Such individuals or entities may use such copy of the source code to maintain the product.
3. Throughout the term of this Contract, the Contractor will deliver all software, including updates to the software, to the Department or the escrow agent within five (5) business days of implementing the use of such software so that all software in the custody of the Department or the escrow agent will be the then current version reflecting all changes and upgrades, but in any event, no less frequently than every six (6) months.
4. The Contractor also must place in escrow one (1) paper copy and one (1) electronic copy of maintenance manuals and additional documentation that are required for the proper maintenance of the data warehouse and the software used to develop, test, and implement the system. Revised copies of manuals

and documentation must be placed in the escrow account in the event they are changed. Such documentation must consist of logic diagrams, installation instructions, operation and maintenance manuals, and must be the same as that which the Contractor supplies to its maintenance personnel to maintain its software. All such materials must be provided to the Department or the escrow agent within five (5) business days of its use or applicability to the use of the MMIS.

5. Except as otherwise provided in this Contract, the Contractor will not be obligated to provide source code (the un-compiled operating instructions for the software) for commercial software unless it is readily available from the licensor. When source code is provided, it must be provided in the language in which it was written and will include commentary that will allow a competent programmer proficient in the source language to readily interpret the source code and understand the purpose of all routines and subroutines contained within the source code. If the source code of such third party is not otherwise provided or freely available, the Contractor will be obliged to ensure that the source code and associated documentation is subject to an escrow agreement meeting the requirements of Section 14, Paragraph 1.
6. In the event that this Contract expires and is not renewed or extended, the Department has the option to continue the escrow agreement until such time that the Department is no longer using the software or documentation covered by this escrow agreement.

15. GENERAL WARRANTIES

1. The Services rendered by the Contractor shall be performed in accordance with all the terms, conditions, covenants, statements, and representations contained in the Contract, including all appendices and attachments.
2. All warranties contained in this Contract shall survive the termination of this Contract, unless otherwise provided herein**.**
3. The Contractor warrants, covenants and represents that it will comply fully with all security procedures of the State, as well as those of the Department in performance of the Contract including but not limited to physical, facility, documentary and cyber security rules, procedures and protocols.
4. The Contractor warrants that all components or deliverables, products or services specified and furnished by or through the Contractor under the Contract meet the completion criteria set forth in the Contract, including all work specifications under the RFP and the Proposal, as well as any subsequent statement(s) of work, and that services will be provided in a workmanlike manner in accordance with industry standards.
5. The Contractor represents and warrants that it shall comply with all laws, ordinances, rules and regulations of any governmental entity in conjunction with the performance of obligations under the Contract. Prior to award and during the Contract term and any renewals thereof, the Contractor must establish to the satisfaction of the Department that it meets or exceeds all requirements of the RFP, the Proposal, the Contract, and any related specifications associated with those

documents or subsequently established, and with any applicable laws, including but not limited to those related to permit and licensing requirements, and shall provide such proof as required by the Department. Failure to comply or failure to provide proof may constitute grounds for the Department to cancel or suspend the Contract, in whole or in part, or to take any other action deemed necessary by the Department.

6. All warranties set forth in this Contract and any subsequent amendments shall apply to any services performed by the Contractor and any Subcontractor unless otherwise expressly disclaimed by the parties therein or such warranty is clearly inapplicable given the type of product or service provided.
7. The warranties set forth in this contract are in lieu of all other warranties, express or implied, including but not limited to, the implied warranties of merchantability and fitness for a particular purpose. Misuse, accident, unsuitable physical or operating environment, modification, or operation inconsistent with standard industry practice, or failure caused by a product for which the Contractor is not responsible may void the warranties.
8. The Contractor warrants, represents and conveys (i) full ownership, clear title free of all liens, or (ii) the right to transfer or deliver perpetual license rights to any products transferred to the Department under this Contract. The Contractor shall be solely liable for any costs of acquisition associated therewith. The Contractor fully indemnifies the Department for any loss, damages or actions arising from a breach of said warranty without limitation.
9. Where the Contractor, the independent software vendor (ISV), or other third party manufacturer provides any project deliverable delivered by or through the Contractor with a standard commercial warranty, such standard warranty shall be in addition to, and not relieve the Contractor from, the Contractor's warranty obligations during the project warranty and extended warranty period(s). Where such standard commercial warranty covers all or some of the project warranty or extended warranty period(s), the Contractor shall be responsible for the coordination during the project warranty or extended warranty period(s) with the ISV or other third party manufacturer(s) for warranty repair or replacement of the ISV's or other third party manufacturer's product.
10. The Contractor must notify the Department in writing immediately upon the discovery of any breach of any of the warranties provided under this Contract.
11. Notwithstanding prior acceptance of deliverables by the Department, the Contractor will expressly warrant all delivered programs and documentation as properly functioning and compliant with the terms of the Contract. The Contractor must correct, at no additional cost or expense to the Department, errors and design deficiencies in the system and replace incorrect or defective programs and documentation within one (1) week of notification from the Department of such deficiencies, or within such period as may be necessary to make correction(s) using due diligence and dispatch as agreed upon between the Department and the Contractor.

12. 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 incurred costs. This warranty will be in effect throughout the term of the Contract and for one (1) year thereafter. Deficiencies properly noted before expiration of the warranty will be covered regardless of such expiration. System modifications and other changes made during the Contract period also will be covered by this warranty. This provision shall not be construed as limiting rights or remedies provided for elsewhere in this Contract.

15.1. HARDWARE & SOFTWARE WARRANTIES

1. In accordance with the RFP, the Contractor shall be required to refresh the PCs and network printers that were supplied to all staff assigned to the State and contract staff every three (3) years. The Contractor hereby warrants and represents that the software and all upgrades do not and will not contain any computer code that would disable the software or upgrades or impair in any way its operation based on the elapsing of a period of time, exceeding an authorized number of copies, advancement to a particular date or other numeral, or other similar self-destruct mechanisms (sometimes referred to as “time bombs,” “time locks,” or “drop dead” devices) or that would permit the Contractor to access the Product to cause such disablement or impairment (sometimes referred to as a “trap door” device).
2. The Contractor warrants and represents that hardware and software components or deliverables specified and furnished by or through the Contractor shall individually, and where specified and furnished as a system, be substantially uninterrupted or error-free in operation and guaranteed against faulty material and workmanship for the warranty period, the remaining term of the Contract, or for a minimum of one (1) year from the date of acceptance, whichever is longer (“project warranty period”). During the project warranty period, defects in the materials or workmanship of components or deliverables specified and furnished by or through the Contractor shall be repaired or replaced by the Contractor at no cost or expense to the Department. The Contractor shall extend the project warranty period for individual component(s), or for the system as a whole, as applicable, by the cumulative period(s) of time, after notification, during which an individual component or the system requires servicing or replacement (down time) or is in the possession of the Contractor, its agents, officers, subcontractors, distributors, resellers or employees (“extended warranty”).
3. Hardware and other equipment offered shall be standard new equipment, current model or most recent release of regular stock product with all parts regularly used with the type of equipment offered; and no attachment or part has been substituted or applied contrary to the manufacturer’s recommendations and standard practice.
4. Repaired, replaced or substituted products shall be subject to all terms and conditions for new parts and components set forth in the Contract. Replaced or repaired product or parts and components of such product shall be new and shall, if available, be replaced by the original manufacturer’s component or part.

Remanufactured parts or components meeting new product standards may be permitted by the Department. Before installation, all proposed substitutes for the original manufacturer-installed parts or components must be approved by the Department. The part or component shall be equal to or of better quality than the original part or component being replaced.

5. If during the regular or extended warranty periods faults develop, the Contractor shall promptly repair or, upon demand, replace the defective unit or component part affected so as to cause the equipment to perform as required. All costs for labor and material and transportation incurred to repair or replace defective product during the warranty period shall be borne solely by the Contractor, and the State or the Department shall in no event be liable or responsible.
6. The Contractor represents and warrants that no anti-use devices have been or will be installed in the software supplied pursuant to this Contract.
7. The Contractor warrants that the software will, at the time of its delivery under this Contract, be free of viruses, worms or other devices (collectively “Device”) capable of halting or inappropriately altering operations or erasing or altering data or programs. Further, the Contractor shall employ industry standard measures to prevent incorporation of such Devices. If it is discovered that such a Deliverable does contain such a Device, then the Contractor shall take appropriate measures to remove such Device, assist the Department with restoration of data and replace such program with a Device-free version of the same program. The Contractor is not responsible for Devices introduced at the Department’s site by the Department or its employees, agents or contractors not associated with the Contractor, or the Department’s failure to employ industry standard measures to prevent incorporation of known Devices.
8. The Contractor warrants that all media on which the software is delivered to the Department will be free from defects.
9. During the warranty period, as well as any optional maintenance periods that the Department exercises, the Contractor must correct any material programming or other errors that are attributable to the Contractor within a reasonable period of time. However, when the Department becomes aware of a defect, the Department must notify the Contractor, either orally or in writing, of such defect and provide sufficient information for the Contractor to identify the problem.
10. Without lessening any warranty rights granted elsewhere in this Contract, with regard to any deliverable that includes or consists of software, the Contractor warrants as to all such software that on acceptance, and for the software manufacturer's warranty period, the software distributor's warranty period, the remaining term of the Contract, or for a minimum of one (1) year, whichever is greater, that:
    a. The software will operate on the computer(s) for which the software is intended in the manner described in the relevant software documentation, the Contractor's proposal, and the RFP;

b. The Contractor will deliver and maintain relevant and complete software documentation, commentary and source code;

c. The source code language used to code the software is readily available in the commercial market, widely used and accepted for the type of programming involved, and support programming in the language is reasonably available in the open market; and

d. The software and all maintenance will be provided in a professional, timely and efficient manner.

15.2. YEAR 2000 WARRANTY

1. 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. Vendor's Product shall include all Products delivered under this Agreement by Vendor other than Third Party Product.

   c. Third Party Product shall include products manufactured or developed by a corporate entity independent from Vendor and provided by Vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. Third Party Product does not include product where Vendor is: 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.

2. Warranty Disclosure

   At the time of bid, Product order or Product Quote, Vendor is required to disclose the following information in writing to Authorized User:

   a. For Vendor Product and for Products (including, but not limited to, Vendor and/or Third Party Products and/or Authorized User's 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 Year 2000 Warranty, Vendor shall pass through

said third party warranty from the third party manufacturer to the Authorized User 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 system(s) in question with the year 2000 warranty statement set forth below.

3. 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 the Department's errors in data entry or data conversion.

This warranty shall survive beyond termination or expiration of the Contract.

4. Nothing in this warranty shall be construed to limit any rights or remedies otherwise available under this Contract.

16. AUDIT AND ACCESS TO PREMISES AND RECORDS

1. The Contractor shall be required to have an independent auditor perform an annual SAS 70 audit of its internal controls, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. The audit firm will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the Department with an exact copy of the report within thirty (30) calendar days of completion.
2. The Contractor shall provide, at no cost, access to the premises and/or records associated with this Contract when requested by the Department or other Federal and/or State oversight entities including, but not limited to, CMS, the Comptroller General of the United States and third parties acting on their behalf, including the Independent Verification and Validation (IV&V) Consultant, and third parties acting on behalf of such entities, to evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under this Contract. This obligation shall extend beyond termination of the Contract. During the term of the Contract, such materials shall be provided in Albany, New York.

3. The Contractor, in accordance with 45 CFR Part 95, 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 45 CFR Part 95.
4. The Contractor must ensure the cooperation of any subcontractor with the requirements of this subsection.

17. DISPUTES

1. If it becomes apparent that: (1) the specifications conflict, or (2) if the specifications are not clear as to (a) the method of performing any part of the work, or as to (b) the types of materials or equipment necessary, or as to (c) the work required to be done in every such situation, the Contractor shall be deemed to have based its proposal upon performing the work and furnishing materials or equipment in the most inexpensive and efficient manner. If such conflicts and/or ambiguities arise, the Department will furnish the Contractor supplementary information showing the manner in which the work is to be performed and the type or types of material or equipment that shall be used.
2. In the event such conflict cannot be resolved, the Contractor and the Department agree to meet 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. A designee of the Commissioner of the New York State Department of Health shall decide any dispute or controversy between the Department and the Contractor, which cannot be disposed of through negotiation. 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.
3. 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.

4. 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.

18. LITIGATION/CLAIMS

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.

19. INDEMNIFICATION

1. Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under the Contract.
2. The Contractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the State and the Department from suits, actions, damages and costs of every name and description relating to personal injury and damage to real or personal tangible property caused by the Contractor, its agents, employees, partners or subcontractors, without limitation; provided however, that the Contractor shall not indemnify for the portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State.
3. The Contractor shall indemnify, defend and hold the Department harmless, without limitation, from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities and cost which may be finally assessed against the Department in any action for infringement of a United States Letter Patent with respect to the Products furnished, or of any copyright, trademark, trade secret or other third party proprietary right in relation to the Products furnished or utilized, provided that the State shall give the Contractor: (i) prompt written notice of any action, claim or threat of infringement suit, or other suit, (ii) the opportunity to take over, settle or defend such action, claim or suit at the Contractor's sole expense, and (iii) assistance in the defense of any such action at the expense of the Contractor. Where a dispute of claim arises relative to a real or anticipated infringement, the State may require the Contractor, at Contractor's sole expense, to submit such information and documentation, including formal patent attorney opinions, as the Commissioner shall require.
4. The Contractor shall not be obligated to indemnify that portion of damages, expenses (including reasonable attorneys' fees), claims, judgment, liabilities, cost or other dispute based upon; i) Department's unauthorized modification or

alteration of a Product; ii) Department's unauthorized use of the Product in combination with the products not furnished by the Contractor; iii) Department's unauthorized use in other than the specified operating conditions and environment.

5. In addition to the foregoing, if the use of any item(s) or part(s) thereof shall be enjoined for any reason or if the Contractor believes that it may be enjoined, the Contractor shall have the obligation, at its own expense and sole discretion as the State's exclusive remedy to take action in the following order of precedence: (i) to procure for the State the right to continue using such item(s) or part(s) thereof, as applicable, (ii) to modify the component so that it becomes non-infringing equipment of at least equal quality and performance; or (iii) to replace said item(s) or part(s) thereof, as applicable, with non-infringing components of at least equal quality and performance, or (iv) if none of the foregoing is commercially reasonable, then provide monetary compensation to the Department up to the dollar amount of the Contract Award. Time is of the essence in matters where the uses of any item(s) or part(s) thereof are enjoined.
6. For all other claims against the Contractor where liability is not otherwise set forth in the Contract as being "without limitation", and regardless of the basis on which the claim is made, the Contractor's liability under the Contract for direct damages shall be limited to two (2) times the dollar amount of the contract including any amendments. Unless otherwise specifically enumerated herein, neither party shall be liable to the other for special, indirect or consequential damages, including lost data or records (unless the Contractor is required to back-up the data or records as part of the work plan), even if the party has been advised of the possibility of such damages. Neither party shall be liable for lost profits, lost revenue or lost institutional operating savings.
7. Notwithstanding the foregoing or anything herein to the contrary, the Department will not consider any limitation of liability for personal injury or death, infringement, or damage to real or personal property, regardless of the nature of the damages sought for any such claim.
8. The Department may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due the Contractor, or may proceed against the performance and payment bond, maintenance or demolition bond, or letter of credit, if any, as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them.
9. The Department does not agree to any indemnification provisions that require the Department to indemnify or hold harmless the Contractor or third parties.

20. CONTRACT AMENDMENT

1. This Contract may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This Contract may not be amended orally. The Contractor shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department and, where appropriate,

approval of the Attorney General, OSC, and CMS, and without prior approval in writing of the amount of compensation for such changes. An approved contract amendment is required whenever a change affects the payment provisions, the scope of work, or the term of the Contract.

2. 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 17 above. Notwithstanding the previous language in this subsection, changes requiring system modifications shall be performed as part of the Evolution Process and shall not require a contract amendment or additional funding.

3. If the Contractor is required by the Department to perform additional work based on new requirements, including changes in State or Federal laws and regulations, the Contractor may submit a formal proposal. Enhanced Federal funding support may be required to implement these changes. The 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. The price proposal submitted by the Contractor shall be prepared in the same format as the Pricing Schedules provided in Attachment P – Pricing Schedules, of the RFP. For example, if the Contractor is proposing a change in the Fixed Annual Operations Fee as a result of the contract amendment, the proposal format shall be the same as Pricing Schedule D - Operations Fixed Administrative Fee. 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 the RFP. The incremental prices shall be accompanied by sufficient documentation demonstrating, to the Department's satisfaction, that changes in the Contractor's cost due to the change in the scope of work justifies the incremental price proposal.

21. ASSIGNMENT OF CONTRACT

1. The Contractor shall not assign, transfer, convey, sublet, or otherwise dispose of the Contract or its right, title or interest therein, or its power to execute such Contract to any other person, company, firm or corporation in performance of the Contract without the prior written consent of the Department and OSC. Failure to obtain consent to assignment from the Department shall be grounds for the Department to revoke and annul such Contract. Notwithstanding the foregoing, the State shall not hinder, prevent or affect assignment of money by a Contractor for the benefit of its creditors. Prior to a consent to assignment of monies becoming effective, the Contractor shall file a written notice of such monies assignment(s) with OSC. Prior to a consent to assignment of a Contract, or portion thereof, becoming effective, the Contractor shall submit the request to assignment to the Department and seek written agreement from the Department,

which will be filed with OSC. The Department reserves the right to reject any proposed assignee at its discretion.

2. Upon notice to the Contractor, the Contract may be assigned without the consent of the Contractor to another State Agency or subdivision of the State pursuant to a governmental reorganization or assignment of functions under which the functions are transferred to a successor Agency or to another Agency that assumes the Department's responsibilities for the Contract.

22. ASSIGNMENT OF CONTRACTOR CLAIMS

The Contractor hereby assigns to the State any and all of its claims for overcharges associated with this Contract which may arise under the antitrust laws of the United States, including 15 USC Section 1, et. seq. and the antitrust laws of the State of New York, including General Business Law Section 340, et. seq.

23. PROVISIONS RELATED TO NEW YORK STATE PROCUREMENT LOBBYING LAW

The State and the Department reserve the right to terminate this Contract in the event it is found that the certification filed by the Contractor in accordance with New York State Finance Law section 139-k was intentionally false or intentionally incomplete. Upon such finding, the State or the Department may exercise its termination right by providing written notification to the Contractor in accordance with the written notification terms of this Contract.

24. PROVISIONS RELATED TO NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT

The Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). The Contractor shall be liable for the costs associated with such breach if caused by the Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of the Contractor's agents, officers, employees or subcontractors.

25. TERMINATION

1. In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this Contract, the Department acting for and on behalf of the State, shall thereupon have the right to terminate this Contract by giving notice in writing of the fact and date of such termination to the Contractor.
2. If, in the judgment of the Department, the Contractor acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate this Contract by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation

based on a proportion of the work completed, including but not limited to the design, development and implementation of the integrated system. In conjunction with OSC, the Department would review any services which had been satisfactorily performed by the Contractor and useable by the Department up to the date of the termination of the Contract. Such compensation cannot exceed the total cost incurred for the work which the Contractor was engaged in at the time of termination and is subject to audit by OSC.

3. By written notice, this Contract may be terminated at any time by the Department for convenience upon thirty (30) calendar days written notice or other specified period without penalty or other early termination charges due. Such termination of the Contract shall not affect any project or purchase order that has been issued under the Contract prior to the date of such termination. If the Contract is terminated pursuant to this subdivision, the Department shall remain liable for all accrued but unpaid charges incurred through the date of the termination. The Contractor shall use due diligence and provide any outstanding deliverables.
4. The Department reserves the right to terminate the Contract in the event it is found that the certification filed by the Contractor in accordance with Section 5-a of the Tax Law is not timely filed during the term of the Contract or the certification furnished was intentionally false or intentionally incomplete. Upon such finding, the Department may exercise its termination right by providing written notification to the Contractor.
5. Upon termination of the Contract, the following shall occur:
   a. The Contractor shall make available to the State for examination all data, records and reports relating to this Contract; and
   b. Except as otherwise provided in the Contract, the liability of the State for payments to the Contractor and the liability of the Contractor for services hereunder shall cease.

26. REMEDIES

1. It is understood and agreed that all rights and remedies afforded below shall be in addition to all remedies or actions otherwise authorized or permitted by law.
2. In the event of the Contractor's material breach, the Department may, with or without formally bidding: (i) purchase from other sources; or (ii) when the Department is unsuccessful after making reasonable attempts, under the circumstances then existing, to timely obtain acceptable service or acquire replacement product of equal or comparable quality, the Department may acquire acceptable replacement product of lesser or greater quality. Such purchases may, at the discretion of the Department, be deducted from the Contract quantity and payments due the Contractor.
3. In any case where a question of non-performance by the Contractor arises, payment may be withheld in whole or in part at the discretion of the Department. Should the amount withheld be finally paid, a cash discount originally offered may be taken as if no delay in payment had occurred. Such amounts as they relate to Federal certification requirements may be deducted during the entire

period that CMS certification is lacking for the MMIS system. Should Federal certification and the associated Federal funds subsequently be granted and provided retroactively, the Department will reimburse the Contractor for amounts withheld back to the date of certification.

4. 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.
5. In the event that the Contractor files a petition under the U.S. Bankruptcy Code during the term of this Contract, the Department may, at its discretion, make application to exercise its right to set-off against monies due the Debtor or, under the Doctrine of Recoupment, credit the Department the amounts owed by the Contractor arising out of the same transactions.
6. The Contractor agrees to reimburse the Department promptly for any and all additional costs and expenses incurred for acquiring acceptable services, and/or replacement product. Should the cost and expenses incurred be less than the Contract price, the Contractor shall have no claim to the difference. The Contractor covenants and agrees that in the event suit is successfully prosecuted for any default on the part of the Contractor, all costs and expenses expended or incurred by the State in connection therewith, including reasonable attorney's fees, shall be paid by the Contractor.
7. Where the Contractor fails to timely deliver pursuant to the guaranteed delivery terms of the Contract, the Department may rent substitute equipment temporarily. Any sums expended for such rental shall, upon demand, be reimbursed to the Department promptly by the Contractor or deducted by the Department from payments due or to become due the Contractor on the same or another transaction.
8. Sums due as a result of these remedies may be deducted or offset by the Department from payments due, or to become due, the Contractor on the same or another transaction. If no deduction or only a partial deduction is made in such fashion the Contractor shall pay to the Department the amount of such claim or portion of the claim still outstanding, on demand. The Department reserves the right to determine the disposition of any rebates, settlements, restitution, liquidated damages, etc., which arise from the administration of the Contract.
9. 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 (retroactive to the beginning date of operations) or re-certification requirements. Damage assessments shall not be made until CMS has notified the State of its decision in writing.

27. NO WAIVER

No term or provision of the Contract shall be deemed waived and no breach excused, unless such waiver or consent to breach shall be in writing and signed

by the party claimed to have waived or consented. No consent by a party to, or waiver of, a breach under the Contract shall constitute a consent to, a waiver of, or excuse for any other, different or subsequent breach. The rights, duties and remedies set forth in the Contract shall be in addition to, and not in limitation of, rights and obligations otherwise available at law.

28. CHOICE OF LAW

Except where the Federal Supremacy Clause requires otherwise, this Contract shall be governed by and construed in accordance with the laws of the State of New York without giving effect to its conflict or choice of laws principles. All disputes, controversies or claims arising out of or in connection with, this Contract shall be litigated in a court of competent jurisdiction within New York State. The parties agree to waive any right to a trial by jury.

29. SEVERABILITY

If any provision of the Contract is determined to be invalid or unenforceable by a court of competent jurisdiction, such determination shall not affect the validity or enforceability of any other part or provision of the Contract.

30. FORCE MAJEURE

1. A force majeure occurrence is an event or effect that cannot be reasonably anticipated or controlled by the State or the Contractor, its subcontractors, or others under the Contractor's or its subcontractor's control. Force majeure includes, but is not limited to, acts of God, acts of war, acts of public enemies, strikes, fires, explosions, actions of the elements, floods, or other similar causes beyond the control of the Contractor or the Department in the performance of the Contract which non-performance, by exercise of reasonable diligence, cannot be prevented. The Contractor shall provide the Department with written notice of any force majeure occurrence as soon as the delay is known.
2. Neither the Contractor nor the Department shall be liable to the other for any delay in or failure of performance under the Contract due to a force majeure occurrence. Any such delay in or failure of performance shall not constitute default or give rise to any liability for damages. The existence of such causes of such delay or failure shall extend the period for performance to such extent as determined by the Contractor and the Department to be necessary to enable complete performance by the Contractor if reasonable diligence is exercised after the cause of delay or failure has been removed.
3. Notwithstanding the above, at the discretion of the Department where the delay or failure will significantly impair the value of the Contract to the Department, the Department may:
    a. Accept allocated performance or deliveries from the Contractor. The Contractor, however, hereby agrees to grant preferential treatment to the Department with respect to product, materials, or services; and/or
    b. Purchase from other sources (without recourse to and by the Contractor for the costs and expenses thereof) to replace all or part of the product,

materials, or services which are the subject of the delay, which purchases may be deducted from the Contract quantities without penalty or liability to the Department; or

c. Terminate the Contract or the portion thereof, which is subject to delays, and thereby discharge any unexecuted portion of the Contract or the relevant part thereof.

4. In addition, the Department reserves the right, at its sole discretion, to make an equitable adjustment in the Contract terms and/or pricing should extreme and unforeseen volatility in the marketplace affect pricing or the availability of supply. "Extreme and unforeseen volatility in the marketplace" is defined as market circumstances which meet the following criteria: (i) the volatility is due to causes outside the control of the Contractor; (ii) the volatility affects the marketplace or industry, not just the particular source of supply utilized for performance of this Contract; (iii) the effect on pricing or availability of supply is substantial; and (iv) the volatility so affects the Contractor's performance that continued performance of the Contract would result in a substantial loss.

31. CAPTIONS

Captions and headings used in this Contract are for convenience of reference only and shall not affect the construction of any provision of this Contract. The singular includes the plural and vice versa. Any reference to gender shall be deemed to include the masculine or feminine. Font size, italics, underlining, bolding, etc., shall not be construed to increase the importance of that particular text beyond that of any other text.

32. ENTIRE AGREEMENT

This Agreement, including the appendices listed on the cover page, constitutes the entire Agreement between the parties with respect to the subject matter. All prior agreements, representations, statements, negotiations and undertakings are superseded. The terms, provisions, representations and warranties contained in this Contract shall survive performance hereunder.

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ATTACHMENT J

BIDDER

MANDATORY

REQUIREMENTS

TRACEABILITY MATRIX

BIDDER MANDATORY
REQUIREMENTS TRACEABILITY MATRIX

As per Section III.B.2.4 the bidder must propose a Requirements Management and Traceability Methodology that will describe how the bidder will track requirements from the time they are defined by a stakeholder to the time they are implemented within the R-MMIS.

The bidder must propose a COTS product that will support a requirements repository that will be used for requirements management and traceability throughout the SDLC process. The bidder must initially populate the requirements repository with the RFP requirements listed below. Each of these requirements will be tracked throughout the life of the contract in accordance with the proposed methodology.

The table below lists the initial RFP ***mandatory*** requirements. The Bidder ***is required*** to acknowledge that they have read the requirement and *agree* that the requirement will be met by placing the word *"**agree**"* in the acknowledge column. Failure to agree to a requirement may be grounds to dismiss the Bidder from further evaluation.

See Excel Spreadsheet Fillable Forms, Attachment J

Attachment K – Certification Checklists

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

BENEFICIARY MANAGEMENT (BE) CHECKLIST

BENEFICIARY MANAGEMENT CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. The Medicaid Buy-In process and the Medicaid Part D data exchange are required, but they are not required to be done in the MMIS as of 02-08-07. Therefore, the business objective BE5 and associated criteria shown below in the Business Objectives section are optional. However, if the MMIS is used for either of these functions, the related criteria apply and are not optional.
3. See Managed Care checklists for Beneficiary Management requirements associated with enrollment in managed care programs.
4. Some States accept the Federal (SSA) determination of eligibility for Supplemental Security Income (SSI) automatically as eligibility for Medicaid. These are called Section 1634 States. Non-Section 1634 States make their own Medicaid eligibility determinations for SSI recipients.
5. SDX is a data exchange by which SSA provides information to the State regarding the eligibility of SSI applicants and recipients.

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45
IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.
PRI - HIPAA privacy rule. This rule is available at http://www.hhs.gov/ocr/hipaa/finalreg.html
CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html
HIPAA - HIPAA act, available from
http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage
SMDL - State Medicare Director Letter of July 6, 2006

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
BE1	Collect and manage information about the Beneficiary population from diverse sources.	
BE2	Maintain information on each Beneficiary's Medicaid benefits to support claims payment and other financial processes.	
BE3	Allow verification of Beneficiary Medicaid eligibility information by external entities.	
BE4	Comply with HIPAA requirements.	
BE5	Manage the Medicare Buy-In and Part D data exchange processes (optionally supported by MMIS).	
BESS1	*Add State-specific business objectives for this business area here.*	

BE1 - COLLECT AND MANAGE INFORMATION ABOUT THE BENEFICIARY POPULATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE1.1	Supports a Beneficiary data set that contains all required data elements.	SMM	X		
BE1.2	Processes all transactions that update the Beneficiary data set on a timely basis as determined by the State, edits fields for reasonableness, and controls and accounts for transactions with errors.	SMM	X		

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

BE1 - COLLECT AND MANAGE INFORMATION ABOUT THE BENEFICIARY POPULATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE1.3	Supports management of Beneficiary information, including archives, with reports, transaction and transaction error tracking, etc.	SMM	X		
BE1.4	Generates notification when Beneficiary information is received from external sources (such as through the State's Integrated Eligibility System or SSA's State Data Exchange) to update Beneficiary records.	IBP		X	
BE1.5	Receives and processes Beneficiary eligibility information from external source (such as through the State's Integrated Eligibility System or SSA's State Data Exchange) for a given period of time; produces total and details information that supports error correction and synchronization. Applies reconciliation changes to master file. Produces a file of changed records to be sent to originating source.	SMM		X	This criteria requirement is met through the Welfare Management System (WMS) that is operated by the Office of Temporary and Disability Assistance
BE1.6	Archives Beneficiary data sets and updates transactions according to State provided parameters.	IBP	X		
BE1.7	If the EPSDT reporting process is performed by the MMIS, provides Beneficiary data to support case identification, tracking, and reporting for the EPSDT services covered under Medicaid (optional).	SMM	X		
BE1.8	Provides an indicator to suppress generation of documents containing Beneficiary identification for confidential services or other reasons.	SMM	X		

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

BE1 - COLLECT AND MANAGE INFORMATION ABOUT THE BENEFICIARY POPULATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE1.9	Maintains clinical, utilization and other indicators of special population, special needs status for such programs as lock-in, disease management, outcomes, and high dollar case management files.	IBP		X	
BE1.10	Maintains record/audit trail of a Beneficiary's requests for copies of personal records (including time/date, source, type, and status of request).	PRI	X		
BE1.11	Maintains record/audit trail of errors during update processes, accounting for originating source and user.	IBP	X		
BE1.12	Allows for authorized users to update Beneficiary records online.	IBP		X	
BE1.13	Supports and tracks the identification of duplicate recipient records based on State-defined criteria.	IBP		X	
BE1SS.1	*Add State-specific criteria for this business objective here.* *Example: Maintains current and 10 years of historical date-sensitive Beneficiary enrollment information. Example: Maintains Beneficiary related data elements defined in the X12N Implementation Guides for the 270, 271, 834, and 837 transactions. Example: Maintains interfaces to external systems to support the citizenship verification requirements of the Deficit Reduction Act (DRA).*				

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

BE2 – MAINTAIN INFORMATION ON BENEFICIARY'S MEDICAID BENEFITS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE2.1	Provides data storage and retrieval for Third Party Liability (TPL) information; supports TPL processing and update of the information.	SMM	X		
BE2.1	Supports the assignment of Beneficiaries to Medicaid benefits/benefit packages based on Federal and/or State-specific eligibility criteria.	IBP		X	
BE2.2	Maintains record of benefit assignment(s) for Beneficiaries.	IBP		X	
BE2.3	Applies appropriate benefit limitations for Beneficiaries based on Federal and/or State-specific criteria.	IBP		X	
BE2.4	Maintains record of Beneficiary benefit limitation information.	IBP		X	
BE2.5	Calculates and applies Beneficiary cost-sharing (including premiums and co-pays) for particular benefits based on Federal and/or State-specific criteria.	IBP	X		
BE2.6	Maintains record of Beneficiary cost-sharing.	IBP	X		
BE2.7	Maintains record/audit trail of any notice of benefit(s) sent to Beneficiaries (including time/date, user/source, and reason for notice).	IBP		X	
BE2SS.1	*Add State-specific criteria for this Business Objective here.*				

BE3 - PROVIDE/ALLOW VERIFICATION OF MEDICAID ELIGIBILITY INFORMATION TO EXTERNAL USERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE3.1	In response to an eligibility inquiry made through the MMIS, provides eligibility status for the date(s) queried, and tracks and monitors responses to the queries (SMM 11281.1B).	SMM	X		
BE3.2	In response to an eligibility inquiry made through the MMIS, provides notification of third-party payers who must be billed prior to Medicaid (SMM 11281.1B).	SMM	X		
BE3.3	In response to an eligibility inquiry made through the MMIS, provides notice of participation in a managed care program (SMM 11281.1B).	SMM	X		
BE3.4	In response to an eligibility inquiry made through the MMIS, provides notification of program and service restrictions, such as lock-in or lock-out (SMM 11281.1B).	SMM	X		
BE3.5	Maintains record/audit trail of responses to eligibility inquiries.	IBP	X		
BE3SS.1	*Add State-specific criteria for this business objective here.* *Example: Supports Beneficiary ID verification 24/7.* *Example: Support the routine production of Medicaid Beneficiary ID cards and track ID cards produced by Beneficiary.* *Example: Support the production of individual Medicaid Beneficiary ID card upon user request, including emergency ID cards, and track ID cards produced by Beneficiary and user.*				

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

BE4 - COMPLY WITH HIPAA REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE4.1	Supports system transmission and receipt of all current version X12N and NCPDP eligibility verification transactions.	HIPAA	X		
BE4.2	Supports production of X12N 270 transactions to query other payer eligibility files and ability to process responses.	IBP		X	
BE4SS.1	*Add State-specific criteria for this business objective here.*				

BE5 - MANAGE THE MEDICARE BUY-IN PROCESS (OPTIONAL)					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE5.1	Identifies and tracks potential Medicare Buy-In Beneficiaries according to State and CMS-defined criteria.	CFR	X		
BE5.2	Transmits State-identified Buy-In Beneficiary information for matching against CMS-specified Federal Medicare Beneficiary database(s).	CFR	X		
BE5.3	Accepts Buy-In Beneficiary response information from CMS-specified Federal Medicare Beneficiary database(s).	SMM	X		

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

BE5 - MANAGE THE MEDICARE BUY-IN PROCESS (OPTIONAL)					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BE5.4	Processes change transactions to update Buy-In Beneficiary information. Identify and track errors or discrepancies between State and Federal Buy-In Beneficiary information.	SMM	X		
BE5.5	Provides Buy-In Beneficiary information for program or management use, including: - transactions processed - errors identified - error correction status - Medicare premiums to be paid by Beneficiary	IBP	X		
BE5.6	Tracks Buy-In exceptions for those Beneficiaries who are identified as eligible, but whose premiums have not been paid	IBP		X	
BE5.7	Supports automated data exchange process(es), as specified by CMS, in order to identify and track Medicare Part D dual-eligible and Low Income Subsidy (LIS) eligible Beneficiaries for the purposes of cost-avoidance on prescription drug claims and calculating spend-down payments.	SMDL	X		
BE5SS.1	*Add State-specific criteria for this business objective here.* *Example: Supports Medicaid premiums for Medicare Part D for dual eligibles*				

BENEFICIARY MANAGEMENT BUSINESS AREA
BENEFICIARY MANAGEMENT (BE) CHECKLIST

BESS1 - FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
BESS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

CLAIMS RECEIPT (CR) CHECKLIST

CLAIMS RECEIPT CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. This is a generic checklist covering all types of claims submitted by all types of providers with the exception of pharmacy Point of Service (a.k.a., Point of Sale, POS) claims. There is a separate checklist for pharmacy POS claims receipt and adjudication.
3. Unless otherwise stated, criteria apply to all claim types paid by the State Medicaid agency including atypical provider claims.
4. This checklist covers the basic functions of claims receipt and receipt of other transactions including attachments.
5. This checklist covers receipt of claims and other transactions by any media supported by the State, e.g., electronic, Web portal, paper. Receipt of claims, other transactions, and attachments are heavily affected by the Health Insurance Portability and Accountability Act (HIPAA).

Sources for this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
CR1	Accept claims and other transactions electronically and via hard copy.	
CR2	Accept attachments and other materials related to claims and other transactions as required for review and approval.	
CR3	Comply with HIPAA requirements.	
CRSS1	*Add State-specific business objectives for the Claims Receipt Checklist here.*	

CR1 - ACCEPT CLAIMS AND OTHER TRANSACTIONS ELECTRONICALLY AND VIA HARD COPY					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CR1.1	Captures accurately all input into the system at the earliest possible time.	SMM	X		
CR1.2	Assigns each claim a unique identifier upon its entering the system.	SMM	X		
CR1.3	Accepts and uses the common hospital paper billing form developed by the National Uniform Billing Committee (NUBC), for non-electronic claims.	SMM	X		
CR1.4	Accepts and uses the common non-institutional paper claim form developed by the National Uniform Claim Committee (NUCC), for non-electronic claims.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

CR1 - ACCEPT CLAIMS AND OTHER TRANSACTIONS ELECTRONICALLY AND VIA HARD COPY					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CR1.5	Accepts and uses the common dental paper billing form developed by the American Dental Association (ADA), for non-electronic claims.	IBP	X		
CR1.6	Controls, tracks, and reconciles captured claims to validate that all claims received are processed.	IBP	X		
CR1.7	Provides the ability to identify claims input for control and balancing (hardcopy and electronic media).	IBP		X	
CR1.8	Provides and maintains a data entry system that includes, but is not limited to, hardcopy claims and claim adjustment/voids which provides for field validity edits and pre-editing for: ③ Provider number ③ Beneficiary ID number ③ Procedure codes ③ Diagnosis codes	SMM	X		
CR1.9	Produces an electronic image of hardcopy claims and claims-related documents, and performs quality control procedures to verify that the electronic image is legible and meets quality standards.	IBP	X		
CR1.10	Screens and captures electronic images, date-stamps, assigns unique control numbers and batches hardcopy claim forms and attachments, adjustment/void forms, and updated turnaround documents.	IBP		X	
CR1.11	Logs each batch into an automated batch control system.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

CR1 - ACCEPT CLAIMS AND OTHER TRANSACTIONS ELECTRONICALLY AND VIA HARD COPY					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CR1.12	Provides the ability to identify claim entry statistics to assess performance compliance.	IBP	X		
CR1.13	Provides a unique submitter number for each billing service or submitter that transmits electronic or paper claims to the MMIS for a single provider or multiple providers.	IBP	X		
CR1.14	Provides an attachment indicator field on all electronic media claims to be used by the submitter to identify claims for which attachments are being submitted separately.	IBP		X	
CR1.15	Provides and maintains a Web portal for providers to directly and efficiently enter claims.	IBP	X		
CR1.16	Supports testing of new provider claims submission systems by allowing providers to submit electronic claims test files that are processed through the adjudication cycle without impact on system data.	IBP	X		
CR1.17	Identifies any incomplete claim batches that fail to balance to control counts.	IBP	X		
CR1.18	Provides and maintains the capability to process standard financial transactions including recoupments and payouts which cover more than one claim/service.	IBP		X	
CR1SS.1	*Add State-specific criteria for this objective here.*				

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

CR2 - ACCEPT ATTACHMENTS AND OTHER ASSOCIATED MATERIALS RELATED TO CLAIMS AND OTHER TRANSACTIONS REQUIRED FOR REVIEW AND APPROVAL					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CR2.1	Accepts, records, stores, and retrieves documents submitted with or in reference to claim submission activity, such as: ③ Operative reports ③ Occupational, physical, and speech therapy reports ③ Durable Medical Equipment (DME) serial number, cost, and warranty data ③ Manufacture's tracking data for implants ③ Waivers and demonstration specific requirements These documents may be freeform or in HIPAA attachment format.	IBP	X		
CR2.2	Receives claim attachments associated with electronic media or paper claims and auto-archives or forwards to appropriate operational area for processing.	IBP	X		
CR2.3	Accepts Medicare crossover claims (for Medicare coinsurance and deductible) or Medicare Explanation of Benefits (EOB) claims attachments.	IBP	X		

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

CR2 - ACCEPT ATTACHMENTS AND OTHER ASSOCIATED MATERIALS RELATED TO CLAIMS AND OTHER TRANSACTIONS REQUIRED FOR REVIEW AND APPROVAL

Ref #	System Review Criteria	Source	Yes	No	Comments
CR2.4	Accepts prior authorization attachments such as: ③ Surgical/anesthesia reports ③ Medical records ③ X-rays/images ③ Orthodontic study models ③ LTC prior Authorization ③ Certain prescription drugs as required ③ Other items required by State or Federal rules	IBP	X		
CR2.5	Accepts other claim related inputs to the MMIS, including but not limited to: ③ Sterilization, abortion, and hysterectomy consent forms ③ Manual or automated medical expenditure transactions which have been processed outside of the MMIS (e.g., spend-down) ③ Non claim-specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts ③ Electronic cost reports ③ Disproportionate share reports ③ Drug rebate ③ Any other inputs required for services under the State's approved plan	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

CR2 - ACCEPT ATTACHMENTS AND OTHER ASSOCIATED MATERIALS RELATED TO CLAIMS AND OTHER TRANSACTIONS REQUIRED FOR REVIEW AND APPROVAL

Ref #	System Review Criteria	Source	Yes	No	Comments
CR2SS.1	*Add State-specific criteria for this objective here.*				

CR3 - COMPLY WITH HIPAA REQUIREMENTS

Ref #	System Review Criteria	Source	Yes	No	Comments
CR3.1	Provides system support for the sending and receiving of electronic claims transactions, containing valid codes, required by 45 CFR Parts 160 and 162, as follows: ③ Retail pharmacy drug claims (NCPDP) ③ Dental health care claims (X12N 837D) ③ Professional health care claims (X12N 837P) ③ Institutional health care claims (X12N 837I) ③ Coordination of benefits data, when applicable ③ Future claims attachments required under HIPAA	HIPAA	X		
CR3.2	Provides secure, HIPAA compliant software and documentation for use by providers to submit electronic claims.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS RECEIPT (CR) CHECKLIST

CR3 - COMPLY WITH HIPAA REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CR3.3	Processes batch 837 claims, rejecting only individual bad claims and accepting all others.	IBP	X		
CR3.4	Employs an electronic tracking mechanism to locate archived source documents or to purge source documents in accordance with HIPAA security provisions.	IBP		X	
CR3SS.1	*Add State-specific criteria for this objective here.*				

CRSS1 - ADD FIRST STATE-SPECIFIC OBJECTIVE HERE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CRSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

PROGRAM MANAGEMENT BUSINESS AREA
DECISION SUPPORT SYSTEM / DATA WAREHOUSE CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:
New York		

DECISION SUPPORT SYSTEM / DATA WAREHOUSE (DSS) CHECKLIST

DECISION SUPPORT SYSTEM / DATA WAREHOUSE (DSS) CHECKLIST BACKGROUND

Background for this checklist:

1. A Decision Support System (DSS) is defined in the SMM Part 11 Chapter 2 Section 11276.5, B. as follows: "A DSS is often a feasible means of managing data needs. DSS is a universal term describing a menu of hardware and software components which can be combined to facilitate access to data and data analysis to serve a wide range of end-users. A DSS provides a mechanism to process data in a manageable quantity and format which is easily accessed by users to manipulate data online. A DSS can enhance the MAR and SUR functionalities by giving States the ability to access large volumes of data to produce customized reports."
2. The data storage and retrieval component of the DSS is often referred to as the "Data Warehouse" (DW) or the DSS relational database. References in the DSS Checklist criteria to the "database" are references to a Data Warehouse if the State uses that language.
3. System review requirements for a DSS are based on a 1996 HCFA survey and report on Medicaid Decision Support Systems, precedents established by approvals of APDs for DSS since 1990, and State individual specifications for the DSS approved for FFP by CMS.
4. User's may also review ACF's technical report on DSS/DW for TANF program objectives available on the ACF website at http://www.acf.hhs.gov/
5. Each State's implementation of a DSS can be different. The certification review team must understand the scope of the State's DSS in order to determine which checklist questions to use. This checklist contains a list of common questions; the checklist will need to be aligned with the actual functionality of the State's DSS prior to its use as part of the State's certification toolkit. Examples of DSS differences are:
    a. Includes (or not) State Management reports, e.g., old MARS
    b. Includes or supplements (or not) old SURS
    c. Produces some Federal reports
    d. Reporting capabilities can range from simple inquiries, e.g., Claim Detail reports, to multi-tiered analytical reports
    e. Can accommodate numerous COTS for data analysis (e.g., patterns of utilization, "What-if" analysis, trend analysis)
    f. Can include Medicaid data only or can link to Vital Statistics, national databases, clinical data, and other sources
    g. Transactions include all Medicaid claims, some Medicaid claims, optional encounter data, optional number of years of historical data
    h. The DSS may be for Medicaid use only or may be shared with other agencies on a cost allocation basis

PROGRAM MANAGEMENT BUSINESS AREA
DECISION SUPPORT SYSTEM / DATA WAREHOUSE CHECKLIST

i. Type, size, configuration of the database or data warehouse may vary by State

6. Data is refreshed periodically on a schedule determined by the State but must be timely enough to meet users' needs.
7. The DSS data warehouse should support security, data cleansing, data archiving, data management, and data standards.

Sources for the criteria in this checklist are as follows:
SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45
IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.
HCFA Report - Report on Medicaid Decision Support Systems, HCFA, 1996. Available from http://www.cms.hhs.gov/MMIS/HCFAReport

BUSINESS OBJECTIVES		
Ref #	**Business Objectives**	**Comments**
DSS1	Support better understanding and management of the Medicaid program by collecting and organizing Medicaid-related data and making this data available in a timely and effective manner.	
DSS2	Provide timely and effective reports for management planning and control.	
DSS3	Support improved analysis for decision making.	
DSSSS1	*Add State-specific business objectives for the Decision Support System/Data Warehouse business area here.*	

DSS1 - SUPPORT BETTER UNDERSTANDING AND MANAGEMENT OF MEDICAID PROGRAM					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
DSS1.1	Identifies relationships between key entities in the Medicaid enterprise.	HCFA Report	X		This criteria requirement is met through the Medicaid Data Warehouse (MDW)
DSS1.2	At a minimum, transfers data from MMIS claims history, recipient enrollment, provider enrollment, and primary reference data (e.g., diagnosis, procedure, National Drug Code (NDC), and pricing) information.	HCFA Report	X		This criteria requirement is met through the MDW

PROGRAM MANAGEMENT BUSINESS AREA
DECISION SUPPORT SYSTEM / DATA WAREHOUSE CHECKLIST

DSS1 - SUPPORT BETTER UNDERSTANDING AND MANAGEMENT OF MEDICAID PROGRAM					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
DSS1.3	Accepts data in a variety of formats from a variety of additional sources, e.g., Vital Statistics, MCO encounter data, Benefit Manager encounter data (pharmacy, dental, mental health), Waiver program data, Census Bureau.	HCFA Report	X		This criteria requirement is met through the MDW
DSS1.4	Refreshes or replaces all historical claim data, recipient enrollment, provider enrollment, and other primary reference data on a scheduled basis.	HCFA Report	X		This criteria requirement is met through the MDW
DSS1.5	Associates clinical data (e.g., claims attachment) with the claim record.	IBP		X	
DSS1.6	Maintains synchronization of claims and encounter record dates with provider and Beneficiary record dates (i.e., a claim or encounter is always linked to the provider status and Beneficiary status segments associated with the date of service).	HCFA Report	X		This criteria requirement is met through the MDW
DSS1SS.1	*Add State-specific criteria for this objective here.*				

PROGRAM MANAGEMENT BUSINESS AREA
DECISION SUPPORT SYSTEM / DATA WAREHOUSE CHECKLIST

DSS2 - PROVIDE TIMELY AND EFFECTIVE REPORTS FOR MANAGEMENT PLANNING AND CONTROL					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
DSS2.1	Supports simple queries and preformatted reports that are easy to access, follow a user-friendly protocol, and produce responses immediately.	SMM	X		This criteria requirement is met through the MDW
DSS2.2	Provides ad hoc reporting capability that presents summarized information on key factors (e.g., number of enrollees, total dollars paid) to executive staff upon request.	SMM	X		This criteria requirement is met through the MDW
DSS2.3	Provides ad hoc query capability for retrieval of data relevant to specific operational units, e.g., claims resolution, prior authorization, and medical necessity review.	SMM	X		This criteria requirement is met through the MDW
DSS2.4	Supports retrieval and presentation of data associated with geographic indicators such as by state, by county, and by zip code.	IBP	X		This criteria requirement is met through the MDW
DSS2.5	Supports Federal reporting requirements when these requirements are met through the DSS.	SMM	X		This criteria requirement is met through the MDW
DSS2.6	Extends system flexibility by adding enhanced reporting above and beyond what is available through other MMIS functions.	SMM	X		This criteria requirement is met through the MDW
DSS2.7	Supports a variety of formats and output options (e.g., Word, Excel, HTML, Access database, or GUI format).	SMM HCFA Report	X		This criteria requirement is met through the MDW

PROGRAM MANAGEMENT BUSINESS AREA
DECISION SUPPORT SYSTEM / DATA WAREHOUSE CHECKLIST

DSS2 - PROVIDE TIMELY AND EFFECTIVE REPORTS FOR MANAGEMENT PLANNING AND CONTROL					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
DSS2.8	Provides online assistance to users to support effective use of data query, data analysis, and report formatting capabilities.	SMM	X		This criteria requirement is met through the MDW
DSS2SS.1	*Add State-specific criteria for this objective here.*				

DSS3 - SUPPORT IMPROVED ANALYSIS FOR DECISION MAKING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
DSS3.1	Maintains easy access to data relevant to the needs of staff as anticipated in the APD and/or RFP, e.g., claims adjudication, prior approval, medical review, utilization review, and analysis of specific payment areas (pharmacy, dental, inpatient, etc.).	HCFA Report	X		This criteria requirement is met through the MDW
DSS3.2	Supports a range of analysis actions including: benefit modeling, utilization management, provider-Beneficiary-MCO profiling, program planning, forecasting, program assessment, provider or contractor performance, quality assurance, fraud detection, comparison of fee-for-service and managed care, and other functions as described in the APD and/or RFP.	HCFA Report	X		This criteria requirement is met through the MDW

PROGRAM MANAGEMENT BUSINESS AREA
DECISION SUPPORT SYSTEM / DATA WAREHOUSE CHECKLIST

DSS3 - SUPPORT IMPROVED ANALYSIS FOR DECISION MAKING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
DSS3.3	Supports analytical staff through sophisticated analytical tools that perform specific analytical functions, e.g., statistical analysis, comparative analysis, financial trends, case-mix adjustments within time ranges specified in the APD and/or RFP.	HCFA Report	X		This criteria requirement is met through the MDW
DSS3.4	Collects and summarizes data for specific user communities (e.g., data marts or cubes) such as program analysis staff, research group, and financial management unit.	HCFA Report	X		This criteria requirement is met through the MDW
DSS3.5	Provides reports that allow users to drill down from summarized data to detailed data.	IBP	X		This criteria requirement is met through the MDW
DSS3.6	Demonstrates support for standard summarized data to be accessed by agency executives (e.g., Executive Information System or dashboards).	IBP	X		
DSS3SS.1	*Add State-specific criteria for this objective here.*				

DSS-SS1 – FIRST STATE-SPECIFIC OBJECTIVE			
Ref #	**System Review Criteria**	**Source**	**Citation**
DSS-SS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*		

PROGRAM MANAGEMENT BUSINESS AREA
FEDERAL REPORTING (FR) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

FEDERAL REPORTING (FR) CHECKLIST

FEDERAL REPORTING (FR) CHECKLIST BACKGROUND

Background for this checklist:

1. The first three objectives relate to the Federal reports required in SMM 2700, for Medicaid Statistical Information System (MSIS), Early Periodic Screening, Diagnosis and Treatment (EPSDT), and Home and Community Based Services (HCBS) Waivers
2. The delivery of adequate MSIS reports should be verified before the State visit. If there are no problems, the first set of criteria need not be verified.
3. The waiver reports are only required if the State has an HCBS waiver. If so, the waiver checklist will be used and the HCBS section of this checklist may be done by the Certification Team member who does the Waiver Checklist.
4. In addition, the MMIS must provide data to be used in the development of CMS financial reports - CMS 37 and CMS 64.

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
FR1	Create and submit to CMS the Federally required MSIS reports.	
FR2	Create and submit to CMS the Federally required EPSDT reports.	
FR3	Create and submit to CMS the Federally required HCBS Waiver reports (optional, not needed if State has no waivers).	

PROGRAM MANAGEMENT BUSINESS AREA
FEDERAL REPORTING (FR) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
FR4	Meet all other Federal Reporting Requirements	
FRSS1	*Add first State-specific business objective for Federal Reporting here.*	

FR1 - CREATE AND SUBMIT THE FEDERALLY REQUIRED MSIS REPORTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FR1.1	Maintains data sets for MSIS reporting as required.	SMM	X		This criteria requirement is met through the Medicaid Data Warehouse (MDW)
FR1.2	Merges into MSIS data from outside sources if required: ③ Capitation payment records from enrollment process ③ Eligibility characteristic data from eligibility intake process ③ Medicaid services processed by non-MMIS State departments, such as mental health services ③ Utilization based on Managed Care	SMM 2700.2	X		This criteria requirement is met through the MDW
FR1.3	Provides and maintains MSIS data for the following adjudicated claims: ③ Inpatient hospital ③ Long term institutional care ③ Prescription drugs ③ Other, not included in the above categories	SMM 2700.2	X		This criteria requirement is met through the MDW

PROGRAM MANAGEMENT BUSINESS AREA
FEDERAL REPORTING (FR) CHECKLIST

FR1 - CREATE AND SUBMIT THE FEDERALLY REQUIRED MSIS REPORTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FR1.4	Provides and maintains encounter data in appropriate claim(s) file.	SMM 2700.2	X		This criteria requirement is met through the MDW
FR1.5	Follows the eligibility reporting guidelines from Attachment A *MSIS Tape Specifications and Data Dictionary* document.	SMM 2700.2	X		This criteria requirement is met through the MDW
FR1.6	Meets MSIS reporting timelines, providing MSIS tapes for submission in accordance with the tape delivery schedules.	SMM 2700.2	X		This criteria requirement is met through the MDW
FR1SS.1	*Add State-specific criteria for this objective here.*				

FR2 - CREATE AND SUBMIT THE FEDERALLY REQUIRED EPSDT REPORTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FR2.1	Produces the CMS-416 report in accordance with CMS requirements. The report must include: ③ The number of children provided child health screening services, ③ The number of children referred for corrective treatment, ③ The number of children receiving dental services, and ③ The State's results in attaining goals set for the state under section 1905(r) of the Act provided according to a State's screening periodicity schedule.	SMM 2700.4	X		This criteria requirement is met through the MDW

PROGRAM MANAGEMENT BUSINESS AREA
FEDERAL REPORTING (FR) CHECKLIST

FR2 - CREATE AND SUBMIT THE FEDERALLY REQUIRED EPSDT REPORTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FR2SS.1	*Add State-specific criteria for this objective here.*				

FR3 - CREATE AND SUBMIT TO CMS THE FEDERALLY REQUIRED HCBS WAIVER REPORTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FR3.1	Produces the CMS-372 and CMS-372S Annual reports on Home and Community Based Waiver Reports, for any HCBS Waivers that exist in accordance with CMS requirements.	SMM 2700.6	X		This criteria requirement is met through the MDW
FR3SS.1	*Add State-specific criteria for this objective here.*				

FR4 - MEET ALL OTHER FEDERAL REPORTING REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FR4.1	Provides data to support the production of CMS-37 and CMS-64 quarterly estimates and expenditure reports.	SMM	X		
FR4SS.1	*Add State-specific criteria for this objective here.*				

PROGRAM MANAGEMENT BUSINESS AREA
FEDERAL REPORTING (FR) CHECKLIST

FRSS1 – FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FRSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

CARE MANAGEMENT BUSINESS AREA
HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

HCBS WAIVERS (WA) CHECKLIST

HCBS WAIVERS CHECKLIST BACKGROUND

Background for this checklist:

1. This checklist targets HCBS waivers only. It does not address Medicaid system requirements for §1115 or §1915(b) managed care waivers. There is a separate set of checklists covering system requirements for managed care program interfaces.
2. This checklist applies when the State uses the Medicaid system to support provider enrollment, member enrollment/ disenrollment, service authorization, claims processing and payment, capitation payment, program integrity and quality management, and reporting functions for HCBS programs. If the HCBS programs are supported by processes and systems outside the scope of the Medicaid system receiving enhanced Federal matching funds, these external processes are not subject to the Federal certification review. More States are folding HCBS system functionality into the mainstream Medicaid system.
3. Automated support for HCBS programs is a miniature copy of basic Medicaid system functionality. This checklist does not incorporate all the requirements of Medicaid provider management, claims adjudication, and other core functions that are found in separate checklists, e.g., Provider Management, Claims Adjudication., and others.
4. This checklist covers requirements not found in non-waiver processes, e.g., “Enroll providers approved to render specialty care services to waiver target population.”
5. Most of the requirements in this checklist are derived from the Home and Community-Based Waiver (HCBS) Application Version 3.4, Technical Guide and Review Criteria, Version 3.4 dated November 2006. The document is updated at least annually. The certification review team should find out if any changes to the application document will affect the certification review criteria in this checklist and update those criteria that are affected prior to conducting the State certification review.
6. The authority for operating a HCBS program is found in §1915(c) of the Social Security Act. §1915(c) which authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements so that a State may offer home and community-based services to State-specified target group(s) who need a level of institutional care provided under the Medicaid State plan. This provision was added to the Act by §2176 of Public Law (P.L.) 97-35 (OBRA 1981) and amended by P.L. 99-272 (COBRA 1985), P.L. 99-509 (OBRA 1986), P.L. 101-508 (OBRA 1990), and §4743 of P.L. 105-33 (BBA 1997).
7. In addition to specific source references to HCBS requirements, the State Medicaid Manual Part 11 Chapter 2, § 2700 requires that the MMIS produce program data necessary to satisfy Federal Medicaid reporting requirements.

Sources for the criteria in this checklist are as follows:

HCBS - Home and Community Based Services waiver program. Application form available from http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp

CARE MANAGEMENT BUSINESS AREA
HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST

HCBS WAIVERS CHECKLIST BACKGROUND

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html
SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45
IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

BUSINESS OBJECTIVES

Ref #	Business Objectives	Comments
WA1	Control enrollment of participants into the HCBS (1915(c)) waiver programs to meet the State's objectives.	.
WA2	Enroll traditional and nontraditional service providers meeting identified standards of care into the program to provide services to the target population.	
WA3	Provide services as described in the individual's approved plan of care.	
WA4	Process waiver provider claims and make timely and accurate payments.	
WA5	Produce program data necessary to satisfy Federal Medicaid reporting requirements, monitor utilization, and assess quality of care provided to participants.	
WASS1	*Add State-specific business objectives for the HCBS* Waiver *checklist here.*	

WA1 - CONTROL ENROLLMENT IN WAIVER PROGRAMS

Ref #	System Review Criteria	Source	Yes	No	Comments
WA1.1	Identifies unduplicated participants enrolled in 1915 (c) waiver program.	HCBS	X		

CARE MANAGEMENT BUSINESS AREA
HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST

WA1 - CONTROL ENROLLMENT IN WAIVER PROGRAMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA1.2	Tracks and reports the number of unduplicated participants in the 1915 (c) waiver program.	HCBS	X		
WA1.3	Generates notices or alerts to agency if number of unduplicated participants enrolled in the wavier program exceeds the number of participants approved in the waiver application.	HCBS		X	This criteria requirement is met through the Medicaid Data Warehouse (MDW) and systems maintained by the Office of Long Term Care
WA1.4	Identifies the date a participant is assessed to meet the waiver level of care (LOC) and the date of the LOC reevaluation.	HCBS		X	This criteria requirement is met through systems maintained by the Office of Long Term Care
WA1SS.1	*Add State-specific criteria for this objective here.*				

WA2 - ENROLL TRADITIONAL AND ATYPICAL WAIVER PROVIDERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA2.1	Captures enrollment information, including National Provider Identifier (NPI) if required, on entity or individual meeting the qualifications contained in the provider agreement including geographic locations and capitation or Fee-for Service (FFS) rates.	HCBS CFR	X		
WA2.2	Prevents enrollment of entities and individuals who do not meet the provider qualifications contained in the provider agreement.	HCBS CFR	X		
WA2.3	Updates information as changes are reported.	IBP		X	

CARE MANAGEMENT BUSINESS AREA
HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST

WA2 - ENROLL TRADITIONAL AND ATYPICAL WAIVER PROVIDERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA2.4	Captures termination information when a waiver provider voluntarily terminates or a provider agreement is cancelled.	IBP	X		
WA2.5	Prohibits enrollment of providers affiliated with individuals debarred by State or Federal Agencies, listed in Abuse Registries, or otherwise unqualified to provide service.	HCBS	X		
WA2SS.1	*Add State-specific criteria for this objective here.*				

WA3 - PROVIDE SERVICES AS DESCRIBED IN THE PLAN OF CARE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA3.1	Stores the plan of care and makes it available for viewing.	HCBS		X	This criteria requirement is met through systems maintained by the Office of Long Term Care
WA3.2	Produces monitoring reports to determine if services approved in the plan of care are provided.	HCBS		X	This criteria requirement is met through systems maintained by the Office of Long Term Care
WA3.3	Identifies the date a participant's plan of care (POC) assessment is completed and the date of the next POC re-evaluation, if applicable.	HCBS		X	This criteria requirement is met through systems maintained by the Office of Long Term Care
WA3SS.1	*Add State-specific criteria for this objective here.*				

CARE MANAGEMENT BUSINESS AREA
HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST

WA4 - PROCESS WAIVER CLAIMS AND MAKE TIMELY AND ACCURATE PAYMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA4.1	Processes claims for medical services	HCBS	X		
WA4.2	Applies edits to prevent payments for services covered under a waiver program to a Medicaid provider who does not have a provider agreement.	HCBS	X		
WA4.3	Prevents or suspends payments for Beneficiaries who have become ineligible for Medicaid.	HCBS	X		
WA4.4	Suspends payments for waiver services furnished to individuals who are inpatients of a hospital, nursing facility or ICF/MR and sends notice to the provider of the admission. (If the State has approved personal care retainer, or respite services provided in an ICF/MR building but not covered under the ICF/MR benefit, an exception may be made.)	HCBS	X		
WA4.5	Limits payment for services to those described within the Beneficiary's approved plan of care. Deny claims exceeding dollar or utilization limits approved in waiver or exceeding the approved individual waiver budget cap.	HCBS		X	This criteria requirement is met through systems maintained by the Office of Long Term Care
WA4.6	Edits waiver services claims for prior authorization, if applicable.	HCBS	X		
WA4.7	Edits waiver services claims for Third Party Liability (TPL) coverage prior to payment to ensure Medicaid is the payer of last resort.	HCBS	X		
WA4.8	Edits waiver services claims for Beneficiary cost share of premium or enrollment fees prior to payment.	HCBS	X		

CARE MANAGEMENT BUSINESS AREA
HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST

WA4 - PROCESS WAIVER CLAIMS AND MAKE TIMELY AND ACCURATE PAYMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA4SS.1	*Add State-specific criteria for this objective here.*				

WA5 - SATISFY FEDERAL REPORTING REQUIREMENTS, MONITOR UTILIZATION, AND ASSESS QUALITY OF CARE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA5.1	Gathers data and produces a variety of financial reports to facilitate cost reporting and financial monitoring of waiver programs.	HCBS SMM	X		
WA5.2	Gathers data and produces utilization reports for monitoring cost neutrality of waiver services to a target population. The average cost of waiver services cannot be more than the cost of alternative institutional care. State may define average either in aggregate or for each participant.	HCBS	X		
WA5.3	Accesses individual Beneficiary claims and/or encounter histories to extract data needed to produce annual report to CMS on cost neutrality and amount of services.	HCBS SMM	X		
WA5.4	Collects and stores data needed to produce reports consistent with data collection plan to assess quality and appropriateness of care furnished to participants of the waiver program.	HCBS		X	This criteria requirement is met through the Medicaid Data Warehouse (MDW) and systems maintained by the Office of Long Term Care
WA5.5	Monitors provider capacity and capabilities to provide waiver services to enrolled participants.	HCBS		X	This criteria requirement is met through systems maintained by the Office of Long Term Care

CARE MANAGEMENT BUSINESS AREA
HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS CHECKLIST

WA5 - SATISFY FEDERAL REPORTING REQUIREMENTS, MONITOR UTILIZATION, AND ASSESS QUALITY OF					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WA5SS.1	*Add State-specific criteria for this objective here.*				

FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
WASS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ENROLLMENT (ME) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

MANAGED CARE ENROLLMENT (ME) CHECKLIST

MANAGED CARE ENROLLMENT (ME) CHECKLIST BACKGROUND

Background for this checklist:

1. Managed Care Enrollment refers to the function of offering a choice of health plans or primary care case managers (PCCMs) to a Medicaid eligible Beneficiary who meets the requirements for the managed care program, or auto-assigning the individual to a plan; recording the decision; and sending the information to the designated data repository. The enrollment function could also be used for Waiver programs, Lock-in programs, Disease Management programs, or any other program in which a Medicaid Beneficiary chooses to enroll or is auto-enrolled.
2. The function may be performed by State employees (Medicaid or other agency), local agency staff, or outsourced contractors, as long as the contractor meets the independence and conflict of interest (COI) requirements in 42 CFR 438.810. The function may be supported by State-owned applications or vendor-owned applications.
3. Managed Care Organizations (MCO) refers to a number of different health plan entities including Health Maintenance Organizations (HMO). States have created variations of MCO and may use different names for them. Primary Care Case Managers (PCCMs) may be called Primary Care Physicians (PCPs) or other names.
4. Enrollment is assumed to include disenrollment and open enrollment. Disenrollment includes member-initiated disenrollment from a plan or PCP, disenrollment during an open enrollment period, and mass disenrollment when a health plan or PCP leaves the program. Open enrollment is the period during which the State allows enrolled members to voluntarily change MCO or PCP.
5. Enrollment in a Managed Care plan is often performed by an Enrollment Broker or Health Choice Counselor. These entities perform the activities cited in 42 CFR 438.50 - 438.56, and may be required to provide some or all of the information required under §438.10.
6. To receive enhanced funding, the enrollment system must meet SMM §11225 requirements as an optional integral component and not duplicate Medicaid Management Information System (MMIS) functionality.
7. If the State contracts for Enrollment Broker Services, including a proprietary system operated by the Enrollment Broker, CMSO will determine how many of the detailed enrollment requirements will be used in the Certification Review.
8. If the State does not collect premiums from Beneficiaries, Objective ME3 (Manage Premium Collections) and associated criteria should be omitted.
9. This checklist covers State Children's Health Insurance Program (SCHIP) enrollment services if SCHIP is administered as an extension of the MMIS and services are delivered through MCOs. SCHIP is not called out in the requirements below because the function is integrated into the MMIS. This checklist covers the functions of enrollment/disenrollment /re-enrollment, and premium, or case

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ENROLLMENT (ME) CHECKLIST

MANAGED CARE ENROLLMENT (ME) CHECKLIST BACKGROUND

management fee payments. Capitation payment may be performed separately from the enrollment function. These payments are made on a per-member per-month (PMPM) basis. The checklist does not cover any other MCO-related function. See other MCO checklists for the other functions.

10. Data exchange between partners may include eligibility interfaces, premium payment interfaces, and enrollment/disenrollment data interchange with MCOs, HMOs, and PCPs.

Sources for the criteria in this checklist are as follows:

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html

IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
ME1	Process accurate and timely automatic or choice-based enrollment, re-enrollment, and disenrollment of Medicaid eligibles into a Managed Care Organization (MCO), Primary Care Case Manager (PCCM) or Primary Care Physician (PCP) program, including into a Health Maintenance Organization (HMO).	
ME2	Support data exchange between stakeholders using standard data formats.	
ME3	Manage premium collections from Beneficiaries, if applicable (optional).	
ME4	Maintain the privacy and security of enrollment information in transit and at rest.	
MSS1	*Add State-specific business objectives for Managed Care Enrollment (ME) Checklist here.*	

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ENROLLMENT (ME) CHECKLIST

ME1 - PROCESS ENROLLMENT AND DISENROLLMENT INTO/ OUT OF MCO OR PCP					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
ME1.1	Captures enrollee choice of MCO or PCP and enters into Beneficiary record.	CFR	X		
ME1.2	Captures enrollee choice of primary care physician (PCP) from the MCO's provider network.	IBP		X	
ME1.3	Assigns enrollee to MCO based on factors such as client age, sex, geographic location; and MCO capitation rate, location.	CFR		X	This criteria requirement is met through the Welfare Management System (WMS) that is operated by the Office of Temporary and Disability Assistance
ME1.4	Assigns member to a primary care physician within MCO.	IBP		X	
ME1.5	Displays enrollees associated with MCO.	IBP	X		
ME1.6	Disenrolls member from MCO.	CFR		X	This criteria requirement is met through the WMS
ME1.7	Disenrolls member without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.	CFR		X	This criteria requirement is met through the WMS
ME1.8	Automatically disenrolls and re-enrolls members in new plans during periods of open enrollment or when an MCO leaves the program.	CFR		X	This criteria requirement is met through the WMS
ME1.9	Automatically disenrolls member from a terminated MCO and places in regular fee-for-service status.	CFR		X	This criteria requirement is met through the WMS
ME1.10	Generates notices to Beneficiary of assignment to or disenrollment from MCO.	IBP		X	

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ENROLLMENT (ME) CHECKLIST

ME1 - PROCESS ENROLLMENT AND DISENROLLMENT INTO/ OUT OF MCO OR PCP					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
ME1.11	Identifies Beneficiaries excluded from enrollment, subject to mandatory enrollment, or free to voluntarily enroll in MCO.	CFR		X	This criteria requirement is met through the WMS
ME1.12	Prioritizes enrollment for Beneficiaries to continue enrollment if the MCO does not have the capacity to accept all those seeking enrollment under the program.	CFR		X	This criteria requirement is met through the WMS
ME1.13	Provides a default enrollment process for those Beneficiaries who do not choose a MCO.	CFR		X	This criteria requirement is met through the WMS
ME1.14	Automatically re-enrolls a Beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less (optional if State Plan so specifies).	CFR		X	This criteria requirement is met through the WMS
ME1.15	Supports ANSI X12N 834 transaction as required by the Health Insurance Portability and Accountability Act (HIPAA).	HIPAA	X		
ME1SS.1	*Add State-specific criteria for this objective here.*				

ME2 - SUPPORT DATA EXCHANGE WITH STAKEHOLDERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
ME2.1	Receives and processes eligibility data from State's Eligibility source system.	SMM	X		
ME2.2	Receives MCO contract information from contract data store (e.g., address, covered	IBP	X		

ME2 - SUPPORT DATA EXCHANGE WITH STAKEHOLDERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
	services, rates).				
ME2.3	Receives and processes provider eligibility data from MMIS or data repository for PCP program.	CFR	X		
ME2.4	Receives and processes PCP registry data from MCOs.	IBP		X	
ME2.5	Calculates or selects premium payment amount and generates PMPM payment (capitation, premium, case management fee).	IBP	X		
ME2.6	Supports ANSI X12N 820 transaction for PMPM premium payment as required by HIPAA.	HIPAA	X		
ME2.7	Transmits enrollment and PMPM payment data to MMIS or data repository.	CFR	X		
ME2.8	Transmits enrollment records and PMPM payments to MCOs.	CFR	X		
ME2.9	Generates identification cards for enrollees or adds MCO/PCP alerts to Medicaid identification cards.	IBP		X	
ME2SS.1	*Add State-specific criteria for this objective here.*				

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ENROLLMENT (ME) CHECKLIST

ME3 - MANAGE PREMIUM COLLECTIONS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
ME3.1	Calculates and generates premium notices to Beneficiaries.	IBP		X	
ME3.2	Processes premium receipts from Beneficiaries.	IBP		X	
ME3.3	Supports inquiries regarding premium collections.	IBP		X	
ME3.4	Produces premium collection reports.	IBP		X	
ME3SS.1	*Add State-specific criteria for this objective here.*				

ME4 - MAINTAIN PRIVACY AND SECURITY OF ENROLLMENT RECORDS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
ME4.1	Complies with provisions for Administrative Simplification under the HIPAA of 1996 to ensure the confidentiality, integrity, and availability of ePHI: • Provides safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies; • Performs regular audits; and • Supports incident reporting.	HIPAA	X		

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ENROLLMENT (ME) CHECKLIST

ME4 - MAINTAIN PRIVACY AND SECURITY OF ENROLLMENT RECORDS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
ME4SS.1	*Add State-specific criteria for this objective here.*				

MSS1 - FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST BACKGROUND

Background for this checklist:

This checklist is used to assess the interfaces between the MMIS and the MCO and reports produced by the MMIS using MCO encounter and capitation payment data.

1. Managed Care Organization (MCO) encompasses different forms of risk bearing, comprehensive health care service organizations including Health Maintenance Organizations (HMO), State-regulated MCO, county or locally operated health care organizations, and other models. The MCO assumes risk to deliver a comprehensive and defined benefit package to enrolled members for a fixed monthly premium payment.
2. Most States have at least one form of MCO. Some States have created a number of different models. This checklist should cover all types of MCO.
3. The checklist assumes that the member enrollment function is covered in the separate Managed Care Enrollment Checklist. Direct communications between the MMIS and MCO information system for the purposes of exchanging member enrollment information are included within the Managed Care Enrollment Checklist.
4. The checklist covers provider enrollment into the MCO, capitation payment, encounter data collection, and Medicaid review activities supported by MCO data processed by the MMIS. It does not cover activities performed by the MCO itself.
5. The Medicaid agency may use other resources external to the MMIS for managing the MCO contractors. The requirements in this checklist assume that the MMIS is the source of data collection and analysis used to manage the MCOs.

Sources for the criteria in this checklist are as follows:

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html

IBP - Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
MC1	Support assessment of members' access to services.	
MC2	Make accurate payment to MCO for managed care services provided to enrolled members.	
MC3	Receive, process, and store MCO encounter records for use by the Medicaid agency in managing MCO performance.	
MC4	Provide information to support assessing quality and cost of care provided to enrollees.	
MC5	Identify services covered under capitation premiums and block duplicate fee-for-service payments and supplemental payments to providers.	
MC6	Collect and report on financial data related to Medicaid managed care programs	
MC7	Collect data and provide reporting to support MCO contractor monitoring (optional).	
MC8	Support specific functions, as applicable, related to the administration of Section 1115 Waivers.	
MCSS1	*Add State-specific business objectives for the Managed Care Organization Interfaces Checklist here.*	

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC1 - SUPPORT ASSESSMENT OF MEMBER ACCESS TO SERVICES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC1.1	Captures information on contracted MCOs, including geographic locations, capitation rates, and organization type.	IBP	X		
MC1.2	Captures information identifying contracted providers within MCO network, including PCPs.	CFR		X	This criteria requirement is met through the Welfare Management System (WMS) that is operated by the Office of Temporary and Disability Assistance
MC1.3	Captures information identifying physicians who have agreed to provide gatekeeper services, number of Beneficiaries assigned, and capacity to accept additional patients.	IBP		X	
MC1.4	Accepts and processes update information as changes are reported.	IBP	X		
MC1.5	Captures termination information when an MCO contract is cancelled.	IBP	X		
MC1.6	Removes and end-dates PCP status from MCO (optional if States require MCO to identify PCPs).	IBP		X	
MC1.7	Provides information to support assessment of adequacy of provider network. This includes identifying and collecting data on the number and types of providers and provider locations.	CFR	X		
MC1.8	Provides information to support review of new enrollments and to prohibit affiliations with individuals debarred by Federal Agencies.	CFR		?	This criteria requirement is met through the WMS
MC1SS.1	*Add State-specific criteria for this objective here.*				

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC2 - MAKE ACCURATE PAYMENTS TO MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC2.1	Calculates per-member per-month (PMPM) capitation payment based on State-defined rate factors such as age, sex, category of eligibility, health status, geographic location, and other.	IBP		X	
MC2.2	Computes capitation payment for the actual number of days of eligibility in a month (i.e., enrollee may not be enrolled for a full month).	IBP		X	
MC2.3	Identifies individuals/enrollees who have terminated enrollment, disenrolled, or are deceased, and excludes those individuals from the monthly MCO capitation payment.	IBP		X	
MC2.4	Generates regular capitation payments to MCOs, at least on a monthly basis in compliance with HIPAA-standard X12 820 Premium Payment transaction where applicable.	IBP	X		
MC2.5	Adjusts capitation payment based on reconciliation of errors or corrections (e.g., retroactive adjustments to a particular capitation payment based on more accurate data that the MMIS obtains retroactively on member enrollments, disenrollments, and terminations).	IBP	X		
MC2.6	Performs mass adjustment to rates according to State policy (e.g., annual adjustment, negotiated rate change, court settlement).	IBP	X		
MC2.7	Performs periodic reconciliations of State member records with MCO, PCP enrollment records.	IBP		X	

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC2 - MAKE ACCURATE PAYMENTS TO MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC2.8	Verifies correct transfer of capitation payment when member disenrolls from one MCO and enrolls in another plan.	IBP		X	
MC2.9	Supports ANSI X12N 820 Premium Payment transaction as required by HIPAA.	HIPAA	X		
MC2SS.1	*Add State-specific criteria for this objective here.*				

MC3 - RECEIVE AND PROCESS ENCOUNTER RECORDS FROM MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC3.1	Collects and stores encounter data on a periodic basis.	CFR	X		
MC3.2	Applies key edits to encounter data, e.g., MCO, physician, member ID numbers; diagnosis and procedure codes. (Note: the encounter record edits can be different from claims edits.)	IBP	X		
MC3.3	Returns erroneous encounter data for correction.	IBP	X		
MC3.4	Performs adjustments to encounter data.	IBP	X		
MC3.5	Periodically produces reports for audits on accuracy and timeliness of encounter data, including matching encounter record to MCO paid claim and to the provider's billing.	IBP	X		

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC3 - RECEIVE AND PROCESS ENCOUNTER RECORDS FROM MCOs					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC3.6	Able to calculate the "Encounter Cost Value," or the cost of services reported on the encounter claim had they been paid on a fee-for-service basis	IBP		X	
MC3.7	Accepts and processes encounter claims in formats as mandated by HIPAA, e.g., X12N 837.	HIPAA	X		
MC3SS.1	*Add State-specific criteria for this objective here.*				

MC4 - PROCESS MCO DATA FOR USE IN ASSESSING QUALITY AND COST OF CARE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC4.1	Accesses and reports on encounter data for the purpose of monitoring appropriateness of care.	CFR	X		
MC4.2	Accesses and reports on encounter data for use in the determination of re-insurance to calculate true out-of-pocket costs.	IBP		X	
MC4.3	Accesses and reports on encounter data for use in profiling MCOs and comparing utilization statistics.	IBP	X		
MC4.4	Collects and sorts encounter data for use in completing MSIS reports.	IBP	X		
MC4.5	Collects and sorts encounter data for use in determining capitation rates.	IBP	X		

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC4 - PROCESS MCO DATA FOR USE IN ASSESSING QUALITY AND COST OF CARE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC4.6	Processes encounter data to detect under-utilization of services by enrollees of the MCO.	CFR	X		
MC4.7	Matches capitation summary data and fee-for-service (FFS) claims data to verify that the MCO payments do not exceed FFS upper limits.	IBP		X	
MC4.8	Compares FFS claims statistics and encounter data, re: cost of care, timeliness of care, quality of care, outcomes.	IBP		X	
MC4.9	Accesses encounter data to identify persons with special health care needs, as specified by the State.	IBP		X	
MC4.10	Produces reports to identify network providers and assess enrollee access to services.	IBP		X	
MC4.11	Is able to produce managed care program reports by category of service, category of eligibility, and by provider type.	IBP	X		
MC4.12	Periodically generates member satisfaction surveys.	IBP		X	
MC4SS.1	*Add State-specific criteria for this objective here.*				

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC5 - IDENTIFY MCO-COVERED SERVICES AND BLOCK DUPLICATE PAYMENTS

Ref #	System Review Criteria	Source	Yes	No	Comments
MC5.1	Blocks payment to fee-for-service (FFS) providers for services included in the MCO benefit package, with the exceptions stated per the State Plan.	CFR	X		
MC5.2	Allows fee-for-service (FFS) payment to providers for services carved out of the MCO benefit package. (These services are usually delivered by providers external to the MCO.)	IBP	X		
MC5.3	Allows payment to fee-for-service (FFS) providers for services rendered in pre-enrollment periods or other periods of transition.	IBP	X		
MC5.4	Allows payment for treatment obtained by an enrollee for an emergency medical condition without prior authorization.	CFR	X		
MC5SS.1	*Add State-specific criteria for this objective here.*				

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC6 - SUPPORT REPORTING OF FINANCIAL INFORMATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC6.1	Generates reports of capitation payment by various categories (e.g., by eligibility group, rate cell, etc.).	IBP		X	
MC6.2	Generates fee-for-service (FFS) claims reporting for services furnished outside of a capitation agreement (i.e., for services "carved-out" of the managed care program).	IBP		X	
MC6SS.1	*Add State-specific criteria for this objective here.*				

MC7 - SUPPORT MEDICAID MANAGED CARE CONTRACTOR MONITORING (OPTIONAL)					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC7.1	Collects basic administrative information, for instance: - the identification of an MCO - contract start and end dates - contract period/year - capitation effective date - maximum enrollment threshold - enrollee count - member month - re-insurance threshold	IBP		X	

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MC7 - SUPPORT MEDICAID MANAGED CARE CONTRACTOR MONITORING (OPTIONAL)					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC7SS.1	*Add State-specific criteria for this objective here.*				

MC8 - SUPPORT ADMINISTRATION OF SECTION 1115 WAIVERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MC8.1	Identifies Beneficiaries who are eligible for a State's Medicaid program by qualifying under a Section 1115 waiver eligibility expansion group. Distinguishes the "1115 expansion eligibles" from other groups of Medicaid-eligibles.	IBP		X	
MC8.2	Collects and maintains the data necessary to support the budget neutrality reporting requirements as specified in the State's 1115 Waiver (including the ability to identify those Beneficiaries who would be ineligible for Medicaid in the absence of the State's 1115 Waiver).	IBP		X	
MC8SS.1	*Add State-specific criteria for this objective here.*				

CARE MANAGEMENT BUSINESS AREA
MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MCSS1 - FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
MCSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

PROGRAM MANAGEMENT REPORTING (PM) CHECKLIST

PROGRAM MANAGEMENT REPORTING (PM) CHECKLIST BACKGROUND

Background for this checklist:

1. This checklist is intended to assess the adequacy of the way the MMIS supports Program Management by managing information and providing reports.
2. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in many States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certifications

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
PM1	Analyze Medicaid program costs and trends to predict impact of policy changes on programs.	
PM2	Monitor payment processes and predict trends.	
PM3	Analyze provider performance to show extent of participation and service delivery.	

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
PM4	Analyze Beneficiary enrollment, participation, and program usage to predict utilization trends.	
PM5	Maintain an efficient and effective management reporting process	
PMSS1	*Add State-specific business objectives for the Program Management Reporting checklist here.*	

PM1 - ANALYZE MEDICAID PROGRAM COSTS AND TRENDS TO PREDICT IMPACT OF POLICY CHANGES ON PROGRAMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PM1.1	Provides information to assist management in fiscal planning and control.	SMM	X		
PM1.2	Provides information required in the review and development of medical assistance policy and regulations.	SMM	X		
PM1.3	Prepares information to support the preparation of budget allocations for the fiscal year.	SMM	X		
PM1.4	Supports the projection of the cost of program services for future periods.	SMM	X		
PM1.5	Compares current cost with previous period cost to establish a frame of reference for analyzing current cash flow.	SMM	X		
PM1.6	Compares actual expenditures with budget to determine and support control of current and projected financial position.	SMM	X		

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PM1 - ANALYZE MEDICAID PROGRAM COSTS AND TRENDS TO PREDICT IMPACT OF POLICY CHANGES ON PROGRAMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PM1.7	Analyzes various areas of expenditure to determine areas of greatest cost.	SMM	X		
PM1.8	Provides data necessary to set and monitor rate-based reimbursement, e.g., institutional per diems and Managed Care Organization (MCO) capitation.	SMM	X		
PM1.9	Maintains provider, recipient, claims processing, and other data to support agency management reports and analyses.	SMM	X		
PM1.10	Provides counts of services based on meaningful units such as but not limited to: ③ Service category (e.g., days, visits, units, prescriptions) ③ Unduplicated claims ③ Unduplicated beneficiaries ③ Unduplicated providers	IBP	X		
PM1.11	Supports online real time summary information such as, but not limited to, number and type of providers, beneficiaries and services.	IBP		X	
PM1.12	Tracks claims processing financial activities and provides reports on current status of payments.	SMM	X		
PM1.13	Provides the capability to produce unduplicated counts within a type of service and in total by month.	IBP	X		
PM1.14	Reports the utilization and cost of services against benefit limitations.	IBP		X	

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PM1 - ANALYZE MEDICAID PROGRAM COSTS AND TRENDS TO PREDICT IMPACT OF POLICY CHANGES ON PROGRAMS

Ref #	System Review Criteria	Source	Yes	No	Comments
PM1.15	Assists in determining reimbursement methodologies by providing expenditure data through service codes including: ③ Healthcare Common Procedure Coding System (HCPCS), current version ③ International Classification of Diseases (ICD), Clinical Modifier, current version ③ National Drug Code (NDC), current	IBP		X	
PM1.16	Produces an annual hospice report showing a comparison of hospice days versus inpatient days for each enrolled hospice Beneficiary and for all hospice providers. version	IBP		X	
PM1.17	Analyzes break-even point between Medicare and Medicaid payments	SMM		X	This criteria requirement is met through the Medicaid Data Warehouse (MDW)
PM1.18	Analyzes cost-effectiveness of managed care programs versus fee-for-service.	IBP		X	
PM1.19	Tracks impact of Medicare drug program.	CFR		X	This criteria requirement is met through the MDW
PM1.20	Reports on any change from baseline for any program or policy change.	IBP		X	
PM1SS.1	*Add State-specific criteria for this business objective here.*				

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PM2 - MONITOR PAYMENT PROCESSES AND PREDICT TRENDS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PM2.1	Reviews errors in claim and payment processing to determine areas for increased claims processing training and provider billing training.	SMM	X		
PM2.2	Provides claims processing and payment information by service category or provider type to analyze timely processing of provider claims according to requirements (standards) contained at 42 CFR 447.45.	SMM	X		
PM2.3	Monitors third party avoidance and collections per State plan.	SMM	X		
PM2.4	Retains all information necessary to support State and Federal initiative reporting requirements.	SMM	X		
PM2.5	Provides access to information such as, but not limited to, paid amounts, outstanding amounts and adjustment amounts to be used for an analysis of timely reimbursement.	SMM	X		
PM2.6	Displays information on claims at any status or location such as, but not limited to, claims backlog, key entry backlog, pend file status, and other performance items.	SMM	X		
PM2.7	Identifies payments by type such as, but not limited to, abortions and sterilizations.	IBP		X	
PM2.8	Develops third party payment profiles to determine where program cost reductions might be achieved.	SMM		X	This criteria requirement is met by the Office of the Medicaid Inspector General (OMIG) using data from the MDW

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PM2 - MONITOR PAYMENT PROCESSES AND PREDICT TRENDS

Ref #	System Review Criteria	Source	Yes	No	Comments
PM2.9	Maintains information on per diem rates, Diagnosis Related Groups (DRG), Resource Utilization Groups (RUG), and other prospective payment methodologies according to the State plan and monitors accumulated liability for deficit payments.	IBP		X	
PM2.10	Automatically alerts administration when significant change occurs in daily, weekly, or other time period payments.	IBP		X	
PM2SS.1	*Add State-specific criteria for this business objective here.*				

PM3 - ANALYZE PROVIDER PERFORMANCE TO SHOW EXTENT OF PARTICIPATION AND SERVICE DELIVERY

Ref #	System Review Criteria	Source	Yes	No	Comments
PM3.1	Reviews provider performance to determine the adequacy and extent of participation and service delivery.	SMM	X		
PM3.2	Reviews provider participation and analyzes provider service capacity in terms of Beneficiary access to health care.	SMM	X		
PM3.3	Analyzes timing of claims filing by provider to ensure good fiscal controls and statistical data.	SMM	X		

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PM3 - ANALYZE PROVIDER PERFORMANCE TO SHOW EXTENT OF PARTICIPATION AND SERVICE DELIVERY

Ref #	System Review Criteria	Source	Yes	No	Comments
PM3.4	Provides access to information for each provider on payments to monitor trends in accounts payable such as, but not limited to, showing increases/decreases and cumulative year-to-date figures after each claims processing cycle.	IBP	X		
PM3.5	Produces information on liens and providers with credit balances.	IBP		X	
PM3.6	Produces provider participation analyses and summaries by different select criteria such as, but not limited to: ③ Payments ③ Services ③ Types of services ③ Beneficiary eligibility categories	IBP	X		
PM3.7	Provides information to assist auditors in reviewing provider costs and establishing a basis for cost settlements.	IBP	X		
PM3.8	Monitors individual provider payments.	IBP	X		
PM3SS.1	*Add State-specific criteria for this business objective here.*				

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PM4- ANALYZE BENEFICIARY ENROLLMENT, PARTICIPATION AND PROGRAM USAGE TO PREDICT UTILIZATION TRENDS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PM4.1	Reviews the utilization of services by various Beneficiary categories to determine the extent of participation and related cost.	SMM	X		
PM4.2	Analyzes progress in accreting eligible Medicare buy-in Beneficiaries.	SMM	X		
PM4.3	Supports analyses of data on individual drug usage.	SMM	X		
PM4.4	Presents geographic analysis of expenditures and Beneficiary participation.	SMM	X		
PM4.5	Provides Beneficiary data (including Long Term Care (LTC), Early Periodic Screening, Diagnosis and Treatment (EPSDT), and insurance information) for designated time periods.	IBP	X		
PM4.6	Summarizes expenditures, based on type of Federal expenditure and the eligibility and program of the Beneficiary.	IBP	X		
PM4.7	Provides eligibility and Beneficiary counts and trends by selected data elements such as, but not limited to, aid category, type of service, age and county.	IBP	X		
PM4.8	Provides Beneficiary enrollment and participation analysis and summary, showing utilization rates, payments and number of beneficiaries by eligibility category.	SMM	X		
PM4.9	Provides the ability to request information online and to properly categorize services based on benefit plan structure.	IBP		X	

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PM4- ANALYZE BENEFICIARY ENROLLMENT, PARTICIPATION AND PROGRAM USAGE TO PREDICT UTILIZATION TRENDS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PM4.10	Reports on dual eligibles pre and post Medicare Part D implementation.	SMM	X		
PM4SS.1	*Add State-specific criteria for this business objective here.*				

PM5 - MAINTAIN AN EFFECTIVE AND EFFICIENT MANAGEMENT REPORTING PROCESS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PM5.1	Supports report balancing and verification procedures.	IBP		X	
PM5.2	Maintains comprehensive list of standard PM reports and their intended use (business area supported).	IBP		X	
PM5.3	Maintains a list of users of each standard PM report.	IBP		X	
PM5.4	Maintains online access to at least four (4) years of selected management reports and five (5) years of annual reports.	IBP		X	
PM5.5	Meets State defined time frames and priorities for processing user requests.	SMM	X		
PM5SS.1	*Add State-specific criteria for this business objective here.*				

PROGRAM MANAGEMENT BUSINESS AREA
PROGRAM MANAGEMENT REPORTING CHECKLIST

PMSS1 – FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PMSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

PROVIDER MANAGEMENT (PR) CHECKLIST

PROVIDER MANAGEMENT (PR) CHECKLIST BACKGROUND

Background for this checklist:

1. This is a generic checklist covering all types of providers. There are limited references to specific provider types, e.g., laboratory, physician.
2. Unless otherwise stated, criteria apply to all provider types enrolled by the State Medicaid agency, including atypical.
3. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certifications

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

IBP - Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
PR1	Enroll and maintain adequate provider network for the Medicaid Beneficiary population.	

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
PR2	Ensure quality of provider network and accuracy of payment arrangement.	
PR3	Maintain provider information.	
PR4	Comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.	
PRSS1	*Add State-specific business objectives for the Provider Management Checklist here.*	

PR1 - ENROLL AND MAINTAIN ADEQUATE PROVIDER NETWORK					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR1.1	Provides secure access to the applications.	IBP	X		
PR1.2	Routes provider applications, and collects and processes provider enrollment and status information.	IBP	X		
PR1.3	Produces notices to applicants of pending status, approval, or rejection of their applications.	IBP	X		
PR1.4	Assigns and maintains provider numbers for all providers if the system is not natively NPI-compliant internally. Maps NPI identifiers to internal assigned numbers. Assigns and maintains provider numbers for providers not eligible for an NPI number.	SMM	X		

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

PR1 - ENROLL AND MAINTAIN ADEQUATE PROVIDER NETWORK					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR1.5	Flags and routes for action if multiple internal State assigned provider numbers are assigned to a single provider.	IBP		X	
PR1.6	Supports communications to and from providers and tracks and monitors responses to the communications.	IBP		X	
PR1.7	Supports a provider appeals process in compliance with Federal guidelines contained in 42 CFR 431.105.	CFR	X		
PR1.8	Maintains date-specific provider enrollment and demographic data.	SMM	X		
PR1.9	Generates information requests, correspondence, or notifications based on the status of the application for enrollment.	IBP		X	
PR1.10	Tracks the sending of State furnished information to enrolled providers.	IBP		X	
PR1.11	Produces responses to requests/inquiries on the adequacy of the Medicaid provider network based on provider/Beneficiary ratios by geographic region, provider type, etc.	IBP		X	
PR1.12	Uses consistent provider naming conventions to differentiate between first names, last names, and business or corporate names and to allow flexible searches based on the provider name.	IBP		X	
PR1SS.1	*Enter State-specific Criteria for this business objective here. Example: Identifies and flags out-of-state providers.*				

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

PR2 - ENSURE QUALITY OF PROVIDER NETWORK AND ACCURACY OF RATES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR2.1	Tracks and supports the screening of applications (and ongoing provider updates) for (National Provider Identifier (NPIs), State licenses, Specialty Board certification as appropriate, review team visits when necessary, and any other State and/or Federal Requirement.	SMM	X		
PR2.2	Tracks and supports any established provider review schedule to ensure providers continue to meet program eligibility requirements.	SMM	X		
PR2.3	Verifies provider eligibility in support of other system processes, i.e., payment of claims.	SMM	X		
PR2.4	Captures Clinical Laboratory Improvement Amendments (CLIA) certification information and the specific procedures each laboratory is authorized to cover. Links the information for use in claims adjudication.	SMM	X		
PR2.5	Cross-references license and sanction information with other State or Federal agencies.	IBP		X	
PR2.6	Generates notices to providers of expiring Medicaid agreements and/or State licenses.	IBP		X	

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

PR2 - ENSURE QUALITY OF PROVIDER NETWORK AND ACCURACY OF RATES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR2.7	Maintains multiple provider specific reimbursement rates with begin and end dates, consistent with State policy. Examples include: per diems, level-of-care per diems, case mix, percentage-of-charge rates, rates based on level of care, preferred provider agreements, managed care agreements, volume purchase contracts, or other cost-containment initiatives with begin and end effective dates.	SMM	X		
PR2SS.1	*Enter State-specific criteria for this business objective here. Example: Identifies providers whose licenses, certifications, and permits are set to expire ninety (90) days prior to the end date of the current certification, licensing, or permit period.*				

PR3 - MAINTAIN PROVIDER INFORMATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR3.1	Accepts, validates, and processes transactions or user entries to update and maintain provider information.	SMM	X		

PR3 - MAINTAIN PROVIDER INFORMATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR3.2	Provides user access to provider data and allows extraction of information. The extracts or reports could include such items as: ③ The current status of providers' records. ③ An alphabetical provider listing ③ A numeric provider listing ③ A provider rate table listing ③ An annual re-certification notice ③ A provider "group affiliation" listing ③ A provider specialty listing ③ A provider listing by category of service	IBP		X	
PR3.3	Tracks and controls the process of reconciliation of errors in transactions that are intended to update provider information.	SMM	X		
PR3.4	Maintains current and historical multiple address capabilities for providers.	SMM	X		
PR3.5	Maintains an audit trail of all updates to the provider data, for a time period specified by the State.	SMM	X		
PR3.6	Maintains providers' Drug Enforcement Administration (DEA) numbers.	SMM	X		
PR3.7	Updates and maintains financial data including current and prior year 1099 reported amounts.	SMM	X		

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

PR3 - MAINTAIN PROVIDER INFORMATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR3.8	Maintains links from providers to other entities, such as Groups, Managed Care Organizations (MCO), Chains, Networks, Ownerships, and Partnerships.	SMM	X		
PR3.9	Provides capability to do mass updates to provider information, based on flexible selection criteria.	SMM	X		
PR3.10	Maintains indicators to identify providers that are Fee-for-Service (FFS), Managed Care Organization (MCO) network only, and other State health care program participants.	SMM	X		
PR3.11	Maintains a flag for providers who are eligible to use Electronic Funds Transfer (EFT) and Electronic Claims Submission.	SMM	X		
PR3SS.1	*Enter State-specific criteria for this business objective here.* *Example: Maintains the flexibility for date-sensitive demographic information including:* ③ *Provider type and specialty(ies) and taxonomy codes* ③ *Multiple provider types* ③ *Multiple provider specialties* ③ *Multiple provider office locations on a single provider record*				

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

PR4 - COMPLY WITH HIPAA REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PR4.1	Requires (when appropriate), captures, and maintains the 10-digit National Provider Identifier.	HIPAA	X		
PR4.2	Accepts the National Provider Identifier in all standard electronic transactions mandated under HIPAA.	HIPAA	X		
PR4.3	Interfaces with the National Plan and Provider Enumerator System (NPPES) to verify the National Provider Identifier of provider applicants once the Enumerator data base is available.	HIPAA	X		
PR4.4	Does not allow atypical providers to be assigned numbers that duplicate any number assigned by the NPPES.	HIPAA	X		
PR4.5	Provides ability to link and de-link to other Medicaid provider IDs for the same provider, e.g., numbers used before the NPI was established, erroneously issued prior numbers, multiple NPIs for different subparts, etc. Captures/crosswalks subpart NPIs used by Medicare (but not Medicaid) to facilitate COB claims processing.	HIPAA	X		

PROVIDER MANAGEMENT BUSINESS AREA
PROVIDER MANAGEMENT (PR) CHECKLIST

PRSS1 - FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
PRSS1.1	*Add criteria for the first State-specific objective here.*				

OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

REFERENCE DATA MANAGEMENT (RF) CHECKLIST

REFERENCE DATA MANAGEMENT (RF) CHECKLIST BACKGROUND

Background for this checklist:

1. Reference Data refers to the body of codes, attributes, and descriptions used by applications within or interfacing with the MMIS. The traditional Reference Subsystem is a composite of applications that periodically update or replace tables of codes.
2. Reference data are created and maintained by many external entities, many of which are named Standard Developing Organizations. Some of these are recognized by HHS as the owners or developers of data standards required by the Health Insurance Portability and Accountability Act (HIPAA).
3. Reference data are also created by State Medicaid agencies. During HIPAA implementation, States mounted an unprecedented effort to reconcile the large number of "Local Codes" that States had invented individually over the past 30 years. This effort resulted in the adoption by most States of the collaboratively approved standards to replace local codes.
4. Reference code sets fall into very large files maintained by external entities, e.g., HCPCS, NCPDP, ICD-9; small files maintained by external entities; and local code files created by the State.
5. Periodicity of file updates or replacements depends on the owner of the data. States usually pay a fee for update services from external entities.
6. Codes are date-specific. The start and end date of a code impacts the pricing or the validity of the information.
7. HIPAA introduced the concept of "mandatory" data standards as opposed to voluntary.

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
RF1	Manage reference data to support claims processing, data to consist of proper procedure, diagnosis, formulary and drug pricing codes, charge information, and data that supports different payment methods (e.g. Outpatient Prospective Payment System (OPPS), Diagnosis Related Group (DRG), etc), and other items as needed by the State.	
RF2	Comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.	
RFSS1	*Add State-specific business objectives for the Reference Data Management Checklist here.*	

OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

RF1 - MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1.1	Maintains reasonable and customary charge information for Medicaid and Medicare to support claims processing: ③ Reimbursement under the Medicaid program for other than outpatient drugs, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Indian Health Services (IHS) and hospital inpatient and outpatient reimbursement is to be the lower of the provider's "usual and customary" charge, the rate established by the State, or the amount, which is allowed under the Medicaid program. "Usual and customary" charges are calculated from the actual charges submitted on provider claims for Medicaid payment. ③ Reimbursement for prescription drugs are usually processed by either a) Federal Upper Limit (FUL) or Maximum Allowable Cost (MAC) with some drugs; the State defined Estimated Acquisition Cost (EAC), which is defined by the Average Wholesale Price (AWP) less 15 to 20 % plus a dispensing fee (ranging anywhere from 0.50 to several dollars); and/or plus a provider specific dispensing fee; or b) the provider's usual and customary charge, paying the lesser of these fees.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

RF1 - MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1.2	Supports Payment for Services by providing reference data, including procedure, diagnostic, and formulary codes (42 CFR 447).	SMM	X		
RF1.3	Processes change transactions to procedure, diagnosis, and formulary codes and other data and responds to queries and report requests.	SMM	X		
RF1.4	Archives all versions of reference information and update transactions.	IBP		X	
RF1.5	Processes update transactions to the reasonable and customary charge data and responds to queries and report requests.	SMM	X		
RF1.6	Retrieves, as needed, archived reference data for processing of outdated claims or for duplicate claims detection.	SMM	X		
RF1.7	Generates a summary of history file transfers.	IBP		X	
RF1.8	Maintains current and historical reference data used in claims processing.	IBP	X		
RF1.9	Maintains online access to all reference tables with inquiry by the appropriate code.	IBP		X	
RF1.10	Maintains an audit trail of all information changes, including errors in changes and suspended changes.	IBP	X		

OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

RF1 - MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1.11	Maintains revenue codes; provides online update and inquiry access, including: (a) Coverage information (b) Restrictions (c) Service limitations (d) Automatic error codes (e) Pricing data (f) Effective dates for all items	IBP		X	
RF1.12	Maintains date sensitive parameters for all Reference Data Management data.	IBP		X	
RF1.13	Maintains current and historical coverage status and pricing information on legend drugs, Over The Counter (OTC) items, and injection codes.	IBP		X	
RF1.14	Supports code sets for the payment of Medicaid-covered non-health care services, e.g. waiver services.	HIPAA	X		
RF1.15	Maintains the drug-pricing file, updating it at scheduled cycle.	IBP		X	
RF1.16	Maintains the trauma indicators to identify potential Third Party Liability (TPL) cases.	SMM	X		
RF1.17	Maintains diagnosis and procedure code narrative descriptions of each code contained in the files.	IBP		X	
RF1.18	Updates all procedure, diagnosis and drug files if required prior to each payment cycle.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

RF1 - MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1SS.1	*Add first State-specific criterion for this business objective here. Example: Accommodates retroactive rate changes as they relate to medical procedures and limitations.* *Example: Maintains current and 10 years of historical date-sensitive NDC Drug Code information.* *Example: Accommodates weekly updates of NDC drug file.*				

RF2 – COMPLY WITH HIPAA REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF2.1	Manages HIPAA-required external data sets (e.g., ICD-9; NDC).	HIPAA	X		

OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

RF2 – COMPLY WITH HIPAA REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF2.2	Maintains all data sets defined by the HIPAA Implementation Guides to support all transactions required under HIPAA Administrative Simplification Rule (e.g., Gender, Reason Code).	HIPAA	X		
RF2SS.1	*Add State-specific criteria for this business objective here.* *Example: Demonstrates flexibility to accommodate newer versions of the ICD diagnosis codes.* *Example: Demonstrates flexibility to accommodate newer versions of the HCPCS and CPT procedure codes.* *Example: Maintains data sets defined in the Implementation Guides for the 824, 277, 997 or 999 X12N acknowledgement transactions.*				

RFSS1 – FIRST STATE-SPECIFIC BUSINESS OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RFSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

CLAIMS ADJUDICATION (CA) CHECKLIST

CLAIMS ADJUDICATION (CA) CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. This is a generic checklist covering all types of claims submitted by all types of providers with the exception of pharmacy Point of Service (a.k.a., Point of Sale, POS) claims. There is a separate checklist for pharmacy POS claims receipt and adjudication.
3. Unless otherwise stated, criteria apply to all claim types paid by the State Medicaid agency including atypical provider claims.
4. This checklist covers the basic functions of claims adjudication including prior authorization.

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45
IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.
HIPAA - HIPAA act, available from
http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
CA1	Route claims for processing and track claim progress, status, and location.	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
CA2	Process claim data against defined service, policy, and payment parameters.	
CA3	Validate that claims are from properly enrolled and eligible providers.	
CA4	Validate that claims are for eligible Beneficiaries.	
CA5	Provide for the timely disposition of prior authorization requests.	
CASS1	*Add State-specific business objectives for this checklist here.*	

CA1 - ROUTE CLAIMS FOR PROCESSING AND TRACK CLAIM PROGRESS, STATUS, AND LOCATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA1.1	Tracks all claims within the processing period - paid, suspended, pending or denied.	SMM	X		
CA1.2	Suspends claims with exceptions/errors and routes for correction to the organizational entity that will resolve the exception/error, unless automatically resolved. The organizational entity will resolve the claim based upon the State's criteria.	SMM	X		
CA1.3	Verifies that suspended transactions have valid error/exception codes.	HIPAA	X		

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA1 - ROUTE CLAIMS FOR PROCESSING AND TRACK CLAIM PROGRESS, STATUS, AND LOCATION					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA1.4	Tracks claims flagged for investigative follow-up because of third party discrepancies.	SMM	X		
CA1.5	Generates audit trails for all claims, maintains audit trail history.	SMM	X		
CA1.6	Verifies that all claims for services approved or disallowed are properly flagged as paid or denied.	SMM	X		
CA1.7	Documents and reports on the time lapse of claims payment, flagging or otherwise noting clean claims (error free) that are delayed over 30 days. (See 447.45 CFR for timely claims payment requirements.)	SMM	X		
CA1.8	Provides prompt response to inquires regarding the status of any claim through a variety of appropriate technologies, and tracks and monitors responses to the inquiries. Processes electronic claim status request and response transactions (ASC X12N 276/277) required by 45 CFR Part 162.	SMM HIPAA	X		
CA1.9	Provides claims history for use by Program Management and Program Integrity.	SMM	X		
CA1.10	Assigns claim status (i.e., approved, denied, pended, rejected) based on the State's criteria.	IBP	X		
CA1.11	Verifies that claim correction activities have entered only valid override code(s) or manual prices.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA1 - ROUTE CLAIMS FOR PROCESSING AND TRACK CLAIM PROGRESS, STATUS, AND LOCATION

Ref #	System Review Criteria	Source	Yes	No	Comments
CA1.12	Identifies and hierarchically assigns status and disposition of claims (suspend or deny) that fail edits (based on the edit disposition record).	IBP		X	
CA1.13	Identifies and tracks all edits and audits posted to the claim in a processing period.	IBP	X		
CA1.14	Provides and maintains, for each error code, a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied.	IBP		X	
CA1SS.1	*Add State-specific criteria for this objective here.*				

CA2 - PROCESS CLAIM DATA AGAINST DEFINED SERVICE, POLICY, AND PAYMENT PARAMETERS

Ref #	System Review Criteria	Source	Yes	No	Comments
CA2.1	Verifies that all fields defined as numeric contain only numeric data.	SMM	X		
CA2.2	Verifies that all fields defined as alphabetic contain only alphabetic data.	SMM	X		
CA2.3	Verifies that all dates are valid and reasonable.	SMM	X		
CA2.4	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA2 - PROCESS CLAIM DATA AGAINST DEFINED SERVICE, POLICY, AND PAYMENT PARAMETERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA2.5	Verifies that all coded data items consist of valid codes, e.g., procedure codes, diagnosis codes, service codes, etc. are within the valid code set HIPAA Transactions and Code Sets (TCS) and are covered by the State Plan.	SMM HIPAA	X		
CA2.6	Verifies that any data item that contains self-checking digits (e.g., Beneficiary I.D. Number) passes the specified check-digit test.	SMM	X		
CA2.7	Verifies that numeric items with definitive upper and/or lower bounds are within the proper range.	SMM	X		
CA2.8	Verifies that required data items are present and retained) including all data needed for State or Federal reporting requirements (see SMM 11375).	SMM	X		
CA2.9	Verifies that the date of service is within the allowable time frame for payment.	IBP	X		
CA2.10	Verifies that the procedure is consistent with the diagnosis.	SMM	X		
CA2.11	Verifies that the procedure is consistent with the Beneficiary's age.	SMM	X		
CA2.12	Verifies that the procedure is consistent with the Beneficiary's sex.	SMM	X		
CA2.13	Verifies that the procedure is consistent with the place of service.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA2 - PROCESS CLAIM DATA AGAINST DEFINED SERVICE, POLICY, AND PAYMENT PARAMETERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA2.14	Verifies that the procedure is consistent with the category of service.	SMM	X		
CA2.15	Flags and routes for manual review claims with individual procedures and combinations of procedures which require manual pricing in accordance with State parameters.	IBP		X	
CA2.16	Verifies that the billed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage (either above or below), then the claim is flagged and routed for manual review for: ③ Possible incorrect procedure ③ Possible incorrect billed amount When too high, possible need for individual consideration.	SMM	X		
CA2.17	Verifies that the claim is not a duplicate of a previously adjudicated claim (including a prior one in the current processing period).	SMM	X		
CA2.18	Verifies that the dates of service of an institutional claim do not overlap with the dates of service of an institutional claim from a different institution for the same Beneficiary.	SMM	X		
CA2.19	Verifies that the dates of service for a practitioner claim do not overlap with the dates of service for another claim from the same practitioner for a single Beneficiary unless the additional services are appropriate for the same date of service.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA2 - PROCESS CLAIM DATA AGAINST DEFINED SERVICE, POLICY, AND PAYMENT PARAMETERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA2.20	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.	SMM	X		
CA2.21	Flags for review claims from a single provider for multiple visits on the same day to a single Beneficiary.	IBP		X	
CA2.22	Verifies that the provider type is consistent with the procedure(s).	IBP	X		
CA2.23	Flags and routes for manual intervention claims that do not contain prior authorization if the services require prior authorization or require prior authorization after State-defined thresholds are met.	IBP		X	
CA2.24	Flags and routes for manual intervention claims that fail State-defined service limitations including once-in-a-lifetime procedures and other frequency, periodicity, and dollar limitations.	IBP		X	
CA2.25	Has the capability to pay claims per capita, from encounter data or fee-for-service.	IBP		X	
CA2.26	Prices out-of-State claims according to State policy (i.e., at the local rate, at the other State's rate or flags and routes for manual pricing).	IBP	X		
CA2.27	Records and edits that all required attachments, per the reference records or edits, have been received and maintained for audit purposes.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA2 - PROCESS CLAIM DATA AGAINST DEFINED SERVICE, POLICY, AND PAYMENT PARAMETERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA2.28	Prices claims according to pricing data and reimbursement methodologies applicable on the date(s) of service on the claim.	IBP	X		
CA2.29	Deducts Third Party Liability (TPL) paid amounts and Medicare paid amounts, as defined in the State Plan, when pricing claims.	IBP	X		
CA2.30	Deducts Beneficiary co-payment amounts, as appropriate, when pricing claims.	IBP	X		
CA2.31	Prices Medicare coinsurance or deductible for crossover claims, depending on State policy, at the lower of the Medicaid or Medicare allowed amount.	IBP		X	
CA2.32	Prices services billed with procedure codes with multiple modifiers.	IBP		X	
CA2.33	Edits claims for consistency and payment limitations using the Medicare Correct Coding Initiative or similar editing criteria, based upon the State Plan.	IBP		X	
CA2.34	Prices claims according to the policies of the program the Beneficiary is enrolled in at the time of service and edits for concurrent program enrollment.	IBP		X	
CA2.35	Provides and maintains test claim processing capabilities including testing with providers.	IBP	X		
CA2SS.1	*Add State-specific criteria for this objective here.*				

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA3 – VALIDATES THAT CLAIMS ARE FROM PROPERLY ENROLLED AND ELIGIBLE PROVIDERS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA3.1	Verifies that the provider is eligible to render service(s) during the period covered by the claim.	SMM	X		
CA3.2	Verifies that the provider is eligible to render the specific service covered by the claim.	IBP	X		
CA3.3	Verifies that the provider is eligible to provide the specific service covered by the plan to the specific Beneficiary.	IBP		X	
CA3SS.1	*Add State-specific criteria for this objective here.*				

CA4 - VERIFY THAT CLAIMS ARE FOR ELIGIBLE BENEFICIARIES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA4.1	Verifies that the Beneficiary was eligible for the particular category of service at the time it was rendered.	SMM	X		
CA4.2	Flags for review claims, for the same Beneficiary, with a diagnosis and procedure which indicate an emergency that occur within one day of a similar claim from the same provider.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA4 - VERIFY THAT CLAIMS ARE FOR ELIGIBLE BENEFICIARIES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA4.3	Identifies, by Beneficiary, the screening and related diagnosis and treatment services the Beneficiary receives for Early and Periodic Screening Diagnosis, and Treatment, (EPSDT).	SMM	X		
CA4.4	Routes and reports on claims that are processed that indicate the Beneficiary's date of death for follow-up by the Beneficiary eligibility or Third Party Liability (TPL) personnel.	IBP	X		
CA4.5	Provides and maintains the capability to monitor services for suspected abusers using a "pay and report", lock-in, or some equivalent system function that will provide reports of the claim activity for these Beneficiaries as scheduled or requested.	IBP	X		
CA4.6	Provides and maintains the capability to pend or deny claims for Beneficiaries assigned to the Beneficiary lock-in program based on state guidelines.	SMM	X		
CA4.7	Provides and maintains the capability to edit claims for Beneficiaries in long term care (LTC) facilities to ensure that services included in the LTC payment rate are not billed separately by individual practitioners or other providers.	SMM	X		
CA4.8	Provides and maintains the capability to process Beneficiary cost sharing (e.g., co-payments, LTC patient liability) on any service specified by the state using a fixed amount or percent of charges.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA4 - VERIFY THAT CLAIMS ARE FOR ELIGIBLE BENEFICIARIES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA4.9	Edits claims for newborns' eligibility based upon State-defined newborn enrollment policies and procedures.	IBP		X	
CA4.10	Edits for Beneficiary participation in special programs (i.e. waivers) against program services and restrictions.	IBP		X	
CA4.11	Limits benefits payable by Beneficiary eligibility category or other Beneficiary groupings.	IBP		X	
CA4SS.1	*Add State-specific criteria for this objective here.*				

CA5 - PROVIDE FOR THE TIMELY DISPOSITION OF PRIOR AUTHORIZATION REQUESTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA5.1	Processes and retains all prior authorization request data.	SMM	X		
CA5.2	Ensures that there is a field for authorization or identification when an override indicator (force code) is used.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA5 - PROVIDE FOR THE TIMELY DISPOSITION OF PRIOR AUTHORIZATION REQUESTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA5.3	Supports receiving, processing and sending electronic health care service review, request for review, and response transactions required by 45 CFR Part 162, as follows: ③ Retail pharmacy drug referral certification and authorization ③ Dental, professional and institutional referral certification and authorization (ASC X12N 278) Optionally, supports Web or Internet submissions or prior authorization requests.	HIPAA	X		
CA5.4	Enables the prior authorization staff to send requests for additional information on paper or electronically.	IBP		X	
CA5.5	Supports searching for prior authorizations based on: ③ Provider name ③ Provider ID ③ Beneficiary name ③ Beneficiary Medicaid ID Number ③ Date of submission range ③ Dates of service requested range ③ Service requested ③ Status of the request	IBP		X	
CA5.6	Supports retroactive entry of prior authorization requests.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA5 - PROVIDE FOR THE TIMELY DISPOSITION OF PRIOR AUTHORIZATION REQUESTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA5.7	Assigns a unique prior authorization number as an identifier to each prior authorization request.	SMM	X		
CA5.8	Edits prior authorization requests with edits that mirror the applicable claims processing edits.	IBP		X	
CA5.9	Establishes an adjudicated prior authorization record, indicating: ③ Single Beneficiary or Beneficiaries ③ Status of the request ③ Services authorized ③ Number of units approved ③ Service date range approved ③ Cost approved ③ Provider approved (unless approved as non-provider-specific)	IBP		X	
CA5.10	Edits to ensure that only valid data is entered on the prior authorization record, and denies duplicate requests or requests that contain invalid data.	SMM	X		
CA5.11	Captures and maintains both the requested amount and authorized amount on the prior authorization record.	IBP		X	
CA5.12	Provides and maintains the capability to change the services authorized and to extend or limit the effective dates of the authorization. Maintains the original and the change data in the prior authorization record.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

CA5 - PROVIDE FOR THE TIMELY DISPOSITION OF PRIOR AUTHORIZATION REQUESTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CA5.13	Accepts updates from claims processing that "draw down" or decrement authorized services.	IBP		X	
CA5.14	Uses imaging equipment to capture, store, and retrieve hard copy prior authorization requests and associated documents.	IBP		X	
CA5.15	Generates automatic approval and denial notices to requesting and assigned providers, case managers, and Beneficiaries for prior authorizations. Denial notices to Beneficiaries include the reason for the denial and notification of the Beneficiary's right to a fair hearing.	IBP		X	
CA5.16	Provides and maintains a toll free telephone number for providers to request prior authorizations.	IBP		X	
CA5SS.1	*Add State-specific criteria for this objective here.*				

CASS1 - FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
CASS1	*Add other criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.* *Example: Apply the claims edits CMS' Correct Coding Initiative (CCI).*				

OPERATIONS MANAGEMENT BUSINESS AREA
CLAIMS ADJUDICATION CHECKLIST

PROGRAM MANAGEMENT BUSINESS AREA
FINANCIAL MANAGEMENT (FI) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

FINANCIAL MANAGEMENT (FI) CHECKLIST

FINANCIAL MANAGEMENT (FI) CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IPB have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. This checklist is intended to assess the adequacy of the way the MMIS handles the financial side of claims processing.

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45. The SMM reference includes the State Buy-In Manual, document number 100-15, available from http://www.cms.hhs.gov/Manuals/IOM/

IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS's.

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
FI1	Produce Individual Explanation of Benefits (EOB).	
FI2	Ensure that accounts payable and receivable transactions are recognized and posted in accordance with State and Federal regulations.	

PROGRAM MANAGEMENT BUSINESS AREA
FINANCIAL MANAGEMENT (FI) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
FI3	Ensure that all financial transactions related to program delivery are processed as defined by State and Federal regulations.	
FI4	Support management of program funds.	
FISS1	*Add State-specific business objectives for the Financial Management business area here.*	

FI1 - PRODUCE INDIVIDUAL EXPLANATION OF BENEFITS (EOB)					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FI1.1	Provides individual EOB notices, within 45 days of the payment of claims, to all or a sample group of the Beneficiaries who received services under the plan as described in §11210.	SMM	X		
FI1SS.1	*Add first State-specific criteria for this business objective here.*				

PROGRAM MANAGEMENT BUSINESS AREA
FINANCIAL MANAGEMENT (FI) CHECKLIST

FI2 - ENSURE THAT ACCOUNTS PAYABLE AND RECEIVABLE TRANSACTIONS ARE RECOGNIZED AND POSTED IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS

Ref #	System Review Criteria	Source	Yes	No	Comments
FI2.1	Updates claims history and on-line financial files with the payment identification (check number, EFT number, warrant number, or other), date of payment, and amount paid after the claims payment cycle.	IBP	X		
FI2.2	Maintains garnishments and tax levies and assignment information to be used in directing or splitting payments to the provider and garnishor.	IBP		X	
FI2.3	Maintains financial transactions in sufficient detail to support 1099 and, if the State has elected to do so W-2 and FICA reporting requirements for personal service care providers and providers of services under self-directed care initiatives.	CFR	X		
FI2.4	Accounts for recovery payment adjustments received from third parties that do not affect the provider's 1099/W2.	CFR	X		
FI2.5	Provides a full audit trail to the source of general ledger transactions generated by the MMIS or other supporting financial packages.	SMM	X		
FI2.6	Provides automated processes for performing periodic bank account or fund allocation reconciliations.	IBP		X	
FI2.7	Maintains a history of claim recovery payments in excess of expenditures and allows distribution to the appropriate parties, including providers, Beneficiaries, or insurers.	SMM	X		

PROGRAM MANAGEMENT BUSINESS AREA
FINANCIAL MANAGEMENT (FI) CHECKLIST

FI2 - ENSURE THAT ACCOUNTS PAYABLE AND RECEIVABLE TRANSACTIONS ARE RECOGNIZED AND POSTED IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS

Ref #	System Review Criteria	Source	Yes	No	Comments
FI2.8	Maintains a history of refunds.	SMM	X		
FI2.9	Withholds the Federal share of payments to Medicaid providers to recover Medicare overpayments.	SMM CFR	X		
FI2SS.1	*Add first State-specific criteria for this business objective here. Example: Maintains all system available data needed for State financial reports.*				

FI3 - ENSURE THAT ALL FINANCIAL TRANSACTIONS RELATED TO PROGRAM DELIVERY ARE PROCESSED AS DEFINED BY STATE AND FEDERAL REGULATIONS

Ref #	System Review Criteria	Source	Yes	No	Comments
FI3.1	Tracks Medicare deductibles and coinsurance paid by Medicaid for all crossover claims, by Beneficiary and program type.	SMM	X		
FI3.2	Processes and retains all data from provider credit and adjustment transactions.	SMM	X		
FI3.3	Produces payment instruments (both warrants and EFT transactions) or transfers payment information to the payment issuing system.	IBP		X	
FI3.4	Issues a remittance advice detailing claims processing activity it the same time as the payment or payment information transfer.	SMM	X		

PROGRAM MANAGEMENT BUSINESS AREA
FINANCIAL MANAGEMENT (FI) CHECKLIST

FI3 - ENSURE THAT ALL FINANCIAL TRANSACTIONS RELATED TO PROGRAM DELIVERY ARE PROCESSED AS DEFINED BY STATE AND FEDERAL REGULATIONS

Ref #	System Review Criteria	Source	Yes	No	Comments
FI3.5	Ensures that the system supports sending electronic claim payment/advice transactions (ASC X12N 835) meeting the standards required by 45 CFR Part 162.	HIPAA	X		
FI3.6	Provides payment via electronic funds transfer (EFT) as an option.	SMM	X		
FI3.7	Nets provider payments against credit balances or accounts receivable amounts due in the payment cycle in determining the payment due the provider.	SMM	X		
FI3.8	Processes voids and replacements for incorrect payments or returned warrants, crediting fund source accounts and creating accounts receivable or credit balances where appropriate.	SMM	X		
FI3.9	Supports stop payment processes.	IBP		X	
FI3.10	Allows on-line access to accounts receivable or provider credit balances to authorized individuals.	IBP		X	
FI3.11	Allows on-line access to remittance advice through a Web-based browser.	IBP		X	
FI3.12	Provides support for identification and application of recovery funds and lump-sum payments.	IBP		X	
FI3.13	Identifies providers with credit balances and no claim activity during a state-specified number of months.	IBP		X	
FI3.14	Notifies providers when a credit balance or accounts receivable has been established.	IBP		X	

PROGRAM MANAGEMENT BUSINESS AREA
FINANCIAL MANAGEMENT (FI) CHECKLIST

FI3 - ENSURE THAT ALL FINANCIAL TRANSACTIONS RELATED TO PROGRAM DELIVERY ARE PROCESSED AS DEFINED BY STATE AND FEDERAL REGULATIONS

Ref #	System Review Criteria	Source	Yes	No	Comments
FI3.15	Displays adjustment/void in a separate section of the remittance advice.	IBP		X	
FI3.16	Allows for withholding of payments in cases of fraud or willful misrepresentation without first notifying the provider of its intention to withhold such payments.	CFR	X		
FI3.17	Supports refunding of Federal share of provider overpayments within 60 days from discovery of an overpayment for Medicaid services.	CFR	X		
FI3SS.1	*Add State-specific criteria for this objective here.*				

FI4 - SUPPORT MANAGEMENT OF PROGRAM FUNDS

Ref #	System Review Criteria	Source	Yes	No	Comments
FI4.1	Provides a financial transaction application for processing non-claim specific financial transactions, including payouts, accounts receivable, refund checks, and returned warrants.	IBP		X	
FI4.2	Supports the process of issuing a manual check, retaining all data required for fund source determination, payee identification, and reason for check issuance.	IBP		X	
FI4.3	Updates records to reflect the processing of uncashed or cancelled (voided) Medicaid checks. Process replacements for lost or stolen warrants and updated records with new warrant information.	CFR	X		

PROGRAM MANAGEMENT BUSINESS AREA
FINANCIAL MANAGEMENT (FI) CHECKLIST

FI4 - SUPPORT MANAGEMENT OF PROGRAM FUNDS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FI4.4	Processes payments from providers for refunds and updates records as needed. Adjusts 1099/W2 reporting.	CFR	X		
FI4.5	Allows for history adjustments to claims processing to reflect changes in funding sources and other accounting actions that do not impact provider payment amounts or 1099/W2 reporting.	CFR	X		
FI4SS.1	*Add first State-specific criteria for this business objective here.* *Example: Supports the export of payment and expenditure data to a Microsoft Excel spreadsheet or other formats specified by the State.* *Example: Provides payment cycle reports to the State by 8:00 a.m. on the day following the payment processing cycle.*				

FISS1 - ADD FIRST STATE-SPECIFIC OBJECTIVE HERE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
FISS1.1	*Add State-specific criteria for this State-specific objective here.*				

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST BACKGROUND

Background for this checklist:

1. Point of Service (POS), a.k.a., Point of Sale or Point-of-Sale, refers to the online real-time receipt, adjudication, and notification to the provider regarding the disposition of a claim. Also referred to as an Electronic Claim Management (ECM) system in Part 11, Section 1128.2. "Point of service" implies that the patient is present and receiving a service concurrently with the creation and transmission of the claim. The transaction is subjected to all required edits and a response (payable, denied, requires more information) is returned to the provider instantly. If the response is "approved for payment," the patient will receive the service with no out-of-pocket expense except where program policy requires a co-pay, deductible, or other Beneficiary share of cost.
2. Included in POS systems are eligibility verification, claim data capture, prior authorization, prospective drug use review, and assistance to the provider in applying for and receiving payment.
3. Almost all non-institutional pharmacy claims are processed as a POS transaction. POS is optional for nursing home and mail order pharmacy claims processing. Other claim types (physician, dentist, laboratory) also could be processed via POS, however, electronic submission with batch processing continues to be the primary method used by these other providers.
4. Pharmacy claims have some specialized functions, e.g., Prospective Drug Use Review (ProDUR). Therefore, this checklist focuses uniquely on Pharmacy POS.
5. The POS process consolidates business processes that are treated as separate functions in a batch processing environment, e .g., claims receipt, eligibility verification, prior authorization validation, adjudication, utilization review, pricing, and response re adjudication status. Therefore, this checklist overlaps requirements found in other checklists. In POS, all actions are rolled into a single event: the claim is created and transmitted. The instant it is received, all edits and validations are applied in a single event, lasting only seconds. A message is transmitted back to the provider regarding the status of the claim: approved for payment; denied; or pended. Payment is still performed separately according the State's payment cycle, e.g., weekly, bi-weekly, or other.
6. Because of the online real-time nature of POS claims processing, interfaces to sources of data needed for complete adjudication (e.g., member eligibility, provider eligibility, claims history, covered drugs, benefit rules, pricing formulas) are critical. The POS system may directly interface to the MMIS data sources, or may use the MMIS sources to update integrated databases.
7. If the POS system is outsourced to a vendor who operates a proprietary system, CMSO will determine how many of the detailed claims

PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST BACKGROUND

adjudication criteria will be used in the certification review.

8. This checklist duplicates some requirements found in the Claims Adjudication checklist (CA). This is done to allow this checklist to be used as a stand-alone with a complete set of requirements. The certification review team may wish to consolidate the Claims Adjudication and POS checklists.
9. This checklist does not cover the Drug Manufacturer Rebate system, updates to the master files (e.g., Formulary, Benefit Rules, Pricing Rules), the payment process, the prior authorization process, Retrospective Drug Utilization Review, or a supporting decision support system (DSS). It also does not cover electronic prescribing functions. The certification review team should refer to other checklists that support file maintenance, e.g., Beneficiary file updates; provider file updates. The checklist does cover the capture, editing, and retention of data required for use in reporting, drug rebate invoicing, the prior authorization system, and utilization review.
10. In preparation for review of the pharmacy claims system, the certification review team should be informed about the State's specific business model for pharmacy. The pharmacy POS system may be outsourced to a fiscal agent or to a separate contractor. The pharmacy benefit may be carved out of managed care contracts and be covered by a separate POS contract. The POS contract may include or exclude formulary, drug file, and pricing information. State may include or exclude specific services (e.g., Drug Manufacturer Rebate, ProDUR, Retro DUR, drug file maintenance, formulary committee, and other services).
11. Primary source for Pharmacy POS requirements is found in 42 CFR, Chapter IV, Part 456, Subpart K, Section 456.722 - Electronic claims management system. (Also referenced in Title 42 Chapter 7 Subchapter XIX 1396r-8 Payment for Covered Outpatient Drugs):

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

IBP - Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
POS1	Maintain interfaces between the POS system and comprehensive, accurate, and up-to-date data sources required to approve and adjudicate claims according to State and Federal rules. Maintain interfaces between POS and reporting applications, e.g., Federal reporting, data warehouse/decision support, drug manufacturer rebate invoicing, program integrity, and others.	
POS2	Ensure timely and accurate adjudication of provider claims.	
POS3	Verify authorization for services that require prior approval in order to manage costs or ensure patient safety.	
POS4	Verify that services are medically appropriate, conform to Federal and State policies, and result in the maintenance or improvement of patient health.	
POS5	Deny claims for members with third party coverage, including Part D Medicare, or flag for pay-and-chase activity.	
POS6	Support other business processes that require pharmacy claims data, e.g., rebate invoicing, retrospective DUR, and decision support.	
POSSS1	*Add State-specific business objectives for this checklist here.*	

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS1 - MAINTAIN INTERFACES BETWEEN THE POS SYSTEM AND DATA SOURCES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS1.1	Provides real-time access to Beneficiary eligibility. Note: Depends on the timing of the updates maintained in the individual State. See State-specific Requirements.	SMM CFR	X		
POS1.2	Provides real-time access to provider eligibility, including the pharmacy and prescriber National Provider Identifier (NPI) and authorization IDs for electronic submission of claims. Note: Depends on the timing of the updates maintained in the individual State. See State-specific Requirements.	SMM HIPAA CFR	X		
POS1.3	Provides real-time access to the State's drug and formulary file or maintains an up to date copy for POS use. Note: Depends on the timing of the updates maintained in the individual State. See State-specific Requirements.	SMM CFR	X		

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS1 - MAINTAIN INTERFACES BETWEEN THE POS SYSTEM AND DATA SOURCES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS1.4	Provides real-time access to benefit business rules.	SMM	X		
POS1.5	Provides real-time access to drug file and pharmacy claims history.	SMM CFR	X		
POS1.6	Ensures that all claims are assigned a unique identification number upon entering the system.	SMM	X		
POS1.7	Interfaces with the MMIS or other payment systems to maintain records of time of claims payment in order for the payment systems to pay claims within 30 days after receipt by the POS system of an error free claim.	SMM CFR	X		
POS1SS.1	*Add State-specific criteria for this objective here.*				

POS2 - ENSURE TIMELY AND ACCURATE ADJUDICATION OF PROVIDER CLAIMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS2.1	Performs online real-time capture and adjudication of pharmacy claims submitted by providers via POS devices, a switch, or through the Internet. Accepts ASC X12N NCPDP claims required by 45 CFR Part 162.	SMM HIPAA CFR	X		

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS2 - ENSURE TIMELY AND ACCURATE ADJUDICATION OF PROVIDER CLAIMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS2.2	Returns to the pharmacy provider the status of the claim and any errors or alerts associated with the processing, such as: ③ Edit failures ③ ProDUR alerts ③ Member (Beneficiary) or coverage restrictions ③ Prior authorization missing ③ Required coordination of benefits. ③ Refill to soon ③ Requires generic substitution ③ Deny experimental drugs ③ Requires unit dose (or not) ③ Package size not approved ③ Drug Efficacy Study Implementation (DESI) are not covered	CFR	X		
POS2.3	Verifies that the Beneficiary is eligible on the date of service and not otherwise restricted, e.g., enrolled in MCO or a Lock in program; or receiving medication through a Waiver program, a carve-out mental health program, or a disease management program.	SMM CFR	X		
POS2.4	Verifies that the pharmacy provider is eligible on the date of service.	SMM CFR	X		

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS2 - ENSURE TIMELY AND ACCURATE ADJUDICATION OF PROVIDER CLAIMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS2.5	Verifies that all fields defined as numeric contain only numeric data.	SMM	X		
POS2.6	Verifies that all fields defined as alphabetic contain only alphabetic data.	SMM	X		
POS2.7	Verifies that all dates are valid and reasonable.	SMM	X		
POS2.8	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.	SMM	X		
POS2.9	Verifies that all coded data items consist of valid codes, including NDC for drug codes.	SMM HIPAA	X		
POS2.10	Verifies that any data item that contains self-checking digits (e.g., Beneficiary I.D. Number) pass the specified check-digit test.	SMM	X		
POS2.11	Verifies that required data items are present and retained (See SMM 11375) including all data needed for State or Federal reporting requirements.	SMM	X		
POS2.12	Verifies that the date of service is within the allowable time frame for payment.	IBP	X		
POS2.13	Demonstrates that individual drugs and compounds which indicate a need for manual pricing intervention are flagged for review.	SMM	X		
POS2.14	Verifies that the claim is not a duplicate of a previously adjudicated claim.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS2 - ENSURE TIMELY AND ACCURATE ADJUDICATION OF PROVIDER CLAIMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS2.15	Pays according to the State plan at the lesser of approved pharmacy reimbursement methods, e.g., ③ AWP minus % + Dispensing Fee ③ Federal MAC (CMS Upper Limit + Dispensing Fee) ③ Usual and Customary Charges to the General Public ③ State MAC (State MAC + Dispensing Fee)	SMM	X		
POS2.16	Processes electronic adjustments of paid claims submitted through the Pharmacy POS system.	SMM	X		
POS2.17	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.	SMM	X		
POS2.18	Checks claims against state-defined service limitations.	CFR	X		
POS2.19	Edits claims to ensure that all required attachments, per the reference records or edits, have been received and maintained for audit purposes or have been submitted prior to the claim and a prior authorization has been established.	CFR	X		
POS2.20	Deducts Beneficiary co-payment amounts, as appropriate, when pricing claims.	IBP	X		
POS2.21	Deducts TPL amounts, as appropriate, when pricing claims.	IBP	X		

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS2 - ENSURE TIMELY AND ACCURATE ADJUDICATION OF PROVIDER CLAIMS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS2.22	Verifies that the claim is for services covered by the State Plan.	CFR	X		
POS2.23	Verifies that all data necessary for legal requirements are retained.	SMM	X		
POS2SS.1	*Add State-specific criteria for this objective here.* *For example:* *Prices pharmacy claims based on most recent pricing information contained in the weekly update of the pharmacy file.* *For example:* *Meets performance standards, e.g.,* ③ *Provides POS availability 23 x 7* ③ *Provides online response notifications to pharmacy providers within 10 seconds of receipt of incoming claim transaction* ③ *Maintains a help desk with hold times not exceeding 2 minutes 95% of the time*				

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS3 - VERIFY AUTHORIZATION FOR SERVICES THAT REQUIRE PRIOR APPROVAL					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS3.1	Interfaces with the pharmacy prior authorization database.	SMM CFR	X		
POS3.2	Demonstrates that there is a field for authorization or identification when an override indicator (force code) is used.	IBP		X	
POS3.3	Interfaces with electronic authorization of health care service transactions required by 45 CFR Part 162, as follows: Retail pharmacy drug referral certification and authorization.	HIPAA	X		
POS3.4	Performs edits to ensure that a prior authorization is present when required.	IBP	X		
POS3.5	Notifies submitter when required prior authorization is missing.	CFR	X		
POS3SS.1	*Add State-specific criteria for this objective here.*				

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS4 - VERIFY THAT SERVICES ARE MEDICALLY APPROPRIATE, CONFORM WITH FEDERAL AND STATE POLICIES, AND RESULT IN THE MAINTENANCE OR IMPROVEMENT OF PATIENT HEALTH					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS4.1	Provides an automated, integrated online real-time ProDUR system or provides assistance to the pharmacist to do a prospective drug utilization review.	CFR	X		
POS4.2	Provides a prospective and concurrent review of prescription practices at the pharmacy and member level.	IBP		X	
POS4.3	Compares the claim against member history and benefit rules to determine if the new claim complies with State standards for: ③ Therapeutic appropriateness ③ Over Utilization ③ Underutilization ③ Appropriate use of generic products ③ Therapeutic duplication ③ Drug-disease contraindications ③ Drug-pregnancy contraindications ③ Drug-drug interactions ③ Incorrect drug dosage or duration of drug treatment ③ Clinical abuse or misuse ③ Consistent with patient age ③ Consistent with patient sex ③ Consistent with refill policy	SMM CFR	X		
POS4.4	Generates alerts (messages) to pharmacy providers as required by State policy.	CFR	X		

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS4 - VERIFY THAT SERVICES ARE MEDICALLY APPROPRIATE, CONFORM WITH FEDERAL AND STATE POLICIES, AND RESULT IN THE MAINTENANCE OR IMPROVEMENT OF PATIENT HEALTH					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS4.5	Allows the pharmacy the ability to override an alert.	IBP	X		
POS4.6	Maintains user controlled parameters for all standards and messages.	IBP		X	
POS4SS.1	*Add State-specific criteria for this objective here.*				

POS5 - MANAGE CLAIMS FOR MEMBERS WITH THIRD PARTY COVERAGE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS5.1	Denies claims for members with appropriate third party coverage, enrollment in MCO, or Medicare Part D assignment. In this case, provides insurance information in the POS message along with notice of denial of payment.	SMM	X		
POS5.2	Identifies claims appropriate for pay and chase function. If the drug is designated as “pay and chase”, processes and pays the claim (if it meets all other criteria), and reports the claim for follow up activities.	CFR	X		
POS5.3	Identifies claims requiring third party payment.	CFR	X		
POS5SS.1	*Add State-specific criteria for this objective here.*				

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POS6 - SUPPORT OTHER BUSINESS PROCESSES THAT REQUIRE PHARMACY CLAIMS DATA, e.g., REBATE INVOICING, RETROSPECTIVE DUR, AND DECISION SUPPORT					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POS6.1	Flags claims for Drug Rebate processing.	CFR	X		
POS6.2	Prepares extracts of pharmacy claims history required by the drug manufacturer rebate process. Claims must include all NDC and other data needed to support the rebate process, as follows: • Period of time covered • NDC number • Total units paid • Product names • Number of prescriptions paid • Rebate amount per unit based on the CMS approved formula	CFR	X		
POS6.3	Prepares extracts of pharmacy claims history (or access to the claims history) for purposes of retrospective DUR, prescriber and pharmacy provider profiling, management reporting, and other decision support functions.	SMM	X		
POS6.4	Provides data to support the State in case of a drug manufacturer dispute over the rebate invoice.	CFR	X		
POS6SS.1	*Add State-specific criteria for this objective here.*				

OPERATIONS MANAGEMENT BUSINESS AREA
PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

POSSS1 – FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
POSSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

PROGRAM MANAGEMENT BUSINESS AREA
SECURITY AND PRIVACY (SP) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

SECURITY AND PRIVACY (SP) CHECKLIST

SECURITY AND PRIVACY CHECKLIST BACKGROUND

Background for this checklist:

1. Within the Health Insurance Portability and Accountability Act (HIPAA) there are two separate Rules governing Privacy and Security.
    a. The Privacy Rule deals with the Rights of individuals to safeguard the privacy of their health care information. Privacy Rule compliance is under the jurisdiction of the Office for Civil Rights.
    b. The Security Rule deals with the requirements of facilities, systems, and processes to safeguard information for which it is liable.
2. There is an overlap between parts of the Privacy Rule and the Security Rule. The overlap occurs when the MMIS is the vehicle or enabler of the process that enforces the Privacy requirements. For this reason, Privacy and Security requirements are combined into one checklist.
3. MMIS certification focuses on system functionality. To enforce compliance with the full range of Privacy and Security requirements, the Medicaid agency uses a range of reports, alerts, audits, and surveys. These are beyond the scope of MMIS certification. This checklist focuses on those functions within an MMIS that demonstrate the agency's ability to meet the system-related requirements of Privacy.

Sources for the criteria in this checklist are as follows:

IBP - Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html. Includes HIPAA Security and Privacy rules.

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
SP1	Control access to system and data.	

PROGRAM MANAGEMENT BUSINESS AREA
SECURITY AND PRIVACY (SP) CHECKLIST

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
SP2	Protect the confidentiality and integrity of electronic Protected Health Information (ePHI).	
SP3	Monitor system activity and act on security incidents.	
SP4	Support individual rights specified in the HIPAA Privacy regulations.	
SPSS1	*Add State-specific business objective for the Security and Privacy Checklist here.*	

SP1 - CONTROL ACCESS TO SYSTEM AND DATA					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP1.1	Verifies identity of all users, denies access to invalid users. For example: ③ Requires unique sign-on (ID and password) ③ Requires authentication of the receiving entity prior to a system-initiated session, such as transmitting responses to eligibility inquiries	CFR	X		
SP1.2	Enforces password policies for length, character requirements, and updates.	CFR	X		
SP1.3	Supports a user security profile that controls user access rights to data categories and system functions.	CFR	X		

PROGRAM MANAGEMENT BUSINESS AREA
SECURITY AND PRIVACY (SP) CHECKLIST

SP1 - CONTROL ACCESS TO SYSTEM AND DATA					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP1.4	Permits supervisors or other designated officials to set and modify user security access profile.	CFR	X		
SP1.5	Includes procedures for accessing necessary electronic Protected Health Information (ePHI) in the event of an emergency; continue protection of ePHI during emergency operations.	CFR	X		
SP1.6	Supports workforce security awareness through such methods as security reminders (at log on or screen access), training reminders, online training capabilities, and/or training tracking.	CFR	X		
SP1.7	Contains a data classification schema with data items flagged to link them to a classification category and has an access privilege scheme for each user that limits the user's access to one or more data classification categories.	IBP		X	
SP1.8	Alerts appropriate staff authorities of potential violations of privacy safeguards, such as inappropriate access to confidential information.	CFR	X		
SP1.9	Contains a data definition for the Designated Record Set (DRS) that allows it to be included in responses to inquires and report requests.	CFR	X		
SP1.10	Supports data integrity through system controls for software program changes and promotion to production.	IBP	X		

PROGRAM MANAGEMENT BUSINESS AREA
SECURITY AND PRIVACY (SP) CHECKLIST

SP1 - CONTROL ACCESS TO SYSTEM AND DATA					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP1SS.1	*Add State-specific criteria for this business objective here.* *Example: Supports various authentication mechanisms, such as* ③ *Biometric identification* ③ *Password and/or personal identification numbers* ③ *Telephone callback procedure* ③ *Tokens (hard token, soft token, one time password devise token)* ③ *Registration and identity proofing (digital signatures)*				

SP2- PROTECT THE CONFIDENTIALITY AND INTEGRITY OF ePHI					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP2.1	Contains verification mechanisms that are capable of authenticating authority (as well as identify) for the use or disclosure requested. For example: ③ Denies general practitioner inquiry for recipient eligibility for mental health services ③ Permits inquiries on claim status only for claims submitted by the inquiring provider	CFR	X		
SP2.2	Supports encryption and decryption of stored ePHI or an equivalent alternative protection mechanism.	CFR	X		

PROGRAM MANAGEMENT BUSINESS AREA
SECURITY AND PRIVACY (SP) CHECKLIST

SP2- PROTECT THE CONFIDENTIALITY AND INTEGRITY OF ePHI					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP2.3	Supports encryption of ePHI that is being transmitted, as appropriate.	CFR	X		
SP2.4	Supports integrity controls to guarantee that transmitted ePHI is not improperly modified without detection (e.g., provide secure claims transmission).	CFR	X		
SP2.5	Provides data integrity of ePHI by preventing and detecting improper alteration or destruction (e.g., double keying, message authentication, digital signature, check sums etc).	CFR	X		
SP2SS.1	*Add State-specific criteria for this business objective here.*				

SP3 - MONITOR SYSTEM ACTIVITY AND ACT ON SECURITY INCIDENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP3.1	Provides the capability that all system activity can be traced to a specific user.	IBP		X	

PROGRAM MANAGEMENT BUSINESS AREA
SECURITY AND PRIVACY (SP) CHECKLIST

SP3 - MONITOR SYSTEM ACTIVITY AND ACT ON SECURITY INCIDENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP3.2	Generates alerts for conditions that violate security rules, for example: ③ Attempts to access unauthorized data and system functions ③ Logon attempts that exceed the maximum allowed ③ Termination of authorized sessions after a specified time of no activity	CFR	X		
SP3.3	Logs and examines system activity in accordance with audit polices and procedures adopted by the Medicaid agency.	CFR	X		
SP3.4	Provides security incident reporting and mitigation mechanisms, such as: ③ Generate warning or report on system activity based on security parameters ③ Terminate access and/or generate report when potential security violation detected ③ Preserve and report specified audit data when potential security violation detected	CFR	X		
SP3.5	Supports procedures for guarding, monitoring, and detecting malicious software (e.g., viruses, worms, malicious code, etc.).	CFR	X		
SP3SS.1	*Add State-specific criteria for this business objective here.*				

PROGRAM MANAGEMENT BUSINESS AREA
SECURITY AND PRIVACY (SP) CHECKLIST

SP4 - SUPPORT INDIVIDUAL RIGHTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SP4.1	Has the capability to respond to an authorized request to provide a report containing the DRS for a given individual.	CFR	X		
SP4.2	Contains indicators that can be set to restrict distribution of ePHI in situations where it would normally be distributed.	CFR	X		
SP4.3	Tracks disclosures of ePHI; provides authorized users access to and reports on the disclosures.	CFR	X		
SP4.4	Has the capability to identify and note amendments to the DRS for a given individual.	CFR	X		
SP4SS.1	*Add State-specific criteria for this objective here.*				

SPSS1 - FIRST STATE-SPECIFIC BUSINESS OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
SPSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective*.				

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

THIRD PARTY LIABILITY (TPL) CHECKLIST

THIRD PARTY LIABILITY (TPL) CHECKLIST BACKGROUND

Background for this checklist:

1. Third Party Liability (TPL) - The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the "payer of last resort," the identification of other payer obligations is a major requirement in the adjudication of claims. In a systems context, TPL usually refers only to those automated TPL-related activities that are contained in core parts of the MMIS.
2. Coordination of Benefits (COB) - Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.
3. In Medicaid, there are two primary functions related to detecting TPL obligations:
    a. Cost-avoidance - Determining the presence of TPL obligations before the claim is paid
    b. Pay-and-chase - Identifying TPL obligations after the claim is paid
4. The following definitions apply to TPL:
    a. Coinsurance - A portion or percentage of the cost for a specific service or item for which the individual is responsible when the service or item is delivered.
    b. Cost Avoidance - A method of preventing inappropriate payments under Medicaid and reducing improper Medicaid expenditures. Whenever the Medicaid agency is billed first and a potentially liable third party exists, the Medicaid agency rejects the claim and returns it to the provider to be billed to the primary payer to determine the third party's liability (42 CFR 433.139(b)).
    c. Deductible - A fixed dollar amount that an individual must pay before the costs of services are covered by an insurance plan.
    d. Estate - Property (real or personal) in which one has a right or interest at time of death.
    e. Health Insurer - Includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a Managed Care Organization (MCO). (The inclusions are explanatory and not mutually exclusive.)
    f. Insurer - Any private insurer or public insurer
    g. Post Payment Recovery (Pay and Chase) - A method used where Medicaid pays the recipient's medical bills and then attempts to recover from liable third parties. Pay and Chase waivers are based on specific services as determined by procedure code or type of service.

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

h. Third Party - Any individual, entity, insurer, or program that is, or may be, liable to furnish health care services or to pay for all or part of the costs of medical assistance covered under a Medicaid State plan. Medicaid is generally the payer of last resort. Examples of a third party are employment-related health insurance, medical child support from non-custodial parents, and Medicare. Every Medicaid jurisdiction is required by §1902(a)(25) of the Act to take reasonable measures to determine the legal liability of third party payers.

Sources for the criteria in this checklist are as follows:

SMM - State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

SMM/TPL - State Medicaid Manual, TPL Section (3900), available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45

CFR - Code of Federal Regulations, available from http://www.access.gpo.gov/uscode/title42/title42.html

IBP - Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

DRA - Deficit Reduction Act of 2005, Section 6035, available from http://thomas.loc.gov/cgi-bin/query/D?c109:5:./temp/~c109koQQwB

HIPAA - HIPAA act, available from http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

SSA - Compilation of the Social Security Laws, January 1, 2005, Vol. 1, available from http://www.ssa.gov/OP_Home/ssact/comp-toc.htm

BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
TP1	Provide efficient and timely identification and maintenance of Third Party Liability (TPL) resources.	
TP2	Obtain the maximum cost avoidance and reimbursement for Medicaid Beneficiaries covered by other insurance.	
TPSS1	*Add State-specific business objectives for the Third Party Liability (TPL) Checklist here.*	

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

TP1 - PROVIDE EFFICIENT AND TIMELY IDENTIFICATION AND MAINTENANCE OF TPL RESOURCES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
TP1.1	Provides the storage and retrieval of TPL information including: ③ Name of insurance company. ③ Address of insurance company. ③ Policy number ③ Group number ③ Name of policyholder ③ Relationship to Medicaid Beneficiary ③ Services covered ③ Policy period ③ Multiple resources under one ③ Group health plan participants ③ Health Insurance Premium Payment (HIPP) participant Beneficiary	SMM	X		
TP1.2	Provides the storage and retrieval of casualty-related information (e.g., motor vehicle accident and workers' compensation information).	SMM	X		
TP1.3	Identifies and follows up on third party information from all sources.	SMM	X		
TP1.4	Identifies claims with trauma diagnosis codes, accident codes and indicators and routes them for follow-up to see if there is TPL	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

TP1 - PROVIDE EFFICIENT AND TIMELY IDENTIFICATION AND MAINTENANCE OF TPL RESOURCES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
TP1.5	Produces letters and tracks original and follow-up letters to employers, insurers, Beneficiaries and others to verify health coverage.	CFR	X		
TP1.6	Automatically generates casualty-related follow-up to Beneficiaries, attorneys, motor vehicle department, etc. according to State-specified criteria.	IBP		X	
TP1.7	Accepts and processes verification data from employers, insurance companies, providers, Beneficiaries, attorneys and others. Verification data should include the 'type of insurance coverage" for each policy (e.g., inpatient, outpatient, physician, pharmacy, dental).	CFR	X		
TP1.8	Maintains all third party resource information at the Beneficiary-specific level.	SMM	X		
TP1.9	Maintains multiple third party coverage information for individual Beneficiaries for all of their periods of eligibility.	SMM	X		
TP1.10	Identifies the source of TPL information (e.g., X12N 270 eligibility determination, insurance company).	IBP		X	
TP1.11	Edits TPL data updates for validity and for consistency with existing TPL data.	IBP	X		
TP1.12	Edits additions and updates to the Beneficiary insurance information to prevent the addition of duplicates.	IBP	X		
TP1.13	Provides a mechanism to correct outdated TPL information.	IBP		X	

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

TP1 - PROVIDE EFFICIENT AND TIMELY IDENTIFICATION AND MAINTENANCE OF TPL RESOURCES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
TP1.14	Generates and maintains an audit trail of all updates to the Beneficiary insurance data, including those updates that were not applied due to errors, for a time period specified by the State.	IBP		X	
TP1.15	Cross-references the health insurance carriers to the employers.	IBP		X	
TP1.16	Allows only authorized staff members to do manual deletes and overrides of alerts/edits.	IBP	X		
TP1.17	Identifies claims designated as “mandatory pay and chase”, makes appropriate payments and flags such claims for future recovery (i.e. identifies services provided to children who are under a medical child support order, and flags diagnosis information to identify prenatal care services provided to pregnant women and preventive pediatric services provided to children.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

TP1 - PROVIDE EFFICIENT AND TIMELY IDENTIFICATION AND MAINTENANCE OF TPL RESOURCES					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
TP1SS.1	*Add State-specific criteria for this objective here.* *Example: Provides the capability to maintain historical data on TPL resource records as well as a hierarchy of coverage types for update purposes.* *Example: If available, receives, processes, and updates medical support information received from the State's child support enforcement agency.* *Example: Creates and maintains employer data that identifies employers and the health care plans they provide to employees.* *Example: Maintains at least 36 months of historical information on third party resources for each eligible member.*				

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

TP2 - OBTAIN THE MAXIMUM COST AVOIDANCE AND REIMBURSEMENT FOR MEDICAID BENEFICIARIES COVERED BY OTHER INSURANCE

Ref #	System Review Criteria	Source	Yes	No	Comments
TP2.1	Screens claims to determine if claims are for Beneficiaries with TPL coverage, if service is covered and if date of service is within coverage period. Denies or suspends, as provided in State rules, claims that are for products or services that are covered. Notifies the provider of claims denied because of TPL coverage.	SMM	X		
TP2.2	Generates automated TPL billing information to providers for beneficiaries with third party coverage.	SMM		X	
TP2.3	Accounts for TPL payments to providers in determining the appropriate Medicaid payment.	SMM	X		
TP2.4	Tracks and reports cost avoidance dollars.	SMM	X		
TP2.5	Allows for payment of claims that would have been rejected due to TPL coverage if provider includes override codes that indicates that benefits are not available.	SMM	X		
TP2.6	Supports recovery from an estate or designated trust.	SMM		X	
TP2.7	Screens verified TPL resources against paid claims history retroactively for three years to identify recoverable funds.	SSA DRA	X		
TP2.8	Accumulates claims up to a specified threshold amount and seeks TPL recovery when the threshold is reached.	SMM	X		

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

TP2 - OBTAIN THE MAXIMUM COST AVOIDANCE AND REIMBURSEMENT FOR MEDICAID BENEFICIARIES COVERED BY OTHER INSURANCE

Ref #	System Review Criteria	Source	Yes	No	Comments
TP2.9	Seek recovery of claims previously paid when TPL coverage is identified by billing the third parties using the X12N 837 Coordination of Benefits transaction or a proprietary format.	SMM CFR HIPAA	X		
TP2.10	Automatically re-bills insurance companies if a response (payment or denial) is not received within State-specified guidelines.	IBP		X	
TP2.11	Associates third party recoveries to individual claims.	SMM	X		
TP2.12	Manages accounts receivable and claims adjustments as TPL related invoices are paid.	IBP		X	
TP2.13	Designates portions of claim amounts collected to reimburse CMS and the State with any remainder paid to the recipient.	SMM	X		
TP2.14	Prepares retroactive reports (reverse crossover) to Medicare Part B or the provider, as appropriate, for all claims paid by Medicaid that should have been paid by Medicare part B.	IBP		X	
TP2.15	Identifies Beneficiaries for referral to the Lock-in program.	SSA	X		

OPERATIONS MANAGEMENT BUSINESS AREA
THIRD PARTY LIABILITY (TPL) CHECKLIST

TP2 - OBTAIN THE MAXIMUM COST AVOIDANCE AND REIMBURSEMENT FOR MEDICAID BENEFICIARIES COVERED BY OTHER INSURANCE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
TP2SS.1	*Add State-specific criteria for this objective here.* *Example: Tracks the estate in order to seek recovery once the surviving spouse dies.* *Example: Automatically generates Health Insurance Premium Payments (HIPP) for eligible Beneficiaries.* *Example: Provides the capability to automatically generate CHAMPUS claim form invoices on claims where CHAMPUS/DEERS coverage is indicated*				

FIRST STATE-SPECIFIC OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
TPSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				

ATTACHMENT L: Deliverables List

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
III.B	**Project Planning Phase**		
	Project Management Methodology	Yes	Proposal Due Date
	Project Management Plan (PMP) Narrative	Yes	Proposal Due Date
	Project Management Plan (PMP) (electronic submission in MS Project)	Yes	Proposal Due Date
	Quality Management Methodology	Yes	Proposal Due Date
	Quality Assurance Procedures	Yes	Proposal Due Date
	Quality Management Plan	Yes	Proposal Due Date
	Quality Management Objectives	Yes	Proposal Due Date
	Quality Management Corrective Action Plans	No	Set by project schedule
	Quarterly Quality Surveys	No	Set by project schedule
	Monthly Quality Assurance Surveys and Status Report	No	Set by project schedule
	Annual Quality Assurance Review of Operating Procedures	No	Set by project schedule
	Data Quality Management Operating Procedures	No	Set by project schedule
	Scope Management Methodology	Yes	Proposal Due Date
	Scope Management Plan	No	Set by project schedule
	Requirements Management and Traceability Methodology	Yes	Proposal Due Date
	Requirements Management and Traceability Plan	No	Set by project schedule
	Requirements Traceability Repository COTS Product	No	Set by project schedule
	Issue Resolution Management Methodology	Yes	Proposal Due Date
	Issue Resolution Management Plan	No	Set by project schedule
	Issue Tracking COTS Product	No	Set by project schedule
	Risk Management Methodology	Yes	Proposal Due Date
	Risk Management Plan	No	Set by project schedule
	Risk Tracking COTS Product	No	Set by project schedule
	Configuration Management Methodology	Yes	Proposal Due Date

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
	Configuration Management Plan	No	Set by project schedule
	Configuration Management System	No	Set by project schedule
	Performance Management Methodology	Yes	Proposal Due Date
	Performance Management Plan	No	Set by project schedule
	Performance Management Monthly Report	No	Set by project schedule
	Executive Management Dashboard	No	Set by project schedule
	Communication Management Methodology	Yes	Proposal Due Date
	Communication Management Plan	No	Set by project schedule
	Contact Management System	No	Set by project schedule
	Weekly, Monthly and Quarterly Status Reports and Meetings	No	Set by project schedule
	Approach to Data Governance	Yes	Proposal Due Date
	Daily Delivery of Data to OHIP Metadata Repository	No	Set by project schedule
	Daily Delivery of Data to Support the MDW	No	Set by project schedule
III.C	**Implementation Phase**		
	Project Initiation Task		
	Description of Project Initiation Activities	Yes	Proposal Due Date
	Project Orientation Plan	No	Contract Start + 5 business days
	Orientation Sessions	No	Set by project schedule
	System Development Lifecycle (SDLC)		
	System Development Lifecycle Description	Yes	Proposal Due Date
	Proposed COTS Product Description	Yes	Proposal Due Date
	Sample deliverables produced for previous MMIS engagement(s) or engagement of similar size and scope, including but not limited to: Functional Requirements Document, Business Process Models, General Design Document, Detailed Design Document, Test Plans for unit, integration, system, user and regression testing, Requirements Traceability Matrix, Data Conversion and Cleansing Plan, and Training Plan.	Yes	Proposal Due Date

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
	Estimation Methodology Description	Yes	Proposal Due Date
	Approach to Business Process Model Maintenance	Yes	Proposal Due Date
	Data Modeling Tool Description	Yes	Proposal Due Date
	SDLC Implementation	No	Set by project schedule
	Business Process Gap Analysis	No	Set by project schedule
	Requirements Validation Task		
	Requirements Validation Methodology	Yes	Proposal Due Date
	Business Process Gap Analysis Approach Description	Yes	Proposal Due Date
	Requirements Validation Plan	No	Set by project schedule
	Requirements Validation JAD Sessions	No	Project kick-off date + 15 business days
	Structured, Interactive Overviews of Proposed System	No	Set by project schedule
	Requirements Repository	No	Set by project schedule
	Requirements Validation Document	No	Set by project schedule
	Attachment M Contractor Requirements Traceability Matrix (initial)	Yes	Proposal Due Date
	Attachment M Contractor Requirements Traceability Matrix (updated)	No	Set by project schedule
	Gap Analysis	No	Set by project schedule
	Policy and Business Rules Validation Report	No	Set by project schedule
	Business Process Gap Analysis	No	Set by project schedule
	System Design		
	System Design Methodology	Yes	Proposal Due Date
	Technological Overview of the Proposed Architecture	Yes	Proposal Due Date
	System Design Processes and Procedures	No	Set by project schedule
	Updated Technological Overview of the Proposed Architecture	No	Set by project schedule
	Logical Design Document	No	Set by project schedule

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
	Logical Data Model	No	Set by project schedule
	Physical Design Document	No	Set by project schedule
	Physical Data Model	No	Set by project schedule
	System Architecture and Infrastructure Plan	No	Set by project schedule
	Network Design Document	No	Set by project schedule
	Design Specifications Document	No	Set by project schedule
	System Development		
	System Development Methodology	Yes	Proposal Due Date
	Updated System Development Methodology	No	Set by project schedule
	Software Product Standards	No	Set by project schedule
	Development and Test Environments	No	Set by project schedule
	Source Code Library	No	Set by project schedule
	Unit Test Plan	No	Set by project schedule
	User Manual	No	Set by project schedule
	Business Operating Procedures	No	Set by project schedule
	Technical and System Operating Procedures	No	Set by project schedule
	Testing		
	Comprehensive Testing Methodology	Yes	Proposal Due Date
	Comprehensive Test Plan	No	Set by project schedule
	Semi-Annual Test Preparation Training	No	Set by project schedule
	System Integration Test Plan	No	Set by project schedule
	System Integration Test Results	No	Set by project schedule
	User Acceptance Test Support	No	Set by project schedule
	Stress and Performance Test Plan	No	Set by project schedule

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
	Stress and Performance Test Results	No	Set by project schedule
	Regression Test Case Repository	No	Set by project schedule
	Parallel and System Recovery Test Plan	No	Set by project schedule
	Parallel and System Recovery Test Results	No	Set by project schedule
	Annual Network Intrusion Test Results	No	Set by project schedule
	Certification Test Case Repository	No	Set by project schedule
	Provider Test Case Development Support	No	Set by project schedule
	Organizational Change Management Task		
	Organizational Change Management Methodology	Yes	Proposal Due Date
	Organizational Change Management Plan	No	Set by project schedule
	Annual Organizational Change Management Plan Updates	No	Set by project schedule
	Business Process Gap Analysis Update (from Requirements Validation Process)	No	Set by project schedule
	Organizational Transition Plan	No	Set by project schedule
	Data Conversion Task		
	Data Conversion Methodology	Yes	Proposal Due Date
	Data Conversion Plan	No	Set by project schedule
	Data Conversion Strategy and Approach	No	Set by project schedule
	Data Conversion Specifications and Data Mapping	No	Set by project schedule
	Data Conversion Test Plans and Test Results	No	Set by project schedule
	Detailed Mapping Document	No	Set by project schedule
	Operational Readiness Task		
	Approach to the Operational Readiness Review	Yes	Proposal Due Date
	Operational Readiness Review (ORR) Plan	No	Set by project schedule
	Operational Readiness Review (ORR) Checklists	No	Set by project schedule
	Final Operational Readiness Review Report	No	Set by project schedule

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
	Implementation Task		
	System Implementation Strategy	Yes	Proposal Due Date
	Updated System Implementation Strategy	No	Set by project schedule
	Implementation Plan	No	Set by project schedule
	Implementation Contingency Plan	No	Set by project schedule
	Implementation Assurance Support	No	Set by project schedule
	Post-Implementation Support Results Report	No	Set by project schedule
	Incumbent Transition Support Task		
	Incumbent Transition Support Strategy	Yes	Proposal Due Date
	Updated Incumbent Transition Support Strategy	No	Set by project schedule
III.D	**Certification Phase**		
	Certification Strategy	Yes	Proposal Due Date
	Updated Certification Strategy	No	Set by project schedule
	Certification Plan	No	Set by project schedule
	Updated Certification Checklists	No	Set by project schedule
	Certification Readiness Checklists	No	Set by project schedule
	Certification Checklist Traceability Deliverable	No	Set by project schedule
	Certification Review Package	No	Set by project schedule
	Correction Acton Plan (if necessary)	No	Set by project schedule
III.E	**System and Operational Enhancements Phase**		
	Approach to Systems and Operational Enhancement Activities	Yes	Proposal Due Date
	Complete Enhancements to Support Attaining Target MITA Maturity Levels	No	Set by project schedule
	Implement Estimation Methodology	No	Set by project schedule

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
	Change Control Management System	No	Set by project schedule
III.F	**Operations Phase**		
	Continuous Improvement Methodology	Yes	Proposal Due Date
	Approach to Business Reengineering	Yes	Proposal Due Date
	Approach to Operational Policy and Procedure Manual Maintenance	Yes	Proposal Due Date
	Approach to Customer Service Center Operations	Yes	Proposal Due Date
	Approach to Transaction Processing Operations	Yes	Proposal Due Date
	Approach to Financial Services Operations	Yes	Proposal Due Date
	Approach to Support Services Operations	Yes	Proposal Due Date
	Approach to Expert and Consulting Services Operations	Yes	Proposal Due Date
	Approach to Reporting Operations	Yes	Proposal Due Date
	Approach to Archiving Operations	Yes	Proposal Due Date
	Continuous Improvement Plan	No	Set by project schedule
	Performance Management Plan	No	Set by project schedule
	Business Reengineering Studies – Three Per Year	No	Set by project schedule
	Operational Policy and Procedure Manuals	No	Set by project schedule
	Weekly, Monthly, Quarterly, Semi-Annual and Annual Operations Reports	No	Set by project schedule
	Annual Business Reengineering Studies	No	Set by project schedule
III.G	**Turnover Phase**		
	Approach to Turnover	Yes	Proposal Due Date
	Approach to Training Successor Staff	Yes	Proposal Due Date
	Turnover Plan	No	Start of Operations Phase + 1 year
	Annual Turnover Plan Updates	No	Set by project schedule
	Resource Statement	No	Start of Operations Phase + 1 year

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
III.H	**Technical and System Architecture Requirements**		
	Detailed Schematics and Supporting Narrative Describing the Proposed Technical, Application, Network and Data Architectures	Yes	Proposal Due Date
	Approach to Web Portal Requirements	Yes	Proposal Due Date
	Methodology for Writing Web Applications	Yes	Proposal Due Date
	Approach to Integration of COTS Business Rules Engine	Yes	Proposal Due Date
	Description of COTS Correspondence Management System	Yes	Proposal Due Date
	Description of COTS Content Management System	Yes	Proposal Due Date
	Description of COTS Workflow Management System Description	Yes	Proposal Due Date
	Description of COTS Reporting Tool and Automated Letter Generator	Yes	Proposal Due Date
	Data Receipt Strategy and Solution	Yes	Proposal Due Date
	Data Delivery Strategy and Solution	Yes	Proposal Due Date
	Strategy and Solution to Metadata Content Capture and Extraction	Yes	Proposal Due Date
	Description of the Proposed Relational Database Management System (RDBMS)	Yes	Proposal Due Date
	Description of the Proposed Data Modeling Tool	Yes	Proposal Due Date
III.I	**Security, Privacy and Confidentiality Requirements**		
	Approach to Security, Privacy and Confidentiality	Yes	Proposal Due Date
	Security, Privacy and Confidentiality Plan	No	Contract Start + 30 calendar days
III.J	**Functional Requirements**		
	See detailed proposal requirement descriptions in section III.J and Attachment S	Yes	Proposal Due Date
III.K	**Facility Requirements**		
	Approach to Facility Management	Yes	Proposal Due Date
	Facility Management Plan	No	Set by project schedule
	Annual Physical Security Plan	No	Set by project schedule

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
III.L	**Business Continuity and Disaster Recovery Requirements**		
	Business Continuity and Disaster Recovery Methodology	Yes	Proposal Due Date
	Business Continuity Plan	No	Contract Start + 30 calendar days
	Disaster Recovery Plan	No	Contract Start + 30 calendar days
III.M	**Organization and Staffing Requirements**		
	Staffing and Organization Plan for Each Project Phase	Yes	Proposal Due Date
	Resumes And Supporting Documentation of Key Staff	Yes	Proposal Due Date
	Detailed Staffing Plan – Planning and Implementation Phase	No	Set by project schedule
	Detailed Staffing Plan – Certification Phase	No	Set by project schedule
	Detailed Staffing Plan – System and Operational Enhancements Phase	No	Set by project schedule
	Detailed Staffing Plan – Operations Phase	No	Set by project schedule
	Detailed Staffing Plan – Turnover Phase	No	Set by project schedule
	Annual Staffing and Organization Plan	No	Set by project schedule
III.N	**Training Requirements**		
	Training Task		
	Training Strategy	Yes	Proposal Due Date
	Recommended Training Course List	Yes	Proposal Due Date
	Training Plan and Annual Updates	No	Set by project schedule
	Training Needs Assessment	No	Set by project schedule
	Recommended Course List by User Role	No	Set by project schedule
	Project Initiation Training	No	Set by project schedule
	Course Curriculum	No	Set by project schedule
	Online Training Manual, Operational Guide and Computer Based Training	No	Set by project schedule
	User and Instructor Training Materials	No	Set by project schedule
	Instructor and Trainee Guides for Train the Trainer Sessions	No	Set by project schedule

RFP Section #	Phase/Task Deliverable	In Proposal?	Due Date
	Training Materials to Support Business and Technical Training	No	Set by project schedule
	Dedicated Training Environment and Data	No	Set by project schedule
	Training – Train the Trainer	No	Set by project schedule
	Training – Technical Training	No	Set by project schedule
	Training – Business Training	No	Set by project schedule
	Annual On-going Training Delivery	No	Set by project schedule

ATTACHMENT M: PRICING SCHEDULES

Use of the Microsoft Excel spreadsheet titled "Attachment M - Pricing Schedules MMIS RFP.xls" in the form and content provided with this RFP is MANDATORY. Failure to use the schedules as provided shall result in disqualification.

Pricing Schedule A - Total Price

Pricing Schedule A summarizes the costs for all contractor activities during the base contract period, including the design and implementation of the Replacement MMIS and five (5) years of operations and system and operational enhancement activities. The Total Price on this schedule should equal the sum of all other pricing schedule totals. There will be no need for the offeror to enter data on this schedule if the "Attachment M - Pricing Schedules MMIS RFP.xls" spreadsheet is used. The Department preserves the option to receive line item reports on all costs. The offeror should insert its name in cell B2 of the spreadsheet. Line 6 System Change Capacity on Pricing Schedule A includes a ten percent (10%) increase (based on the Operations – Annual Administrative Fee), is calculated automatically, and is to be used solely for the purposes stated in Section V.I.3.2 Optional Capability Increase.

Pricing Schedule B – Phase 1 Implementation Pricing

Pricing Schedule B includes all planning, joint application design sessions, design, conversion, construction, testing, implementation, and certification pricing for the Replacement MMIS expressed as a fixed price. Payment for each milestone will be made upon completion to the Department's satisfaction and calculated using the percentages identified on Pricing Schedule B. Using the attached "Attachment M - Pricing Schedules MMIS RFP.xls" spreadsheet, offerors need only insert the total implementation price proposed in the shaded cell (B29) and the contract year (e.g., 1, 2 or 3) for the anticipated contract year completion in cells C9, C11, C13, C15, C17, C19 and C21. The total Phase 1 Implementation price MUST be less than or equal to 25% of the proposed Total Price on Pricing Schedule A.

Pricing Schedule C – Phase 2 Implementation Pricing

Pricing Schedule C includes all planning, joint application design sessions, design, conversion, construction, testing, and implementation pricing for the Replacement MMIS COTS Financial system expressed as a fixed price. Payment for each milestone will be made upon completion to the Department's satisfaction and calculated using the percentages identified on Pricing Schedule C. Using the attached "Attachment M - Pricing Schedules MMIS RFP.xls" spreadsheet, offerors should insert the total implementation price proposed in the shaded cell (B27) and the anticipated contract year completion in cells C9, C11, C13, C15, C17, C19, C21, C23, and C25.

Pricing Schedule D - Operations Price – Annual Administrative Fee

In Pricing Schedule D, offerors must specify a fixed price to operate the Replacement MMIS for the five years of the Operations Phase. The contractor will be paid an amount equal to twenty percent (20%) of the total proposed price for each year of operations. Using the attached "Attachment M - Pricing Schedules MMIS RFP.xls" spreadsheet, offerors need only complete the pricing in the shaded cells. (See the explanation for Pricing Schedule D.1 for instructions to complete the "Other" cells.) Offerors must include the percentages applied for corporate allocation (cell B43) and markup (cell B46). Equal monthly payments will be made to the contractor over the scheduled five years of operations.

Pricing Schedule D.1 – Operations Price – Explanation of "Other" Pricing

In Pricing Schedules D.1, offerors must detail the other expenses from "Personnel-related pricing", "Facility pricing" and "Other operations pricing" detailed on Pricing Schedule D.

Pricing Schedule E – Operations – Annual Volume Adjustment

Pricing Schedules E is used to determine the payment due for the additional effort required should the annual contract volume exceed the base volume projection but is less than or equal to the upper claim threshold projection (see section V.I.3.3 of this RFP). Offerors should enter the percentage for contract years 4 through 10 which will be multiplied times the annual administrative fee (for contract years 4 through 8), to determine the annual adjustment. Using the attached "Attachment M - Pricing Schedules MMIS RFP.xls" spreadsheet, offerors need only complete the shaded cells indicating the percentage rate. The prices for contract years 9 and 10 are for the optional extension years and are not included in the initial contract funding amount nor will the price be shown on Pricing Schedule E.

Pricing Schedule F – Supplemental Staff Price

In Pricing Schedules F, offerors should submit the fixed hourly rate for each labor category identified and calculate the total annual price for each labor category and the total for each contract year. Using the attached "Attachment M - Pricing Schedules MMIS RFP.xls" spreadsheet, offerors need only complete the shaded cell indicating the hourly rate for each labor category. The hourly rate must be a fully loaded rate and include all personnel, overhead, indirect, travel, profit, equipment usage, and other miscellaneous costs. The contractor will be reimbursed at the hourly rates proposed for time each individual is used on identified and approved Department projects. Time spent by these individuals for such activities as training or administrative time is to be included in the Operations annual administrative fee and will not be paid separately.

System Change Capacity and Reimbursable (Postage)

There are no pricing schedules associated with line 6 System Change Capacity or line 7 Reimbursable (Postage) on Pricing Schedule A. Line 6 System Change Capacity on Pricing Schedule A includes a ten percent (10%) increase (based on the Operations – Annual Administrative Fee), is calculated automatically, and is to be

used solely for the purposes stated in Section V.I.3.2 Optional Capability Increase. Line 7 Reimbursable (Postage) is the Department's estimate for postage a set forth in Section V.I.3.2 Cost Reimbursement of the RFP and is included to calculate the required contract funding.

Pricing Schedule G – Turnover

In Pricing Schedules G, offerors should submit the fixed price for all activities required to support the turnover tasks required by this RFP and as detailed in the Turnover Plan approved by the Department. Using the attached "Attachment M - Pricing Schedules MMIS RFP.xls" spreadsheet, offerors need only insert the price in the shaded cell.

Please Note: Use fillable Excel spreadsheet for Attachment M.

When the Bidder submits a proposal to this RFP, the Bidder should submit an executed Commitment Letter, in the form set forth below, from a financial institution which is licensed to transact business in the State of New York, on the financial institution's letterhead. The executed commitment letter should be included as part of the Bidder's Proposal.

Date

State of New York
Department of Health
Office of Health Insurance Programs
Corning Tower, Room 2019
Empire State Plaza
Albany, New York 12237

To Whom It May Concern:

RE: [R-MMIS RFP]
RFP No. 1002031048

Irrevocable Standby Letter of Credit Commitment Letter

[Name of Financial Institution] is licensed to transact business in the State of New York.

Please accept this communication as a letter of commitment to issue an irrevocable Standby Letter of Credit (SLOC) in the amount of 50 million U.S. dollars ($50,000,000) in the event [Bidder] is awarded a contract in connection with the above-referenced RFP.

[Name of Financial Institution] and [Bidder] understand and acknowledge that in the event [Bidder] is awarded a contract in connection with the above referenced RFP, the proposed SLOC is subject to review and approval by the Department of Health prior to issuance.

The subject SLOC will be furnished for the initial contract period through the term of the Contract and all extensions thereof, plus one hundred and eighty (180) calendar days thereafter.

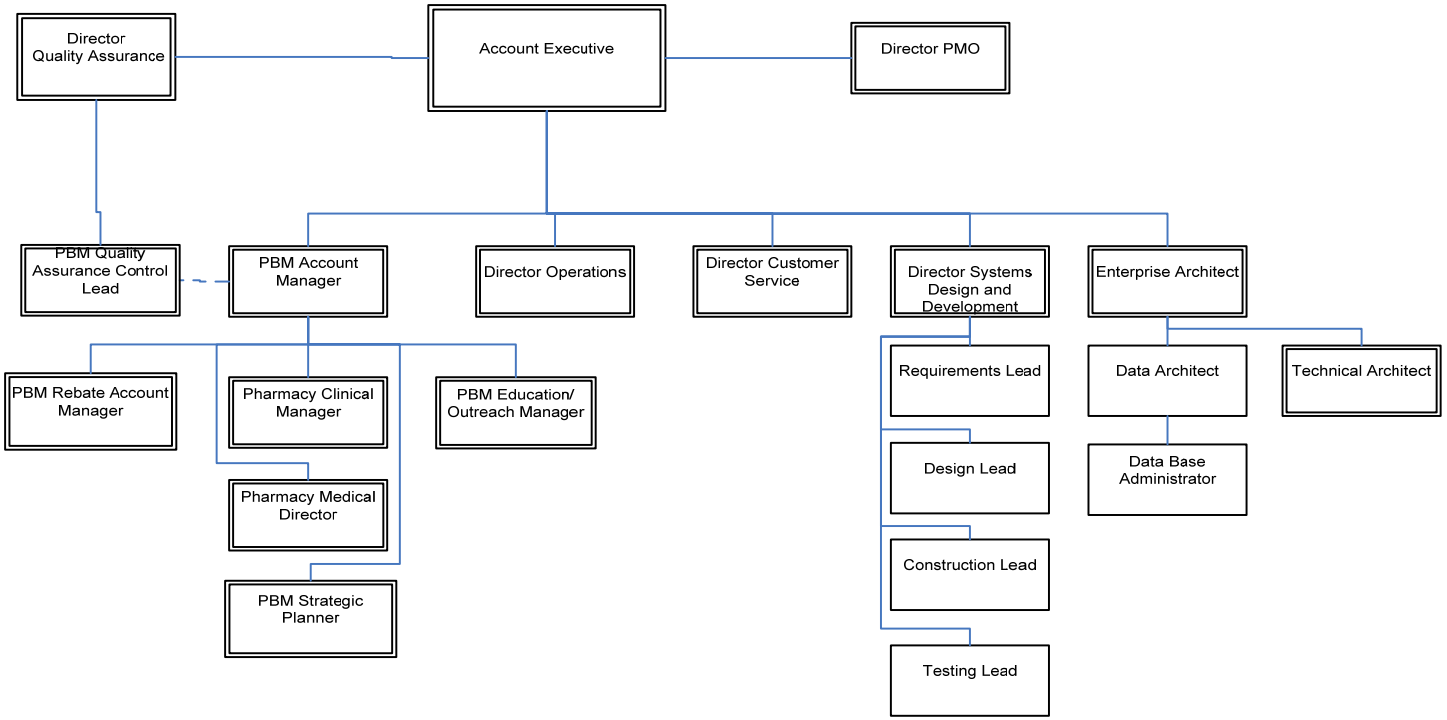
Sincerely,

[Name and Title]
[Address, Telephone and email]

This Attachment defines the key staff, core staff and supplemental titles as defined in section III.M Organization and Staffing requirements.

For Key staff: The contractor must name individuals and provide resumes in its proposal that will fill the twenty-one (21) key staff positions. The contractor must also complete twenty-one (21) Qualifications and Experience Charts provided at the end of this attachment. The contractor may also supply any other supporting documentation it feels necessary to show that key staff possess the demonstrated knowledge, skills and abilities detailed, below. Key staff must be available at the contract start date.

The Department must approve all key staff positions in advance. Should any turnover among key staff take place during the life of this contract, all replacement staff must meet the requirements of this RFP and be approved by the Department. The following organization chart defines the reporting structure for the key staff positions that are required to satisfy the requirements in this RFP.



R-MMIS Key Staffing Requirements

Administrative Key Staff	General Responsibility	Qualifications / Experience
Account Executive	• Ultimate responsibility for the R-MMIS • Acquisition of adequate resources • Formal communication and correspondence with the Department • Foster cooperative relationship among State and Contractor staff • Ensures compliance with all SLAs; and • Ensures compliance with the approved Quality Management Plan • Production of a monthly report to the Department that includes results on performance measures and SLAs defined in this RFP • Contract Administration • Scheduling and provision of resources • Focal point of contact for the Department regarding financial and administrative issues and concerns	At least five (5) years previous account executive experience on a large-scale Information Technology project. At least two (2) years previous experience with an MMIS or with major operations-related components of an MMIS or other large healthcare systems and an ongoing relationship management with a large client. At least three (3) years implementing quality improvement and customer satisfaction monitoring programs. Demonstrated ability to effectively communicate with customer's senior management; and Demonstrated strong analytical, organizational and problem solving abilities

Administrative Key Staff	General Responsibility	Qualifications / Experience
Director Quality Assurance	• Responsible for conducting quality reviews for all aspects of the R-MMIS • Monitor performance to ensure compliance with the contract • Responsible for implementing continuous improvements • Ensures all services provided meet or exceed contract requirements • Ensures the quality of all deliverables including but not limited to reports, documentation, testing, and responses to telephone inquiries and correspondence	• At least three (3) years experience in managing the Quality Assurance component of a large-scale integrated healthcare claims processing system, preferably with the proposed MMIS solution • At least five (5) years experience in managing technical and business quality programs in a complex IT environment; • Demonstrated ability to communicate effectively, orally and in writing with all levels of management; • Demonstrated experience in configuration management discipline; • At least two (2) years experience analyzing performance metrics and identifying corrective actions needed to comply with contract requirements; • Demonstrated ability to manage independent testing of software quality.

Administrative Key Staff	General Responsibility	Qualifications / Experience
Director PMO	• Project management responsibilities • Requirements tracking • Estimations • Scheduling of Projects • Resource contention resolution • Focal point of contact for the Department regarding project status, meetings, reporting requirements, scope changes • Creates and executes project work plans and revises as appropriate to meet changing needs and requirements • Runs projects/programs from design and development to production. • Defines resources and schedule for project/program implementation. • Create strategies for risk mitigation and contingency planning. • Plans and schedule project deliverables, goals, and milestones. • Directs and oversees project team and manages conflicts within group. • Performs team assessments and evaluations. • Efficiently identifies and solves project issues. • Demonstrates leadership to define requirements for project risk. • Designs and maintain technical and project documentation. • Strong organizational, presentation, and customer service skills	• At least five (5) years in project management oversight responsibilities, e.g., planning, design, development, implementation, and operation of large-scale Information Technology project • At least three (3) years health care claims processing environment, preferably with the architecture and interfaces related to the proposed R-MMIS solution • At least three (3) years experience in scheduling and controlling all aspects of a large-scale IT system preferably in the health care field. • Demonstrated strong analytical, organizational and problem solving abilities • Demonstrated ability to implement a large-scale IT system on-time and on-budget

Administrative Key Staff	General Responsibility	Qualifications / Experience
Director Operations	Responsible for the functional operation of the R-MMIS, including but not limited to; • Managing the day-to-day operation of inbound and outbound claims processing functions in accordance with this RFP • Ensures all operational components are performed in accordance with this RFP • Managing the day-today financial processing of the R-MMIS • Ensures all jobs are run and reports are produced in a timely manner • Manage claims processing staff to meet the requirements and SLAs in this RFP • Report operational metrics to the Department at a minimum monthly	• At least five (5) years experience in managing the claims processing component of a large-scale integrated healthcare claims processing system, preferably with the proposed MMIS solution • At least three (3) years significant business operational experience in Medicaid or another healthcare production environment; • Demonstrated experience developing and leading process improvement programs; • Demonstrated experience planning, implementing, and administering complex operational processes and procedures; • Demonstrated ability to identify and promulgate diverse and complex operational issues orally and in writing with all levels of management; and • Demonstrated strong analytical, organizational and problem solving abilities. • Bachelor's degree in Business Management or related field is required; MBA or related higher level degree is preferred.
Director Customer Service	• Responsible for managing all provider service activities in accordance with the requirements in this RFP • Primary point of contact with the Department for activities related to provider activities; • Report and resolve production issues timely and accurately; • Oversee all Call Center activities	• At least five (5) years experience in managing the Provider Services component of a large-scale integrated healthcare claims processing system, preferably with the proposed MMIS solution • At least two (2) years experience managing a call center • Bachelor's degree in Business Management or related field is required;

Technical Key Staff	General Responsibility	Qualifications / Experience
Director Systems Design and Development	• Management of the planning, design, testing and implementation of the R-MMIS • Ensures that all System Design and Development is performed in accordance with the proposed SDLC • Initiates recommendations to the Department for system application improvements • Implements and oversees processes that accurately estimate design and development efforts • Reports system design and development activities to the Department weekly • Management of the system operational enhancement team • Management of the overall change control over the R-MMIS	• At least seven (7) years experience in MMIS design, development, implementation, operations, maintenance, and modifications. Experience with implementing major modifications to an MMIS or with major operations-related components of an MMIS or large-scale integrated healthcare claims processing system; and experience with the complete architecture and interfaces related to the proposed R-MMIS • Demonstrated comprehensive experience managing the planning, developing, testing, and implementing of software application changes; • Demonstrated comprehensive experience using the proposed software development lifecycle methodologies and COTS products; • At least five (5) years experience simultaneously managing large scale concurrent projects and effectively responding to unanticipated Department business priorities; and • At least five (5) years experience managing a staff of over 50 in a complex IT environment. • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.
Requirement Team Lead	Under the leadership of the Director of System Design and Development the incumbent will be responsible for leading a team to perform but not be limited to the following: • Manage, conduct, facilitate and document JAD and other forms of requirement sessions with stakeholders • Document all requirements in the requirements repository • Along with the members of the Design Team: o Perform "as is" business process modeling for all aspects of the R-MMIS. This is to be accomplished by visiting stakeholder sites and gathering information o Recommend business process improvements and	• Must have extensive business and technical knowledge of the proposed R-MMIS • Must be able to direct and work with user groups to design the workflows required to support the business processes. • Must have three (3) years experience in the proposed SDLC suite of COTS products • At least five (5)years experience leading and facilitating JAD sessions • Must have five (5) years experience in Business Process Modeling

Technical Key Staff	General Responsibility	Qualifications / Experience
	complete "to be" business process models • Produce the required artifacts for requirements gathering based upon the approved SDLC	
Design Team Lead	• Under the leadership of the Director of System Design and Development the incumbent will be responsible for leading a team to perform but not be limited to the following: • Design and document all changes necessary to the R-MMIS based upon approved requirements in the requirements repository • Along with the members of the Requirement Team: o Perform "as is" business process modeling for all aspects of the R-MMIS. This is to be accomplished by visiting stakeholder sites and gathering information o Recommend business process improvements and complete "to be" business process models • Produce the required artifacts for system design based upon the approved SDLC • Under the direction of the Enterprise Architect, for each of the MITA Business Areas (or possibly a finer Business Area decomposition), the Design Lead will direct the development of the activities and resources required to support the business processes within the business area.	• At least five (5) years experience leading a large design team in an MMIS or with major operations-related components of an MMIS or large-scale integrated healthcare claims processing system; • Must have three (3) years experience in the proposed SDLC suite of COTS products • Must have five (5) years experience in Business Process Modeling • Demonstrated comprehensive experience managing the planning, developing, testing, and implementing of software application changes;
Construction Team Lead	Under the leadership of the Director of System Design and Development the incumbent will be responsible for leading a team to perform but not be limited to the following: • All construction activities based upon approved design documents • Unit testing of all program modules and COTS interfaces • Documentation and other artifacts for construction based upon the approved SDLC	• At least seven (7) years experience in managing and overseeing large scaled projects comprised of sub-projects and distinct deliverables; • At least seven (7) years experience leading a development team of over 30 staff in a large scale IT project • At least five (5) years experience coordinating and delegating the assignments and tasks for a project staff numbering over 30 staff in an MMIS or large-scale integrated healthcare claims processing system

Technical Key Staff	General Responsibility	Qualifications / Experience
Testing Team Lead	Under the leadership of the Director of System Design and Development the incumbent will be responsible for leading a team to perform but not be limited to the following: • All testing activities based upon approved design documents • Any and all testing required by the Department as defined in this RFP • Development of all test scripts • Automation and validation of all test results • SIT testing of all program modules and COTS interfaces • Documentation and other artifacts for testing based upon the approved SDLC	• At least eight (8) years experience directing the testing activities in an MMIS or large-scale integrated healthcare claims processing system • At least five (5) years experience in the proposed COTS product to be used to automate the testing process • At least three (3) years experience in the automatic generation of test transactions and automated validation of test results • Must have extensive experience and deep knowledge of the proposed R-MMIS solution
Enterprise Architect	• Acquisition and implementation of all hardware and software required to operate the R-MMIS • Management of the planning, design, and implementation of the technical aspects of the R-MMIS • Responsible for the proper, timely, and efficient performance of the MMIS enterprise business processes. • That the business policies and rules for a business process are applied. • The information needed to support a business processes is accurate and timely. • Along with the PMO Director and Technical Systems Manager, coordinate project tasks so that architectural components will be available when needed. • Primary technical contact with the Department	• At least eight (8) years of experience in the planning and design of the technical aspects of an MMIS preferably in the proposed hardware and software environment • At least five (5) years experience in evaluating and identifying new technologies preferably in an MMIS or large-scale integrated healthcare claims processing system • At least five (5) years experience in directing the design of process workflows and automated components preferably in the proposed COTS product • At least five (5) years experience in directing performance measurements and performance tuning in MMIS or large-scale integrated healthcare claims processing system • Must have extensive experience and deep knowledge of the proposed R-MMIS solution • Bachelor’s degree in Information Technology or related field is

Technical Key Staff	General Responsibility	Qualifications / Experience
	• Evaluate and identify new technologies for implementation • That the communication channels among process participants are adequate. • Focal point of contact for the Department regarding technical issues and concerns	required; MBA or related higher level degree is preferred.
Technical Architect	• Responsible for the technical operational aspects of the R-MMIS • Installation and operation of all hardware and software required to operate the R-MMIS • Primary technical contact with the Department • Management of the overall change control over the R-MMIS • System performance tuning, improvement and balancing	• At least five (5) years experience in MMIS design, development and implementations • At least three (3) years experience with implementing the proposed architecture in an MMIS or a large-scale integrated healthcare claims processing system; and • At least three (3) years experience with the complete architecture and interfaces related to the proposed R-MMIS • Demonstrated comprehensive experience managing the planning, developing, testing, and implementing of software application changes; • Demonstrated comprehensive experience using software development lifecycle methodologies; • Demonstrated ability to simultaneously manage large scale concurrent projects and effectively respond to unanticipated Department business priorities; and • At least five (5) years experience in managing a staff of fifty (50) or more in a complex IT environment. • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.
Data Architect	• Responsible for physical and logical database design. • Participate in design meetings to assess database impacts resulting from systems modifications. • Performance tuning, improvement and balancing	• At least five (5) years experience in database design, development, implementation, operations, maintenance, and modifications. • At least three (3) years experience with logical and physical database designs in an MMIS or large-scale integrated healthcare claims processing system; and

Technical Key Staff	General Responsibility	Qualifications / Experience
		• At least five (5) years experience with the proposed database software • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.
Database Administrator	• Design and maintain data elements and the database(s) for all components of R-MMIS • Coordinate data between the R-MMIS and the MDW • Monitor database performance and perform database reorganization as needed. • Develop database utilities and automated reporting • Analyze, consolidate and tune database for optimal efficiency • Oversee backup, clustering, mirroring, replication and failover	• At least five (5) years experience as a Data Administrator with the proposed RDMS. • At least three (3) years experience as a Data Administrator in an MMIS or large-scale integrated healthcare claims processing system in the proposed database software • At least three (3) years experience with the proposed R-MMIS data model. • At least three (3) years experience with the proposed data modeling COTS product • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.

PBM Key Staff	General Responsibility	Qualifications / Experience
PBM Quality Assurance/Control Lead	• Responsible for all Quality Control/ Assurance in the PBM program • Responsible for all training programs for NY PBM program • Reports to the Director Quality Assurance	• B.S in Business Administration • Must be computer literate in a variety of programs, • At least two (2) years experience in business writing. • At least three (3) years direct experience with a PBM at least one of which must have been in quality assurance and controls
PBM Account Manager	• Reports to the Account Manager • Primary liaison/point of contact with the Department's pharmacy staff. • Oversees all aspects of the pharmacy program during implementation and operation. • Responsible for managing the day to day activities of the PBM program. Oversees and evaluates operational and clinical aspects of the pharmacy program. • Develops and manages workplans to achieve program goals. • Provides advice and recommendations that are related to the clinical quality and cost management of the Program • Keep the Department up to date regarding cost containment new drugs, conversion from brand name drugs to generic drugs and how it will impact cost, Preferred Drug List configuration, technological improvements, e-prescribing, pharmacy innovations, litigation and State/Federal legislation (i.e., Medicare, prescription drug mandates, etc.) that may affect the Program.	• Five (5) or more years experience in direct PBM Management. • MA or MS in business or related field. • Demonstrated ability to effectively communicate with customer's senior management. • Demonstrated strong analytical, organizational and problem solving abilities related to pharmacy best practice. • Demonstrated ability to simultaneously manage large scale concurrent projects and effectively respond to Department business priorities. • Demonstrated ability to proactively address issues that could potentially affect the pharmacy program. • Strong leadership experience and the ability to demonstrate the authority and integrity to command and coordinate the appropriate resources necessary to implement and manage the pharmacy program.
PBM Clinical Manager	• Responsible for clinical services. Clinical liaison between Offeror and the Department. • Assess and document the performance of pharmacy utilization management programs, and provide recommendations for	• NYS licensed Pharm D. At least three (3) years PBM clinical management experience; • At least three (3) years drug utilization management experience;

PBM Key Staff	General Responsibility	Qualifications / Experience
	improvements. • Provide recommendations for pharmacy clinical edits related to client, e.g., therapeutic duplication, drug-to-drug interaction, early refills, drug-to disease interaction, etc. • Effectively collaborate with the Department and other stakeholders in order to support the above activities. • Conduct drug/clinical research for presentation to the Department's Pharmacy & Therapeutics Committee (P&TC)	• Specialty training or demonstrated experience in the clinical management products/service process for a large, complex business, preferably a state Medicaid program; • Demonstrated ability to effectively engage in clinical discussion while in a public setting; • Demonstrated clinical writing skills and clinical interpretation skills. • Demonstrated ability to effectively conduct clinical/drug research.
PBM Medical Director	• Responsible for providing medical opinions on all aspects of the PBM program.	• Licensed physician • At least five (5) years experience in drug utilization review and other pharmacy utilization programs; • Must possess a broad knowledge of clinical medicine, basic medical sciences and clinical laboratory science; • No sanctions by Medicare or Medicaid.
PBM Strategic Planner	Work with PBM staff to monitor the market, examine utilization, prescribing trends, rebate opportunities, new technologies, and strategies to achieve program goals Provide the Department with up to date developments in the prescription drug field and collaborate with other State Medicaid programs. Develop and manage work plans to implement agreed upon strategic direction for the PBM program.	• At least three (3) years of direct PBM experience; • Four-year degree in business or related field; • Demonstrated strong analytical, organizational and problem solving abilities related to pharmacy best practice; • Demonstrated ability to identify market, prescribing and utilization trends; • Demonstrated ability to communicate effectively, orally and in writing with all levels of management; • Demonstrated ability to analyze data and develop action plans. • Demonstrated ability to collaborate with others in order to achieve the pharmacy benefit program's strategic goals.
PBM Rebate Account Manager	Responsible for • Management and oversight of all day to day rebate operations, including but not limited to OBRA and	• At least five (5) years experience managing Medicaid pharmacy rebates operations, preferable with experience relating to both OBRA and Supplemental rebates.

PBM Key Staff	General Responsibility	Qualifications / Experience
	Supplemental Rebate invoicing, reconciliation, supplemental rebate negotiations and bid solicitation, reporting and analysis and responses to audit findings and requests for information.	• Demonstrated knowledge of Federal law and regulations relating to the Medicaid Drug Rebate Program: knowledge of NYS pharmacy laws and regulations is preferred. • At least three (3) years experience with contract negotiations; • Bachelor's degree in Business Management or related field is required; MBA or related higher level degree is preferred.
PBM Education/Outreach Manager	Responsible for • Communication and training of all groups impacted by PBM activities; • All aspects of prescriber, provider and enrollee education for the PBM contract.	• NYS licensed Pharm D. • At least three (3) years experience in developing and conducting training sessions and educational programs; • Demonstrated ability to promulgate information about complex processes and procedures; • Demonstrated ability to effectively engage in clinical discussions with health care professionals; • Demonstrated ability with a variety of computer programs; • Demonstrated ability to communicate effectively, both orally and in writing

For Core staff: Core staff are key staff that do not need to be named in the contractor's proposal. The contractor is required to propose forty-nine (49) core staff (from the titles below) to fill out the base staff of seventy (70). The quantity of each title and their organizational placement will be left up to the contractor based upon its experience and expertise. These forty-nine staff must be shown in the Staffing and Organization Plan submitted with the proposal. This will assist the Department in ensuring that the contractor has a comprehensive understanding of the scope of this RFP.

Upon receiving a transmittal from the Department requesting certain titles and quantities the contractor must provide resumes within 30 calendar days that at a minimum meet the qualifications for the title. Core staff will be hired for the duration of the project and once assigned to the project will be governed by the requirements defined in this RFP relating to key staff.

R-MMIS Core Staffing Requirements

Core Staff	General Responsibility	Qualifications / Experience
Development Manager	• Oversee the analysis, design, and programming of complex project • Assist lower level technical staff in the execution of highly technical activities • Coordinating activities on multiple staff projects, designing testing plans, assuring quality control, and providing technical leadership to a work unit.	• At least eight (8) years experience in managing and overseeing large scaled projects comprised of sub-projects and distinct deliverables; • At least five (5) years experience coordinating and delegating the assignments and tasks for a project staff numbering over 20; • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.

Core Staff	General Responsibility	Qualifications / Experience
Senior Developer	• Research and develop estimates and write design specifications for proposed system modifications, as well as code and test complex computer programs. • Service-oriented Design and Analysis • Workflow design, development and implementation	• At least six (6) years experience with writing application software preferably in the software language being proposed • At least five (5) years experience in data access, data structures, data manipulation and database programming in the proposed RDMS • At least five (5) years experience in testing and implementation, technical and user documentation, and software conversions; • At least three (3) years experience in the proposed hardware/ software environment • Available to assist and/or lead in the design of program specifications and the implementation of software solutions. • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.
Developer	• Coding and debugging applications in the proposed software languages • Unit test computer programs, interface with co-workers and other project personnel, • Prepare test JCL, • Prepare unit test cases • Business Rules Implementation • Assure computer programs are in compliance with specifications through careful review of test results.	• At least two(2) years experience with writing application software, preferably in the software language being proposed • At least two (2) years experience in data access, data structures, data manipulation and database programming in the proposed RDMS • At least two (2) years experience in testing and implementation, technical and user documentation, and software conversions; • Bachelor's degree in Information Technology or related field is required;

Core Staff	General Responsibility	Qualifications / Experience
Pharmacy Educator	Prescriber, provider and enrollee education initiatives for the PBM contract.	• NYS licensed RPh with two (2) years experience • Experience in conducting educational sessions to providers is preferred • Able to travel
Clinical Pharmacist	Provide clinical support to the NY Clinical Program Manager and the Department.	• NYS licensed Pharm D with two (2) years experience • Experience in drug formulary, UM programs, benefit design strategies, and other drug therapy related products and services • Coordinate calls and requests for information regarding drug therapy, formulary and clinical program related issues
Pharmacy Researcher/ Statistician	Research/ Data Collection & Program Analysis. Provide statistical consultation to clinicians and conduct statistical analyses to evaluate the clinical and economic effectiveness of State clinical programs.	• MS or PhD in statistics. • Three or more years of prior research experience in the field of pharmacy statistics or other public health programs.
Pharmacist	Provide clinical support to the NY Clinical Program Director and the Department; Provide analytical support to the NY PBM Strategic Planner and the Department.	• NYS licensed Pharmacist • Two or more years experience in related duties
NY Rebate Attorney	Develop legal agreements, rebate contracts. Provide guidance to the State on legal actions related to rebate activities.	• NYS licensed attorney • Three or more years experience with pharmacy rebate related issues.
NY Rebate Analyst	Assists Rebate Account Manager with analyzing rebate program and ensuring that program goals are met	• Bachelor's degree in business, math or financing with experience in data analysis. • Two or more years experience in rebate administration.
NY Rebate Pharmacist	Assist Rebate Account Manager with oversight of all day to day rebate operations.	• NYS licensed RPh or Pharmacist. • Three or more years experience with rebate operations. • Demonstrates strong analytical, organizational and problem solving abilities.

Core Staff	General Responsibility	Qualifications / Experience
NY Rebate Negotiator	Conduct NY supplemental rebate negotiations	• Bachelor's degree in business, financing or related field. MBA or related higher level degree is preferred. • Demonstrated experience in conducting prescription drug rebate negotiations with drug manufacturers and labelers; experience in leading rebate negotiations is preferred. • Strong analytical, organizational and problem solving abilities
Call Center Lead Pharmacist	Responsible for clinical operations at Call Center	• NYS licensed Pharm D

For Supplemental staff: Supplemental staffs are staff that the Department, from time-to-time, may ask the contractor to provide over the life of the contract. Rates for these staff will be governed by section V.I.3.1 Operations Phase Payments. The contractor must bid an hourly rate for these types of staff. Upon receipt of a transmittal from the Department requesting certain titles and quantities, the contractor must provide staff that, at a minimum, meet the qualifications for the title.

Supplemental Staff	General Responsibility	Qualifications / Experience
Turnover Coordinator	Responsible for all activity associated with the turnover of the R-MMIS to the Department or a subsequent contractor	• Minimum 8 years experience in managing and overseeing large scaled projects
Development Manager	Analyze, design, and program complex projects and assist lower level technical staff. This will include coordinating activities on multiple staff projects, designing testing plans, assuring quality control, and providing technical leadership to project teams.	• Minimum 8 years experience in managing and overseeing large scaled projects comprised of sub-projects and distinct deliverables; • Minimum six (6) years experience coordinating and delegating the assignments for the a staff numbering over 20; • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.
Senior Business Analyst	• Creates logical and innovative solutions to complex problems; • Presents proposals to stakeholders • Works closely with stakeholders examining existing business models and flows of data and designs an appropriate improved IT solution. • Works closely with developers and a variety of stakeholders to ensure technical compatibility and stakeholder satisfaction	• Minimum of six (6) years experience with the analysis and redesign of business processes • Minimum of five (5) years of experience in workflow analysis with the proposed COTS product • Minimum of four (4) years leading a group of staff numbering over 5 in the development of program specifications and the implementation of software solutions. • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.
Business Analyst	• Designs new IT solutions to improve business efficiency and productivity • Translates stakeholder requirements into design documents	• Minimum of three (3) years experience with analysis and redesign of business processes • Minimum of two (2) years of experience in workflow analysis with the proposed COTS product • Bachelor's degree in Information Technology or related field is required;

Supplemental Staff	General Responsibility	Qualifications / Experience
Senior Developer	• Research and develop estimates and write design specifications for proposed system modifications, as well as code and test complex computer programs. • Service-oriented Design and Analysis • Workflow design, development and implementation	• Minimum of six (6) years experience with writing application software in the proposed hardware and software environment • Minimum of five (5) years of experience in data analysis, data access, data structures, data manipulation, databases, programming, testing, software conversions; • Minimum of four (4) years leading a group of staff numbering over 5 in the design of program specifications and the implementation of software solutions. • Bachelor's degree in Information Technology or related field is required; MBA or related higher level degree is preferred.
Developer	• Coding and debugging applications in the proposed software languages • Unit test computer programs, interface with co-workers and other project personnel, • Prepare test JCL, • Prepare unit test cases • Business Rules Implementation • Assure computer programs are in compliance with specifications through careful review of test results.	• Minimum of 2 years experience with writing application software, data analysis, data access, data structures, data manipulation, databases, design, programming, testing and implementation, technical and user documentation, software conversions; in the proposed hardware and software environment • Bachelor's degree in Information Technology or related field is required

Supplemental Staff	General Responsibility	Qualifications / Experience
Database Specialist	• Design and document database architecture • Build database scheme, tables, procedures and permissions • Set up data sharing and disk partitioning • Analyze and sustain capacity and performance requirements • Monitor systems and platforms for availability. • Oversee backup, clustering, mirroring, replication and failover • Restore and recover corrupted databases • Install and test upgrades and patches • Implement security and encryption	• Minimum four (4) years experience as a database administrator in a large IT environment preferably in a an MMIS or large-scale integrated healthcare claims processing system • Minimum of eight (8) years experience in the contractor's proposed database that is beyond the requirements of a developer or senior developer • Minimum of three (3) years experience in the installation and operation of a database in an MMIS or large-scale integrated healthcare claims processing system • Minimum two (2) years experience implementing database security and encryption • Bachelor's degree in Information Technology or related field is required;
Network Specialist	• Maintains and supports computer communication networks within and or between organizations • Monitors network usage and performance • Plans and implements future IT projects	• Minimum four (4) years experience as a network specialist in a large IT environment • Minimum of four (4) years experience in the contractor's proposed network architecture • Minimum two (2) years experience implementing network security and encryption • Bachelor's degree in Information Technology or related field is required; •

Supplemental Staff	General Responsibility	Qualifications / Experience
Trainer	• Assess relevant training needs for staff individuals and providers • Design training courses and programs necessary to meet training needs • Plan and personally deliver training courses where necessary • Uses various adult learning methods	• Requires a 4 year degree • Three (3) years relevant training experience, or equivalent • Three (3) years experience in delivering training
Technical Writer	• Communicate technical messages to specific stakeholders at levels they can fully understand • Working with analysts, developers and managers to clarify technical issues and obtain information to produce user manuals; • Writing, editing and presenting information in clear and simple manner in an agreed upon format, making sure the information is organized effectively;	• Requires a 4 year degree • At least three (3) years relevant experience • At least three (3) years experience in developing stakeholder material

For each of the Key Staff being proposed the contractor must submit a resume and the Qualifications and Experience Chart below.

Qualifications and Experience Chart

Title	Proposed Candidate's Name	Department's Qualification/Experience Requirement	Years and percentage of time when Qualification/Experience was obtained	Company in which Qualification/Experience was obtained	Description of Tasks that were performed

The following example is provided for illustration only.

Title	Proposed Candidate's Name	Department's Qualification/Experience Requirement	Years and percentage of time when Qualification/Experience was obtained	Company in which Qualification/Experience was obtained	Description of Tasks that were performed
Account Executive	Mr. John Jones	At least five (5) years previous account executive experience on a large-scale Information Technology project.	1999-2003 – 50% 2003- Present - 100%	XYZ Company ABC Company	Was the Account Executive for the YZK Project which had a budget of $20M and a staff size of 95 Reported to the Vice President of Northeastern Operations Responsibilities included 1. xxx 2. xxx 3. xxx Account Executive for etc.
		At least two (2) years previous experience with an			

Title	Proposed Candidate's Name	Department's Qualification/Experience Requirement	Years and percentage of time when Qualification/Experience was obtained	Company in which Qualification/Experience was obtained	Description of Tasks that were performed
		MMIS or with major operations-related components of an MMIS or other large healthcare systems and an ongoing relationship management with a large client.			
		At least three (3) years implementing quality improvement and customer satisfaction monitoring programs.			
		Demonstrated ability to effectively communicate with customer's senior management; and			
		Demonstrated strong analytical, organizational and problem solving abilities			
		At least five (5) years previous account executive experience on a large-scale Information Technology project.			

Fill in columns 4, 5 and 6 (column 4: years and percentage of time when qualification/experience was obtained; column 5: company in which qualification/experience was obtained; and column 6: description of tasks that were performed) for every entry in column 3 (Department's qualification/experience requirement). ***The contractor must be specific when delineating tasks in column 6. Simply restating the statements in column 3 will be considered non-responsive***

ATTACHMENT Q

New York State Department of Health
M/WBE Procurement Forms

The following forms are required to maintain maximum participation in M/WBE procurement and contracting:

1. Bidders Proposed M/WBE Utilization Form
2. Minority Owned Business Enterprise Information
3. Women Owned Business Enterprise Information
4. M/WBE Utilization Plan

5 M/WBE Letter of Intent to Participate

6. M/WBE Staffing Plan

New York State Department of Health

BIDDERS PROPOSED M/WBE UTILIZATION PLAN

Bidder Name:	
RFP Title:	**RFP Number**

Description of Plan to Meet M/WBE Goals

PROJECTED M/WBE USAGE

	%	Amount
1. Total Dollar Value of Proposal Bid	**100**	**$**
2. MBE Goal Applied to the Contract		**$**
3. WBE Goal Applied to the Contract		**$**
4. M/WBE Combined Totals		**$**

New York State Department of Health

MINORITY OWNED BUSINESS ENTERPRISE (MBE) INFORMATION

In order to achieve the MBE Goals, bidder expects to subcontract with New York State certified MINORITY-OWNED entities as follows:

MBE Firm (Exactly as Registered)	Description of Work (Products/Services) [MBE]	Projected MBE Dollar Amount
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$_____**
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$_____**
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$_____**

New York State Department of Health

WOMEN OWNED BUSINESS ENTERPRISE (WBE) INFORMATION

In order to achieve the WBE Goals, bidder expects to subcontract with New York State certified WOMEN-OWNED entities as follows:

WBE Firm (Exactly as Registered)	Description of Work (Products/Services) [WBE]	Projected WBE Dollar Amount
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$_____**
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$_____**
Name **Address** **City, State, ZIP** **Employer I.D.** **Telephone Number** **( ) -**		**$_____**

New York State Department of Health
M/WBE UTILIZATION PLAN

Agency Contract:_____ Telephone:_____
Contract Number:_____ Dollar Value:_____
Date Bid:_____ Date Let:_____ Completion Date:_____

Contract Awardee/Recipient:_____
Name
_____
Address
_____
Telephone
Description of Contract/Project Location:_____

_____

_____
Subcontractors Purchase with Majority Vendors:

Participation Goals Anticipated:_____ % MBE _____% WBE
Participation Goals Achieved: _____ % MBE _____% WBE

Subcontractors/Suppliers:

Firm Name and City	Description of Work	Dollar Value	Date of Subcontract	Identify if MBE or WBE or NYS Certified

Contractor's Agreement: My firm proposes to use the MBEs listed on this form			
Prepared By: (Signature of Contractor)	Print Contractor's Name:	Telephone #:	Date:
Grant Recipient Affirmative Action Officer Signature (If applicable):			

FOR OFFICE USE ONLY	
Reviewed: By:	Date:
M/WBE Firms Certified:_____	Not Certified:_____
CBO:_____	MCBO:_____

New York State Department of Health

MWBE ONLY

MWBE SUBCONTRACTORS AND SUPPLIERS
LETTER OF INTENT TO PARTICIPATE

To: _____ Federal ID Number: _____
(Name of Contractor)

Proposal/ Contract Number: _____

Contract Scope of Work: _____

_____

The undersigned intends to perform services or provide material, supplies or equipment as:_____

_____

Name of MWBE: _____

Address: _____

Federal ID Number: _____

Telephone Number: _____

Designation:

☐ MBE - Subcontractor

☐ WBE - Subcontractor

☐ MBE - Supplier

☐ WBE - Supplier

Joint venture with:

Name: _____

Address: _____

_____

Fed ID Number: _____

MBE ☐

WBE ☐

Are you New York State Certified MWBE? _____Yes _____No

The undersigned is prepared to perform the following work or services or supply the following materials, supplies or equipment in connection with the above proposal/contract. (Specify in detail the particular items of work or services to be performed or the materials to be supplied): _____

_____

_____

at the following price: $ _____

The contractor proposes, and the undersigned agrees to, the following beginning and completion dates for such work.

Date Proposal/ Contract to be started: _____

Date Proposal/ Contract to be Completed: _____

Date Supplies ordered: _____ Delivery Date: _____

The above work will not further subcontracted without the express written permission of the contractor and notification of the Office. The undersigned will enter into a formal agreement for the above work with the contractor ONLY upon the Contractor's execution of a contract with the Office.

_____ _____

Date Signature of M/WBE Contractor

_____

Printed/Typed Name of M/WBE Contractor

INSTRUCTIONS FOR M/WBE SUBCONTRACTORS AND SUPPLIERS LETTER OF INTENT TO PARTICIPATE

This form is to be submitted with bid attached to the Subcontractor's Information Form in a sealed envelope for each certified Minority or Women-Owned Business enterprise the Bidder/Awardee/Contractor proposes to utilize as subcontractors, service providers or suppliers.

If the MBE or WBE proposed for portion of this proposal/contract is part of a joint or other temporarily-formed business entity of independent business entities, the name and address of the joint venture or temporarily-formed business should be indicated.

New York State Department of Health
M/WBE STAFFING PLAN

Check applicable categories: ☐ **Project Staff** ☐ **Consultants** ☐ **Subcontractors**

Contractor Name_____

Address

_____

_____

	Total	Male	Female	Black	Hispanic	Asian/ Pacific Islander	Other
STAFF							
Administrators							
Managers/Supervisors							
Professionals							
Technicians							
Clerical							
Craft/Maintenance							
Operatives							
Laborers							
Public Assistance Recipients							
TOTAL							

_____

(Name and Title)

_____

Date

[TO BE COMPLETED ON OFFEROR'S LETTERHEAD]

Mr. Joseph Zeccolo
New York State Department of Health
Corning Tower, Room 2019
Albany, NY 12237

[**Insert Current Date]**
Re: NYS Department of Health (Department)
Replacement Medicaid Management Information System (R-MMIS) Fiscal Agent Services Project

Dear Mr. Zeccolo:

[Insert Offeror's Name] submits this firm and binding offer to the Department in response to the above-referenced RFP and agrees as follows:

1. A statement that the offeror has the necessary qualifications and experience delineated in Section B.2 of this section of the RFP;

2. A statement that the primary facility will be located within ten (10) miles of the New York State Capitol building in Albany, New York and all other facilities will be located within the continental United States;

3. Offeror provides the following statement which describes the legal structure of the entity submitting the proposal _____ **[Insert Offeror's Response];**

4. Offeror accepts the contract terms and conditions contained in this RFP, including any exhibits and attachments;

5. Offeror acknowledges receipt of all Department amendments to this RFP, as may be amended;

6. Offeror provides a statement confirming that the offeror is either registered to do business in New York State, or if formed or incorporated in another jurisdiction than New York State, can provide a Certificate of Good Standing from the applicable jurisdiction or provide an explanation, subject to the sole satisfaction of the Department, if a Certificate of Good Standing is not available _____ **[Insert Offeror's Response];**

7. Offeror (i) does not qualify its proposal, or include any exceptions from the RFP and (ii) acknowledges that should any alternate proposals or extraneous terms be submitted with the proposal, such alternate proposals and extraneous terms will not be evaluated by the Department;

8. Offeror agrees that the proposal will remain valid for a minimum of 365 calendar days from the closing date for submission of proposals;

9. Offeror agrees that it has the sole responsibility for obtaining any third party financing which may be necessary for the offeror to submit a proposal, and further that the offeror understands and agrees that should an award be made, the State of New York and the Department of Health will in no manner underwrite, act as a signatory or co-signatory or in any manner guarantee participation in the securing of the offeror's financing;

10. Offeror (and/or any subcontractor(s)) provides a statement which complies with the four conflict of interest requirements set forth in RFP Section IV.B.8., Conflict of Interest. Where any potential or actual conflict is disclosed, a description shall also be included as to how a potential or actual conflict and/or disclosure of confidential information relating to the contract will be avoided. If there is no conflict of interest a statement so indicating should be included;

11. Offeror is/is not **[indicate one]** providing an Appendix to this letter identifying use of any subcontractor(s). If a proposal is submitted which proposes to utilize the services of a subcontractor(s), the offeror must provide, in an Appendix to this Transmittal Letter, one subcontractor summary for each listed subcontractor's summary document and certify that the information provided is complete and accurate.

The summary document for each listed subcontractor should contain the following information:

a. Complete name of the subcontractor;
b. Complete address of the subcontractor;
c. Type of work the subcontractor will be performing;
d. Percentage of work the subcontractor will be providing;
e. Evidence that the subcontractor is (i) either registered to do business in New York State, or if formed or incorporated in another jurisdiction than New York State, can provide a Certificate of Good Standing from the applicable jurisdiction or provide an explanation, subject to the sole satisfaction of the Department, if a Certificate of Good Standing is not available.
f. A general description of the scope of work to be performed by the subcontractor; and
g. The subcontractor's assertion that it does not discriminate in its employment practices with regards to race, color, religion, age (except as provided by law) sex, marital status, political affiliation, national origin, or handicap; and,

The undersigned individual affirms and represents that he/she has the legal authority and capacity to sign and submit this offer on behalf of **[Insert Offeror's Name]** as well as to execute a contract with the Department.

_____
Signature

_____
Print Name

Insert: [Offeror's Full Name]

[Offeror's Mailing Address]

[Title of Signatory]

[E-mail of Signatory]

[Telephone Number of Signatory]

[Fax Number of Signatory]

[Name of Proposal Contact]
(if different from Signatory)

[Mailing Address for Proposal Contact]

[Title of Proposal Contact]

[E-mail of Proposal Contact]

[Telephone Number of Proposal Contact]

[Fax Number of Proposal Contact]

ATTACHMENT S

Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in section IV.E Administrative Requirements Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

☐ An on-line Vendor Responsibility Questionnaire has been updated or created at OSC's website: https://portal.osc.state.ny.us within the last six months.

☐ A hard copy Vendor Responsibility Questionnaire is included with this proposal/bid and is dated within the last six months.

☐ A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

ATTACHMENT T

Appendix G

NOTICES

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

(a) via certified or registered United States mail, return receipt requested;
(b) by facsimile transmission;
(c) by personal delivery;
(d) by expedited delivery service; or
(e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

State of New York Department of Health
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Computer Sciences Corporation
Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this AGREEMENT by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this AGREEMENT. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.